DOCTORS ACADEMY
BETTER EDUCATION. BETTER HEALTH.
ISSN 2052-1715

WJMER

World Journal of Medical Education and Research

An Official Publication of the Education and Research Division of Doctors Academy

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Introduction

The World Journal of Medical Education and Research (WJMER) (ISSN 2052-1715) is an online publication of the Doctors Academy Group of Educational Establishments. Published on a quarterly basis, the aim of the journal is to promote academia and research amongst members of the multi-disciplinary healthcare team including doctors, dentists, scientists, and students of these specialties from around the world. The principal objective of this journal is to encourage the aforementioned, from developing countries in particular, to publish their work. The journal intends to promote the healthy transfer of knowledge, opinions and expertise between those who have the benefit of cutting edge technology and those who need to innovate within their resource constraints. It is our hope that this will help to develop medical knowledge and to provide optimal clinical care in different settings. We envisage an incessant stream of information flowing along the channels that WJMER will create and that a surfeit of ideas will be gleaned from this process. We look forward to sharing these experiences with our readers in our editions. We are honoured to welcome you to WJMER.

Volume 8, Issue 1, 2014, World Journal of Medical Education and Research (WJMER). An Official Publication of the Education and Research Division of Doctors Academy Group of Educational Establishments.

Electronic version published at	:	Doctors Academy, PO Box 4283, Cardiff, CF14 8GN, United Kingdom
Print version printed and published at	:	Abbey Bookbinding and Print Co., Unit 3, Gabalfa Workshops, Clos Menter, Cardiff CF14 3AY
ISBN	:	*978-93-80573-45-8*
Designing and Setting	:	Doctors Academy, DA House, Judges Paradise, Kaimanam, Trivandrum, 695018, Kerala, India
Cover page design and graphics	:	Sreekanth S.S
Type Setting	:	Lakshmi Sreekanth
Contact	:	wjmer@doctorsacademy.org.uk

Editorial

Dr Halder N
MBChB, MRCpsych, MSc, CT Dip. PG Cert. Med Ed.,
neel.halder@alphahospitals.co.uk

I am delighted and honored to have been asked to be a guest editor of this special edition of the World Journal of Medical Education and Research. I am equally delighted that so many renowned Psychiatrists have contributed as authors in some excellent, informative, educational and thought-provoking papers. Professor Dinesh Bhugra (CBE) is a Professor of Mental Health and Diversity at the Institute of Psychiatry at King's College London, and prolific author/ editor of over 30 books. He was the past President of the Royal College of Psychiatrists and the current President Elect of the World Psychiatric Association, and we are grateful for his editorial piece, and other contributions to this journal. Other authors within this issue include Professor Sue Bailey, Professor of Child Mental Health and current President Royal College of Psychiatrists; Dr Jonathan Campion, Visiting Professor of Population Mental Health, and Director for Public Mental Health, South London and Maudsley NHS Foundation Trust; Professor Garden, Director of the Centre for Medical Education at Lancaster University; Professor Patricia Casey, previous and current editor of The Psychiatrist, and Advance in Psychiatric Treatment respectively; Jaswant Guzder, Associate Professor, Department of Psychiatry at McGill University, Montreal, Canada; and Professor Jacky Hayden (CBE), Dean of Postgraduate Medical Studies at the North Western Deanery.

Just as important however, are the contributions from others, especially those new to research and academic writing. I am a staunch advocate of introducing undergraduates and junior doctors to the rewards of research (indeed most of my best work are in collaboration with medical students), and would very much like an increasing pool of authors from this group. To that end, myself and a fellow colleague, Dr Hankir (who I'm indebted to for his valuable contribution in putting this journal together), are in the process of introducing a international award in Psychiatry, specifically aimed at undergraduates and junior doctors, inviting them to submit academic essays or audit and research pieces. Entrants will be judged and marked according to a set criterion, and the winners will receive certificates and a monetary prize, to be awarded annually from 2015, at the Annual International Academic and Research Conference by Doctors' Academy.

