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Parrots as therapy for psychiatric patients

Camilla Haw

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the columns

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Changes to training in academic medicine

Changes to training in academic medicine might cause problems for trainees who are interested in pursuing a career in academic psychiatry. The new system comprises academic clinical fellowships and clinical lectureships. During an academic clinical fellowship trainees will be expected to secure an externally funded training fellowship in research or medical education. After the attainment of a higher degree, trainees might enter the clinical lecturer grade, which will offer opportunities for postdoctoral level research or career progression in medical education.

My concerns are related to the stages at which recruitment will take place. The Modernising Medical Careers website states that the next allocation of academic clinical fellowships will be for appointment to posts at the ST1 level, to commence in August 2007 (<http://www.mmc.nhs.uk>). A recent article stated that until these cohorts emerge from training there will be interim arrangements to fill 'new' clinical lectureships (Dimitri & Stephenson, 2006). However recent advertisements for new clinical lecturer posts have stated that candidates should already have national training numbers and an MD/PhD. This does not appear to be an interim arrangement but rather the introduction of the new model.

Where does this leave a current trainee who (under the old system) hoped to pursue a higher research degree in a clinical lecturer position, who is now definitely not eligible for a new clinical lecturer post and is at too high a training stage to apply for an academic clinical fellowship at ST1 level?

A Department of Health publication (2006) is helpful although vague, stating that applications for academic clinical fellowships will be invited from senior house officers or specialist registrars, depending on the grade of trainee the programme can accommodate. Will old style clinical lectureships continue to exist and be advertised as such until the new system is underway? Will all academic clinical fellowships in August be at the ST1 level? It would be useful to have clarity on

the availability of such fellowships in psychiatry at the ST4 level.

DEPARTMENT OF HEALTH (2006) *New Academic Training Pathways for Medical and Dental Graduates*. Department of Health. http://www.mmc.nhs.uk/download_files/A-pocket-guide.pdf

DIMITRI, P. & STEPHENSON, T. (2006) New careers in academic medicine. *BMJ Career Focus*, **333**, 138.

Arun Chopra Senior House Officer in Psychotherapy, Nottinghamshire Healthcare NHS Trust, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA, email: arun2111@hotmail.com

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Prejudice within

Recently during one of my on calls I had to ring the emergency medical number because a young patient on clozapine suddenly became hypotensive, hypoxic and unresponsive. The attitude of my medical colleagues who came to attend the patient left me feeling perturbed and belittled. I have had similar experiences while covering the A&E department and was often asked how we managed to engage patients with psychosis and obtain information from them. I was never sure if this was praise for me or put down for my patients.

Antipathy towards psychiatry among medical professionals is well known. Silence and resignation from the psychiatric community have done nothing to decrease the stigma or the discrimination and prejudice. Psychiatry also faces stigma from within. I say this because I had difficulty coming to terms with my own mental illness.

My symptoms of depression started in early 2004, but I attributed them to a number of causes – house move, new job, bad week, a stressful day and even bad weather. I was diagnosed with depression a few months later and prescribed antidepressants. I was not willing to accept that I had depression. Comments that I had heard about others like 'it doesn't take her long to flip' and 'it's not depression, it's personality disorder' echoed through my mind. I stopped taking my antidepressants and even asked a colleague if she thought I had personality disorder.

Things came to a head and I had to take time off work. A close friend, on finding out that I had depression remarked, 'I thought you were a strong person.' I was ashamed and did not want people to know about my illness. Then came the anger. I was angry because I did not have a scar or a deranged report to show for my illness. Why was psychiatry still in the dark ages? I had failed me. My fraternity had failed me. With time and help I improved and then came the guilt. I realised that I had no right to lecture people about stigma and recognition of mental illness. I was as bad as them – no I was even worse. I had doubt about my suitability as a trainee psychiatrist, but with time came acceptance. I realised how lucky I was to get timely help and thought of people who for months and sometimes years do not get any validation of their suffering.

Now, a year later, I am comfortable with my illness. I hope to come off my antidepressant in the near future. I would not wish it on anyone but it has taught me a lot. I have grown as a person. I hope I don't have a relapse but if I do, I am confident that I will overcome it with the help of my family, friends, my doctor and last but certainly not the least my will power, because I am a strong person. Depression has made me strong.

Acknowledging the existence of prejudice is the first step towards overcoming it. Reticence is the next hurdle.