This journal therefore deliberately has a wide representation of contributors, from medical students, to trainees, consultants, and professors, and from roles that include being clinicians, medical educators, and full time academics.

I have also endeavored to include a diverse range of subjects with links to Psychiatry, to reflect the many interesting fields within this great specialty. So we explore themes covering transcultural psychiatry, psychopharmacology, medical education, forensic and learning disability, the media, stigma, and alternative therapies (music therapy), comparisons between mental and physical health, child and adolescent psychiatry, and how to set up an undergraduate psychiatry society.

Within my talks on encouraging others to publish, I make a point that all types of research and written pieces are valid, including opinion pieces, personal views, information pieces, interviews, audits, original research, qualitative and quantitative pieces, and literature reviews. I am pleased that all of these listed are represented within this journal issue.

With mental health being such a diverse field, the contents still fall short of representing all that the subject has to offer. Perhaps that will have to wait for another special edition.

Table of Contents

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Review Article
DAUIN 20140058

Putting Culture Back into Psychiatry

Prof Bhugra D FRCP, FRCPE, FRCPsych, FFPH, MPhil, PhD*; Mr Halder N MBChB, MRCPsych, MSc, CT Dip. Med Ed**; Mr Hankir A MBChB ***

Institution
**Professor of Mental Health and Cultural Diversity, King's College London, London SE5 8A*

***Consultant Psychiatrist Alpha hospital, Bury & Senior Honorary Lecturer, Manchester University, Manchester, England.*

****National Institute for Health Research Academic Clinical Fellow in Psychiatry, Manchester University. Harvard Medical School Global Clinical Scholars Research Training Program, Harvard Medical School, Boston, USA.*

WJMER, Vol 8: Issue 1, 2014

Abstract
Everyone has cultural values, norms and models ingrained and it is culture which teaches us about our cognitive schema and therefore our world view. Indeed, each and everyone one of us has our very own 'cultural identity' which is related to the cultural framework we carry within us and which differentiates one group from another and works at both individual and group levels. There is little doubt that, both in physical and mental illness, culture impacts upon presentation of symptoms or their 'idioms of distress'. Individuals who experience physical or mental distress are at the heart of the therapeutic interaction and surrounded by cultural and social milieus which must be taken into account if therapeutic engagement is to improve. In this article, we propose that the assessment of cultural identity and possible cultural explanations of an individual's illness should be explored routinely during history taking.

Key Words
Culture, Cultural psychiatry, 'Idioms of distress', Illness, Disease

Corresponding Author:
Prof Bhugra D, E-mail: Dinesh.bhugra@kcl.ac.uk

Introduction

Everyone has cultural values, norms and models ingrained and it is culture which teaches us about our cognitive schema and therefore our world view. In addition, society and cultures - through their policymakers - determine what health care is available, how that is developed and delivered and what resources are allocated for training. Demographic factors and social policies such as how much resource is allocated to prevention and infection control will also affect presentation of physical and mental illnesses. The implicit contract between psychiatrists and cultures and societies remains a complex one. Culture can shape how and what mental health symptoms are expressed (the so -called 'idioms of distress'), and the meanings given to these symptoms, and the interaction between the patient and health care system. This relationship between doctors and potential patients (all members of the society have the likelihood of becoming ill and becoming treatment-seeking patients) influences the context and the setting within which the therapeutic interactions take place and therapeutic alliance is moulded.

Model of culture and individual

Hahn[1] describes interrelated modes of socio-cultural creation of events of sickness and healing which include 'construction', 'production' and 'mediation'. These persistently accompany and complement the pathogenic and therapeutic modes recognised and redressed by Biomedicine. Symbols, beliefs, sentiments, rules, thoughts and cognitive schema as well as rules and standards for interaction are inherent parts of what is described and understood as culture. Hahn[1] goes on to propose that patterned interactions are what guide actions that are judged accordingly by what is defined as the society. These interactions affect conditions of health and suffering. Social definition of illness is the 'construction' whereas socio-cultural influences are mediators. According to Hahn[1] the least recognised and understood is the 'production' which is said to be constructed by socially organised interpersonal relationships. It is inevitable that these are strongly influenced by beliefs and relationships which themselves may be pathogenic.

Disease versus Illness

There is little doubt that, both in physical and mental illness, culture impacts upon presentation of symptoms. For example the concepts of vai-badi with the explanation that hot or cold food causes arthritic pain is very common in India and among Indian diaspora, as is 'Dhat' syndrome, where the 'harmful' leaking of semen can produce anxiety, depression and somatic symptoms[2, 3]. Similarly Punjabi women with depression and anxiety often complain of 'sinking heart'[4]. In psychiatric disorders culture can cause the illness and also perpetuate the symptoms. Cultural psychiatry has developed as a speciality over the last 70 years or so, with the term transcultural psychiatry being introduced by Eric Wittkower in Montreal in 1950. Eisenberg[5] and Kleinman[6] argue that in psychiatry, as in the rest of medicine a differentiation between disease and illness must be made. Disease is about pathology whereas illness develops when disease starts to affect others around the patient. Disease literally means dis-ease- a malfunctioning of a biological or psychological process and illness refers to both psychosocial experience and perceived disease. Illness thus includes perception of the problem and its affective, social and relational aspects. In terms of diagnosis and management of individuals presenting with symptoms (they have not yet become patients) doctors including psychiatrists are trained and interested in identifying and dealing with disease whereas patients by and large are interested in what disease does to their social functioning i.e. illness and its implications on their functioning and existence. Thus doctors deal with diagnosis and although often patients are interested in diagnosis they want to know why something has gone wrong and this shifts from symptoms to functioning. Thus often a major disjunction exists between the patient's views and explanatory models and those of the doctor. However the spread and dissonance between the patient and the doctor therefore leads to a tension. A shrewd and competent clinician, however, should be able to bridge this divide.

Of course diagnosis is important for a number of reasons i.e. in order to collect epidemiological data, to dedicate funding and to allocate resources accordingly. To make matters even more complex there is the society-defined concept of sickness which determines what is deviant and thus how much sick leave is granted and the rules for sick leave. For example, DSM-5 as a diagnostic and classificatory system[7] is a response to what goes on in the USA where local cultural values determine what constitutes pathology and what does not. In psychiatric practice some of the variation is biological, some social, some psychological and some statistical. As more and more countries are leaning towards commodification of health with increasing role for private providers it is important that this contract between medicine and society is renewed to ensure that patients get the best treatments they need and deserve. This social contract defined by Gough[8] is the cultural equivalent of discussions about what is normal and what is needed to deal with those who are described as abnormal. Although as Gough[8] had pointed out the original social contract was between the king and his subjects and this too was an implicit contract. The subjects promised obedience to the king, who in return offered them protection and good government. Both sides honour their side of the contract, otherwise the contract ends and with it the allegiance. As societies became more advanced and progressed the social contract began to be applied between the organisations and professions on the one side and the society on the other. Sometimes the professionals are given the freedom at times to determine what is needed for a healthy society, whereas at others stakeholders dictate to the profession what is needed and required. Recent challenges have meant that the psychiatric practice must adapt to various changes in societies across the globe and these include migration (both internal and external), increasing movement of people, changing patient expectations and advances play a major role in engagement between patients and clinicians.

Cultural psychiatry

Cultural Identity: All of us have a cultural identity which is related to the cultural framework we carry within us and which differentiates one group from another and works at both individual and group levels. Depending upon a number of factors an individual may give up some aspects of their cultural identity more readily than others. In addition it is worth remembering that individuals have multiple cultural identities which may relate to the culture they are born in, brought up in, study in, form relationships in and work in. For those who migrate from rural to urban areas or across countries, the process of acculturation becomes significant. Acculturation is a complex period of adjustment to the new culture through direct or indirect contact and may lead to the individuals giving up some parts of their cultural values or attitudes. Acculturation itself is not straight-forward and may be accompanied by stress.