Ayesha S. Ahmed Senior House Officer, Bradgate Mental Health Unit, Glenfield General Hospital, Leicester, email: ayeshasahmed25@yahoo.co.uk

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Health shop treatments for depression

Reed & Trigwell (*Psychiatric Bulletin*, October 2006, **30**, 365–368) raise important issues about treatments recommended by health shops for symptoms of depression. The use of herbal medication, as alternative or complementary medicine, is equally relevant in low- and middle-income countries. The practice of Ayurvedic medicine and the use of herbal remedies are deeply rooted in Eastern cultures. It is common to see patients using herbal medications along-



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side Western medicine. This certainly does not differ in patients with psychiatric illnesses. Herbal remedies are sought for symptoms of depression, phobias and other psychiatric disorders. Advertisements that offer a herbal remedy for any sexual problem are abundant in the newspapers. Memory boosters are also much sought after.

Most people obtain these herbal remedies from small shops in villages and towns. Some obtain them from the village 'medicine man'. Herbal remedies are also sold in larger shops with minimum regard to the legislation in place. A survey carried out in the out-patient psychiatry clinic at the North Colombo teaching hospital found that 25.5% of psychiatric patients had used herbal medication at some point. A longer duration of psychiatric illness was related to the greater use of herbal medication. A majority of patients who used herbal remedies were not aware that there can be harmful interactions with other medications. This can have disastrous consequences when herbal medication is used in a complementary role.

Use of herbal remedies as alternative medication may also contribute to a delay in seeking treatment. Patients may prefer to use herbal remedies, which are less stigmatising than psychotropic medication. This may result in a delay in treatment which may have negative effects on prognosis.

***K. A. L. A. Kuruppuarachchi** Professor of Psychiatry, University of Kelaniya, Faculty of Medicine, Ragama, Sri Lanka, email: lalithkuruppa@lycos.com, **L. T. Wijeratne** Lecturer in Psychiatry, University of Kelaniya, Faculty of Medicine, Ragama, Sri Lanka

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Smoking has no place in psychiatric hospitals

O'Gara & McIvor (*Psychiatric Bulletin*, July 2006, **30**, 241–242) address the issue of smoke-free legislation and mental health units and endorse the view that smoking cessation should be encouraged in psychiatric hospital settings. The concern remains that some psychiatric units will be exempt from the smoking ban. This can only further alienate psychiatry from medicine and increase stigma against psychiatric patients and services. Admission of smokers with mental illness to smoke-free psychiatric units may lead to behavioural deterioration, but some evidence refutes this argument. The implementation of a smoking ban, establishing a smoke-free psychiatric service and abolishing tobacco products, created minor management difficulties on a locked psychiatric unit (Ryabik *et al*, 1994). The effects of prohibiting cigarette smoking on the behaviour of patients on a 25-bed psychiatric in-patient unit were assessed immediately after implementation

of a smoking ban and 2 years later. No behavioural disruptions were observed after the ban, and discharges against medical advice did not increase immediately after the restriction on smoking or 2 years later (Velasco *et al*, 1996).

Signs and symptoms of nicotine withdrawal and alterations in psychopathology were evaluated among psychiatric patients with acute illness admitted to a hospital with a smoking ban (Smith *et al*, 1999). Despite patients' reports of feeling distressed and of experiencing nicotine withdrawal symptoms, abrupt cessation of smoking did not affect psychopathological symptoms during admission (Smith *et al*, 1999).

The above evidence shows that smoking has no place in psychiatric hospitals, and that a smoking ban can only improve the well-being of patients, staff and visitors.

RYABIK, B. M., LIPPMAN, S. B. & MOUNT, R. (1994) Implementation of a smoking ban on a locked psychiatric unit. *General Hospital Psychiatry*, **16**, 200–204.

SMITH, C. M., PRISTACH, C. A. & CARTAGENA, M. (1999) Obligation cessation of smoking by psychiatric inpatients. *Psychiatric Services*, **50**, 91–94.

VELASCO, J., EELLS, T. D., ANDERSON, R., *et al* (1996) A two year follow up on the effects of smoking ban in an inpatient psychiatric service. *Psychiatric Services*, **47**, 869–871.

Faouzi Dib Alam Specialist Registrar, Royal Preston Hospital, Preston PR2 9HT, email: docftalam@aol.com

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Access to articles for hospital journal clubs

Evidence-based critical appraisal of articles in journal clubs forms an essential part of psychiatric training. The College emphasises the importance of journal clubs as part of the postgraduate teaching programme (Royal College of Psychiatrists, 2003) and a journal club presentation will be one of the workplace-based assessments undertaken by trainees to demonstrate competencies in the new curriculum (Royal College of Psychiatrists, 2006).