Inevitably the impact of recently accelerating globalisation has led to massively increased movement of people as well as goods and resources. Migration can be both internal and external to a country. People migrate for a number of reasons such as educational, professional, economic and political or any combination thereof. Thus migrants are not a homogenous group and the

actual acts of migration will also affect individuals in different ways. Some individuals migrate singly whereas others move in groups; some will be primary migrants whereas others may follow the primary migrants. Some migration experiences and pathways will be more pleasant and manageable than others. For professionals such as doctors who migrate the actual process may lead to changes in their status and income with specific issues related to settling down in the new country. It is entirely possible that professionals who migrate for educational or economic advancement may well be highly motivated and prepared to adjust to the new circumstances even though their status may well change post-migration. On the other hand those who have been pushed out for political reasons may feel rejected by their own country and may not fit in neatly into the new country thus affecting their self-esteem and may feel alienated. This low self-esteem may lead to poorer adjustment or isolation in the new society. The process of migration has been rather arbitrarily divided into three stages: pre-migration, migration and post-migration, although these may not be entirely distinct stages and a large degree of overlap may exist[9, 10]. Pre-migration is the period when an individual having decided to migrate starts to prepare themselves and others around them about the potential migration and become aware of practicalities needed for this purpose. The stage of migration itself is seen as the actual physical process within which individuals relocate themselves but the mental processes may take longer in adjustment and acculturation. Post-migration phase is seen as the period of adjustment immediately after migration but may well last for years.

Stress of migration: There are a number of factors which are likely to influence post-migration adjustment and acculturation[11]. Eight theoretical constructs of loss, fatalism (embedded in a sense of control), expectations of and from the new society, negative life events and social support, along with loss of or clash of values and skills deficit have been identified[12, 13].

Gender and other factors such as education, social class, housing, employment and economic factors will also affect depression. Chandra[14] points out that the feminisation of migration is increasing with globalisation and women face a differential impact on their mental health as a result of migration. This is particularly true of doctors. Older adults, children and adolescents and lesbian, gay and transgender (LGBT) individuals are more prone to stress and developing depression following migration Other factors, especially perceived or real racism in the new society, may contribute to the genesis of depression by generating feelings of persecution and affecting aspiration and achievement.

Cultural Bereavement

In addition to the losses described above, it is worth remembering that loss may be accompanied by bereavement. Psychoanalytic explanations such as the loss of all that is important and left behind may lead to melancholia and depression and has been described as cultural bereavement[15, 16]. Stress of migration may also produce physical illnesses and clinicians must be aware of the interaction between physical and mental illness.

Culture conflict: Two members of the same culture especially in families may clash on values. Often it is between parents and children whereas the former may hold more traditional vues and attitudes and the latter may be more modern in their outlook thereby causing tension and actual conflict. This may result in intergenerational differences regarding engagement with mental health services[17]. Culture conflict describes tensions between individuals or within the same individual to integrate perceived irreconcilable values. Culture conflict has been shown to be related to deliberate self-harm among South Asian females in the UK[18] .

Culture Shock: Culture shock is the experience that some migrants may face after migration[19,20]. Culture shock is described as an emotional reaction with both negative and positive aspects to it. Culture shock affects an individual's functioning related to stress, alienation and helplessness and high levels of culture shock can lead to high levels of dysphoria[21].

Syndemics: Community understanding of the illness has to be seen in the context of political, social and economic factors. Syndemic refers to two or more epidemics i.e. a notable increase in the rate of specific diseases interacting synergistically, thus contributing to increased burden and co-morbidities[22]. In order to prevent a syndemic each disease must be tackled separately and together. Thus syndemic also refers to the consequences of the biological interactions among the health conditions present[23,24]. Social conditions such as poverty can lead to certain physical illnesses which can be linked with psychiatric disorders thus syndemics refer to co-existent afflictions of or within the same individuals as well as interacting diverse health conditions[25]. Therefore public health research must focus on syndemics but also more importantly how cultures affect illnesses so that any public health intervention can be more effective and efficacious.

Conclusions

Individuals who experience physical or mental distress are at the heart of the therapeutic interaction and surrounded by cultural and social milieus which must be taken into account if therapeutic engagement is to improve. The idioms of distress are influenced very strongly by cultural values and culturally influenced patterns of thinking and behaving. Patients cannot be seen in isolation from their cultures and it is critical that clinicians are aware of the cultural needs of their patients. We propose the assessment of cultural identity and possible cultural explanations of an individual's illness should be explored routinely during history taking.

Reference

1. Hahn RA: A socio-cultural model of illness and healing. In White L, Tursky B,Schwartz GE (eds): Placebo-theory, research and mechanisms. NY: Guilford Press.1988 pp 167-195
2. Bhopal R S : Bhye-Bhaddi-a food and health concept of Punjabi Asians. *Social Science and Medicine* 1986,23,687-688
3. Sumathipala A, Siribaddana SH, Bhugra D (March 2004). "Culture-bound syndromes: the story of dhat syndrome". *Br J Psychiatry* **184** (3): 200–9.
4. Krause I-B: Sinking heart: a Punjabi communication of distress. *Social Science and Medicine* 1989,29,563-575
5. Eisenberg L: Disease and illness: distinction between professional and popular ideas of sickness. Culture Medicine and psychiatry,1977,1,9-23
6. Kleinman A : Patients and healers in the context of culture, Berkley, CA: University of California Press 1980,pp 259-286
7. APA: Diagnostic and statistical manual of mental disorders DSM-5, Washington, DC, APP1,2013
8. Gough JW: The Social Contract. Oxford: Clarendon Press 1936
9. Bhugra D (2003): Migration and depression. *Acta Psychiatrica Scandinavica* Suppl. 418: 67-72.
10. Bhugra D, Ayonrinde O (2004): Depression in migrants and ethnic minorities. *Advances in Psychiatric Treatment* **10** (1): 13-17.
11. Berry J: Acculturation and Identity. In Bhugra D, Bhui K (eds): Textbook of Cultural Psychiatry. Cambridge: CUP. 2007, pp169-178
12. Furnham A and Bochner S *Culture Shock*. London: Routledge. 1986
13. Ruiz P, Maggi I C and Yusim A : The impact of acculturative stress on the mental health of migrants. In D Bhugra and S Gupta (eds) Migration and Mental Health. Cambridge: Cambridge University Press, 2011, pp 159-171.
14. Chandra P : Mental health issues related to migration in women. In D Bhugra and S Gupta (eds): *Migration and Mental Health*. Cambridge: Cambridge University Press, 2011 pp 209-219.
15. Eisenbruch M : The cultural bereavement interview: a new clinical research approach for refugees. *Psychiatric Clinics of North America* 1990, 13: 715-735.
16. Eisenbruch M (1991): From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science and Medicine* 1991 33: 673-680.
17. Aqeel Hashmi, Neel Halder, Yaseen Aslam Characteristics of first and second generation Asian mental health patients in Bolton, UK. *World Cultural Psychiatry Research Review* December 2011, Vol 6 (no 2): 95-101
18. Bhugra D : *Culture and Self-harm: Attempted Suicide in South Asians in London*. Maudsley Monographs 46. London: Psychology Press. 2004
19. Oberg K : Culture shock, adjustment to new culture environments. *Practical Anthropology* 1960 ,**7**: 177-182.
20. Bock P (ed): *Culture Shock*. NY: Knopf. 1981
21. Pantelidou S and Craig T K : Culture shock and social support: a survey of Green migrant students. *Social Psychiatry & Psychiatric Epidemiology* 2006, 41: 771-781.
22. Frumkin H(2002):Urban sprawl and public health. *Public Health Reports* 2002,117, 201-217
23. Alcabes P, Schoenbaum E and Klein R Correelates of the decline of CD4 lymphocytes among injection drug users infected with HIV *American Journal of Epidemiology* 1993, 137,989-1000
24. Rose A, Sinka K, Watson J,Mortimer J and Charlet A An estimate of the contribution of HIV infection to the recent rise in tuberculosis in England and Wales. *Thorax*, 2002, 57,442-445
25. Singer M, Clair S : Syndemics and public health: reconceptualising disease in bio-social context. *Medical Anthropology Quarterly*, 2003, 17(4):4