However, since the loss of the National Health Service licence regarding copyright privilege it has become increasingly difficult to organise journal clubs. Previously, once a paper was identified, it could be photocopied and sent out in advance or handed out at the session. Now each individual attending must be sent details of the paper, and they must download and print their own copy. This involves excessive time and also increases cost (as printing is more expensive than photocopying). It also means that many trainees fail to have a copy of the paper for discussion, either because of lack of computer access, lack of time or perhaps through laziness. This certainly does not

facilitate good-quality teaching and learning.

We wonder if other teaching programmes have had similar experiences and if they have found a more convenient way to organise access to journal articles. One way forward would be for the College to authorise the reproduction of its own publications for members organising journal clubs, allowing photocopying of articles from several peer-reviewed, hopefully high-quality journals.

ROYAL COLLEGE OF PSYCHIATRISTS (2003) *Basic Specialist Training Handbook*. Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/PDF/bst.pdf>

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Curriculum Pilot Pack*. Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/training/curriculum/pilotpack.aspx>

Jessica Beard Specialist Registrar, Northern Deanery Higher Specialist Training Scheme in General and Old Age Psychiatry, ***Peter L. Cornwall** Consultant Psychiatrist, Tees, Esk and Wear Valleys NHS Trust, St Luke's Hospital, Middlesbrough TS4 3AF, email: lenny.cornwall@tey.northy.nhs.uk

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Parrots as therapy for psychiatric patients

I would agree with Pease & Brown (*Psychiatric Bulletin*, December 2006, **30**, 463) that parrots are probably not suitable for health centres, not because of confidentiality problems but because they can be noisy and it is unfair to keep them constantly caged. When parrots breach confidentiality it is with phrases they have heard repeatedly and with emotion. There are cases of parrots squawking lovers' names and leading to the break up of both human and parrot relationships (for example, the sad story of Ziggy in *Daily Telegraph*, 17 January 2006).

I have kept pet parrots for 20 years and can recommend them for the house bound, the lonely and patients with depression, especially middle-aged women suffering from the 'empty nest syndrome'. They can be extremely loyal and loving, providing companionship and better quality entertainment than television. They are highly intelligent, social animals, and African Greys can learn to use words in a meaningful way. They do, however, have complex needs and some species, such as cockatoos, should be avoided as they become neurotic if their emotional demands are not met. Amazons (the green ones) are a good bet. Their longevity can also be a problem (for example when elderly owners require nursing home care). It is important to purchase an English-bred bird, preferably one that has been hand-reared. I would advise prospective owners to contact The Parrot Society UK (<http://www.theparrotsocietyuk.org>) who produce a



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number of thoughtful publications on the care and needs of these birds.

Camilla Haw Consultant Psychiatrist, Isham House, St Andrew's Hospital, Billing Road, Northampton NN1 5DG, email: chaw@standrew.co.uk

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Forensic telepsychiatry

We read the article by Jones *et al* on setting up a telepsychiatry service (*Psychiatric Bulletin*, December 2006, **30**, 464–467) with interest and optimism, having developed the first forensic telepsychiatry service in Nottinghamshire in 2005 (Saleem & Stankard, 2006). To date, we have undertaken 30 forensic assessments, 4 of which have resulted in hospital admissions. Assessments were primarily undertaken using existing video-link facilities within local magistrates' courts and HM prisons. Our experiences support the opinion that this saves time, cost (Zollo *et al*, 1999) and improves access to psychiatric services (Zaylor *et al*, 2000).

However, although Jones *et al* describe the development of services, they do not state whether they have assessed patients themselves using videoconferencing facilities. If they have, it would be useful to establish links between telepsychiatric services within the UK, forensic or otherwise.

At the College's invitation, we are conducting a workshop on this subject in Prague, at the Annual Meeting of the Forensic Faculty in February 2007. We have also developed a forensic telepsychiatric steering group, with a research sub-committee, in Nottingham. We are coordinating several research projects which are exploring the use of teleconferencing facilities within forensic psychiatry. We would welcome any

additional views and opinions on expanding this work.

It is crucial for services across the UK to share experiences and promote practices. The promotion of telepsychiatry has the potential to change current practice positively. This is particularly important if we are to succeed in delivering timely, easily accessible and clinically sound psychiatric services, with the additional spotlight on cost-efficiency with respect to health service delivery.

SALEEM, Y. & STANKARD, P. (2006) I'm only at the end of a videolink. *BMJ Career Focus*, **333**, 223.