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Social Research
DAUIN 20140059

Media and the Coverage of Psychiatry

Dr Halder N, MBChB, MRCpsych, MSc, CT Dip. PG Cert. Med Ed.*; Dr Niazi A, MBBS, MRCPsych,DPM, DCP**; Dr Ahmed Z, MBBS, MRCPsych, DCP***; Dr Casey P, FRCPI, FRCPsych, MD****

Institution
**Consultant Psychiatrist and Senior Honorary Lecturer, Manchester University*

***Executive Clinical Director/ Consultant Psychiatrist, Louth Meath Mental Health Services., St Brigid's Hospital Ardee, Co Louth*

****Staff Grade CAMHS, St John's Hospital, Livingston, West Lothian*

*****Professor of Psychiatry, University College Dublin and Consultant Psychiatrist, Mater Misericordiae University Hospital*

WJMER, Vol 8: Issue 1, 2014

Abstract

Background and aim: Psychiatric issues have often been a focus for the media. Studies have differed in their findings about how the subject matter is portrayed in newspapers.
We compared tone and content of Irish print with the British, broadsheets and tabloids, and the coverage of physical and mental illness.
Methods: A selection of Irish and British broadsheet and tabloid newspapers were examined page by page by researchers for period of 6 months. Various parameters investigated including who the authors were, commenting on the tone, focus and topic of the articles. A comparison of the parameters between the two countries was made.
Results: The total numbers of newspapers studied in six months were 579. In comparison the tone of heading and article was neutral for both Irish and English articles. The tone was more negative (and sensationlist) on tabloids compared to dailies and Sunday newpapers. Predominantly for articles related to mental and physical illnesses tone of headline and article itself was neutral in daily and Sunday broadsheets and dramatic in daily tabloids.
Conclusions: To ensure accuracy of information and a more balanced article, we feel more articles should be written by health care professionals themselves, especially for tabloids. Databases now exist where journalists can contact the health care professionals for various illnesses.

Key Words
Media, Newspapers, Tabloids, Broadsheets, Stigma, Physical health, Mental health, Ireland, England.

Corresponding Author:
Dr Halder N, E-mail: neel.halder@alphahospitals.co.uk

Background

More than any other branch of medicine, psychiatry has become the focus of factual and fictional representations in the media and the arts. Many aspects of psychological theories have been adopted into media studies courses[1]. For many years there has been concern at the portrayal of psychiatry in the media, with even words like "schizophrenia" being used as a "metaphor"[2]. In one Italian newspaper study use of word "schizophrenia" was used to describe incoherence/contradiction/split (85%), dangerousness/aggressiveness (4.4%) and eccentricity/oddness (10.5%) times than the diagnosis itself[3]. The print media is of particular interest to psychiatrists wishing to address issues such as public information, misinformation and stigma since this medium is a greater source of health related information than its electronic counterpart[3] and because there is a relationship between public opinion and media images[4] with obvious implications for attitudes to psychiatry. The negative portrayal of psychiatry in newspapers has been confirmed by some studies[5, 6] which have shown that the image of psychiatry and psychiatric patients has either deteriorated or remained the same with some minor cosmetic changes e.g. appropriate headlines, increasing use of direct quotes from psychiatric experts over time[7, 8]. One of the major concerns has been the large focus on forensic issues[9, 10] and that articles of interest rarely receive front page coverage except when the content relates to legal aspects of psychiatry[11], often sensational in tone. In particular there has been concern within the profession at the use and understanding of the psychiatric diagnosis and terms used in the media and especially the tone of some

headlines in the British press such as "Hospital Bungle Released Beast for Sex Spree" or in the Irish press "Boy, 12 facing Mental Prison".