ZAYLOR, C., WHITTEN, P. & KINGSLEY, C. (2000) Telemedicine services to a county jail. *Journal of Telemedicine and Telecare*, **6**, 93–95.

ZOLLO, S., KIENZLE, M., LOEFFELHOLZ, P., *et al* (1999) Telemedicine to IOWA's correctional facilities: initial clinical experience and assessment of program costs. *Telemedicine Journal*, **5**, 291–301.

***Paul Stankard** Specialist Registrar in Forensic Psychiatry, Nottinghamshire Healthcare NHS Trust, Wells Road Centre, Nottingham NG3 3AA, email: pcstankard@doctors.org.uk, **Saleem Younus** Consultant Forensic Psychiatrist, Nottinghamshire Healthcare NHS Trust, Wells Road Centre, Nottingham NG3 3AA

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Mental healthcare for psychiatrists

We read the article by White *et al* (*Psychiatric Bulletin*, October 2006, **30**, 382–384) with great interest, as we have conducted a similar postal survey of 1640 general practitioners and psychiatrists in Devon and Cornwall regarding depression and stigma. We also achieved a high response rate (75%), indicating the importance of this issue to doctors. When we asked about sources of help respondents would turn to if they were

experiencing excessive stress, more reported that they would seek help from family and friends (95%) and from colleagues (65%). Our slightly different findings might be because we asked about 'stress' rather than 'mental illness', but the overall trends are similar.

The barriers to disclosing mental illness reported by White *et al* are supported by our findings. However, we found that barriers to seeking help very often included concerns about letting colleagues down and confidentiality, with concern about career progression cited by only 16% (although women were twice as concerned about this as men).

White *et al* found that 20% of psychiatrists admit to self-prescribing for mental illness, but in our study the rate was only 7%. The fact that our respondents were more willing to disclose stress to colleagues and reported less self-prescribing perhaps reflects a more open culture in Devon and Cornwall since the introduction of an effective occupational health service.

Overall, our study in the South-West confirms the findings of White *et al* in the West Midlands. Both studies address the poorly researched but important area of doctors' attitudes towards mental illness and we agree with the recommendations of White *et al*. There is still a long way to go in terms of educating doctors about looking after and improving their own mental health and in reducing stigma within the medical profession.

***Alison Lee** Specialist Registrar in Child and Adolescent Psychiatry, Torbay Hospital, South Devon Healthcare Trust, Torquay, TQ2 7BA, email: alisonjanelee@yahoo.com, **Elizabeth Adams** Specialist Registrar in Substance Misuse, Cornwall Partnership Trust, **Rupert White** Consultant Psychiatrist in Substance Misuse, Cornwall Partnership Trust

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the college

The Royal College of Psychiatrists' Winter Business Meeting 2007

The Winter Business Meeting was held at the Royal College of Psychiatrists on 23 January 2007. There were 27 members of the College present.

1. Minutes

The minutes of the Winter Business Meeting held at the Royal College of Psychiatrists on 24 January 2006 were approved as a correct record.

2. Obituary

The obituary list of members and associates who had died since the

Annual General Meeting in 2006 was received.

3. Election of Honorary Fellows

The following were elected to the Honorary Fellowship for 2007:

Lord Denis Victor Carter
(to be awarded posthumously)
Professor Anthony Ward Clare, FRCPsych
The Rt Hon The Baroness Hale
of Richmond, DBE, PC
Dr Sheila Mann, FRCPsych
Professor Bruce Singh,
MBBS, PhD, FRACP, FRANZCP.

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Annual elections – Honorary Officers

Notice to Members and Fellows

Fellows and Members of the College are reminded of their rights in connection with the forthcoming elections for the offices of Dean, Registrar and Treasurer.

All Honorary Officers are eligible for re-election.

The nominating meeting of the Central Executive Committee will be held on 20 April 2007 and the last date for receiving nominations will be 19 May 2007.

The relevant Bye-Laws and Regulations are printed below.



Bye-Laws Section XII. The Other Honorary Officers

1. The Central Executive Committee shall, in accordance with the Regulations, make its nominations for the offices of Dean, Registrar, Treasurer, and Librarian¹ at the first meeting after the name of the President for the next ensuing College year has become known. Written nominations² for the above Honorary Offices, accompanied in each case by the nominee's written consent to stand for election, may also be lodged with the Registrar at such time as may be prescribed by the Regulations, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Central Executive Committee.

2. The Dean, Registrar, Treasurer, and Librarian¹ shall be elected by the Members of the College, in each case in accordance with the procedure prescribed by the Regulations.