By contrast, other studies have failed to substantiate the view that psychiatry is portrayed negatively[12, 13] and found that among Irish newspapers most articles were either supportive or neutral in the tone of coverage, revealing a more positive approach than is evident in other countries. A study conducted in United States noticed a decrease in crime reporting committed by people with schizophrenia in 2010 as compared with 2000 but no difference was found in metaphorical use of the terms "schizophrenia" over ten years[15].

Some Irish media presenters, such as Vincent Brown[16] have claimed that the blame does not rest solely at the door of the media, pointing to the poor services for many patients and shifted the focus to psychiatrists themselves by calling for more active involvement with the media, so that working together the negative images and stereotypes directed at psychiatric "patients" can be overcome.

However the negative coverage has not only been directed at psychiatric illnesses but physical illnesses were also treated in the same manner although the focus was slightly different[17] with negative commentary criticising doctors while those covering psychiatry tended to criticise patients. In 1999 the Irish Division of Psychiatry, launched a campaign titled "Changing minds"[18] (2000) in response to these criticisms. Its aim was to change some of the negative stereotypes of psychiatric illnesses that exist by active participation with the media. It also launched a press guide backed by the National Union of Journalists for reporting on schizophrenia[19]. The World Psychiatric Association launched a global programme "Open the Doors" to reduce stigma and discrimination because of schizophrenia in collaboration with the media[20].

The present study represents an extension of two earlier investigations[13, 21] into the coverage of psychiatry in Irish newspapers. There is also a comparison with the British print media. The method in the present study is expanded to include all sections of the newspaper including the letters page and sports pages as well as identifying references to psychiatry in unrelated articles e.g. mention of exercise to reduce depression.

Hypothesis

The hypotheses are that

a. Irish print coverage is no different in tone from that in other countries such as Britain
b. There is a difference between broadsheet or tabloid newspapers in the frequency and tone of coverage of psychiatric issues with broadsheets faring better.
c. That the coverage of physical illness is more favourable than that of mental illness

Methods

A selection of Irish broadsheet and tabloid newspapers were examined page by page by researchers for period of 6 months as described below.

Two daily broadsheets including **Irish Times** and **Irish Independent,** three Sunday broadsheets including **Sunday Business post**, **Sunday Independent** and **Sunday Tribune** and one daily tabloid **The Irish Sun were** chosen to be included in the study. These are the newspapers, which were used, in the previous study and using the same will reduce bias and also it will be possible to assess if there is any improvement overtime as compared to the previous study[13].

To compare with the British print media daily broadsheets/Sunday newspapers included, these were **The Mail/Mail on Sunday, The Times/ Sunday Times, The Telegraph/Sunday Telegraph** and **The Mirror/Sunday Mirror.**

To avoid bias we used the same time period and also the same months of the year as the previous study. We examined newspapers from 1st July to 31st December 2008.

Each newspaper was scanned for articles directly relevant to psychiatry or psychiatric patients as well as general pieces that mentioned psychiatry in the text. In addition headlines in which psychiatric terms e.g. obsessed schizophrenic etc. used were also included. All sections of the newspaper were examined including the letters page, sports column pages and supplements. The items (articles, references and headlines) were examined for the following attributes:

Item type (news, feature, letter)
Subject of item (forensic, psychiatric services etc)
Profession of author (Health professional, journalist (general, medical correspondent), not given.
Whether opinion of mental health professional sought.
Tone of headline [Positive, neutral, critical, judgemental, sensational (dramatic, factual)]
Tone of article [Positive, neutral, critical, judgemental, sensational (dramatic, factual)]
Page of item.
Presence of a photograph (other than of the writer)
Gender of writer.
Focus (patients, illness, service provider, therapist, services)
Topic (Medicine, services, patients, general

information)

The same attributes as above were used for the physical illnesses and on the basis it was examined if their coverage is any different than the mental illness.

Definitions: Mental health professional is defined as psychiatrists, psychologists, nurse or any person working in the mental health services on a professional basis. The tone of an article is defined as critical if it is negative but reasons for the criticism are provided and/or alternative suggested. Judgemental articles on the other hand are those that simply contained negative portrayals with no alternative suggested. The tone of sensational articles is dramatic and/or not factually based.