Regulations XII. Election of the Other Honorary Officers

1. The method of electing the Dean, Librarian,¹ Registrar, and Treasurer shall be the same as that for electing the President, save that nominations from Members of the College who are not members of the Central Executive Committee shall be lodged with the Registrar between the first day of June in any calendar year and the date which is four clear weeks after that meeting of the Central Executive Committee which is the first held after the name of the President for the next ensuing College year has become known. The Editor, the Deputy Registrars, the Associate Deans and the Vice-Presidents shall be appointed following advertisement and interview.

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Proposal for a special interest group in forensic psychotherapy

Procedure for establishing a special interest group:

1. Any member wishing to establish a special interest group shall write to the Registrar with relevant details.
2. The Registrar shall forward the application to the Central Executive Committee.
3. If the Central Executive Committee approves the principle of establishing such a special interest group then it will direct the Registrar to place a notice in

the *Bulletin*, or its equivalent, asking members of the College to write in support of such a group and expressing willingness to participate in its activities.

4. If at least 120 members reply to this notice within 4 months of publication, then the Central Executive Committee shall formally approve the establishment of the special interest group.

In accordance with this procedure, the Central Executive Committee has approved a proposal for the establishment of a special interest group in forensic psychotherapy.

Background to the proposal

Mentally disordered offenders are a group for whom therapeutic treatment often involves a complex approach, drawing on many areas of psychiatry. Psychotherapeutic treatment has to work at the interface of the criminal justice system and often takes place within secure settings. Most patients have complex problems often involving comorbid disorders such as mental illness, personality disorder and addictive disorders, as well as their violent and offending behaviour. Managing these patients can take its toll on staff and institutions. Applying psychotherapy to the treatment and management of this group is a developing field. For these reasons there is a recognised need to support forensic psychotherapy as a specific sub-speciality both of forensic psychiatry and medical psychotherapy.

Given planned changes according to Modernising Medical Careers, which will have a significant effect on dual CCT training, the National Strategy in Forensic Psychotherapy has been working with the College to ensure that the sub-speciality of forensic psychotherapy maintains and develops its presence. Although forensic psychotherapy is often described as a dual-interest specialty between the disciplines of forensic psychiatry and psychotherapy it also extends to other branches of psychiatry such as general psychiatry, addiction psychiatry, child and adolescent psychiatry and learning disability.

If we were able to form a special interest group in forensic psychotherapy we would aim to:

- share knowledge and work in the field to help develop the specialty
- bring together psychiatrists from allied specialties with an interest in the field
- contribute towards training and continuing professional development for psychiatrists
- support the discipline during changes in training and the implementation of

Modernising Medical Careers, and ensure that the field remains visible and supports interest across a wide College membership

- help support educational and training initiatives for psychiatrists working with particular patient groups, for example, people with personality disorder, learning disability and addictive disorders
- act in an advisory role and resource, if appropriate, for other College Faculties.

We would hope to establish an ongoing forum for psychiatrists, via regular meetings and events, to develop professional networking, research and educational opportunities in this field. We hope very much that you will be able to support this proposal.

Members are invited to write in support of this group and express willingness to participate in its activities. Interested members should write to the Registrar care of Miss Sue Duncan at the College. If 120 members reply to this notice within 4 months of publication, then the Central Executive Committee shall formally approve the establishment of this special interest group.

Professor Sue Bailey Registrar, Royal College of Psychiatrists

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Honorary Fellowships

Nominations for the College's Honorary Fellowship will be discussed at the October meeting of the Education Training and Standards Committee.

The regulations of the College state under Bye-Law Section V that 'Subject to the Regulations the College may elect as an Honorary Fellow any person, whether or not that person is a member of the medical profession, who either is eminent in psychiatry or in allied or connected sciences or disciplines or has rendered distinguished service to humanity in relation to the study, prevention or treatment of mental illness or to subjects allied thereto or connected therewith or has rendered notable service to the College or to the Association.'

Nomination forms are available from Miss K. Hillman, Department of Postgraduate Educational Services (email: khillman@rcpsych.ac.uk), to whom nominations for Honorary Fellowship should be sent by 30 June 2007. Such nominations must contain recommendations by no fewer than six Members of the College, and include full supporting documentation.

Robert Jackson Head of Postgraduate Educational Services, Royal College of Psychiatrists

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1. The Central Executive Committee agreed in October 2006 that there should no longer be an Honorary Librarian; the Bye-Laws and Regulations are currently being amended to reflect this.
2. Nomination forms may be obtained from Candace Gillies-Wright, email: cgillies-wright@rcpsych.ac.uk.