Results

The total numbers of newspapers studied in six months were 579. In total 357 articles/references to psychiatry and 746 articles/references to other medical conditions in Ireland were identified in the six months under study.This represents a mean of 0.61 items per paper, per day for psychiatry and 1.29 items per paper per day for other medical

Article type	Broadsheet (daily)	Tabloid(daily)	Broadsheet(Sunday)
News	64.1% (143)	56.9% (29)	54.2% (45)
Features	26.5% (59)	29.4% (15)	38.6% (32)
Letters	9.4% (21)	13.7% (7)	7.2% (6)

Table 1: *Category of articles by type of newspaper for mental health.*

Article type	Broadsheet (daily)	Tabloid(daily)	Broadsheet(Sunday)
News	76.7% (376)	73.0% (81)	56.6% (82)
Features	18.0% (88)	24.3% (27)	37.2% (54)
Letters	5.3% (26)	2.7% (3)	6.2% (9)

Table 2: Category of article by type of newspaper for other medical conditions.

Eight percent of articles relating to mental health/ illness were published on the front page of the daily broadsheets and slightly more in the Sunday papers while around 12% appeared on the front page of the tabloid. Overall the number of articles on the front page was 9% for mental health/illness and 11% for other medical conditions.

In total 12.0%(43) articles were written by health professionals, 64.1%(229) articles by general journalists, 10.9%(39) articles by medical correspondents who are not health professionals, and in 12.9%(46) articles author was not mentioned (Chi^2 18.77, df 6, p 0.004) for psychiatry. For physical (medical) articles, in total 5.8%(43) articles were written by health professionals, 56.6% (422) by general journalists, 27.9%(208) by medical correspondents and in 9.8% (73) articles author was not mentioned (Chi^2 201.75,df6 p 0.004).This comparison can also be seen in table 3 and 4.

Author	Broadsheet (daily)	Tabloid(daily)	Broadsheet(Sunday)
Health professional	15.1% (34)	0.0% (0)	10.7% (9)
General journalist	59.6% (134)	87.5% (42)	63.1% (53)
Medical journalist	12.9% (29)	0.0% (0)	11.9% (10)
Not given	12.4% (28)	12.5% (6)	14.3% (12)

Table 3: Profession of author for psychiatry related articles.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Author	Broadsheet (daily)	Tabloid (daily)	Broadsheet (Sunday)
Health professional	6.1% (30)	5.4% (6)	4.8% (7)
General journalist	47.3% (232)	56.8% (63)	87.6% (127)
Medical journalist	40.6% (199)	2.7% (3)	4.1% (6)
Not given	5.9% (29)	35.1% (39)	3.4% (5)

***Table 4**: Profession of author for articles related to other medical conditions.*

Author	Irish Broadsheets	English Broadsheet
Health professional	15.1% (34)	5.8% (4)
General journalist	59.6% (134)	49.3% (34)
Medical journalist	12.9% (29)	13.0% (9)
Not given	12.4% (28)	31.9% (22)

***Table 5**: Comparison between authors in Irish and English Broadsheets regarding Psychiatry.*

conditions. The different types of articles in newspapers can be seen in table 1 and 2.

In comparison health professionals wrote more articles in Irish broadsheets than English broadsheets. Majority of the articles both in Irish and English papers about psychiatry related issues were written by general journalists as seen in table 5.

In total 12.9%(38) articles were written by health professionals, 57.1%(168) articles by general journalists, 12.9%(38) articles by medical correspondents who are not health professionals, and in 17.0%(50) articles author was not mentioned (Chi^2 16.25, df 3, p 0.0010).

In 56.9 % (203) articles opinion of medical professional regarding psychiatric conditions was obtained. The daily and Sunday broadsheets were significantly more likely to seek the opinion of a mental health professional (63.2% and 54.2% respectively) in contrast to 33.3% in the tabloid newspapers. (Chi^2 15.43, df 2, p 0.000). For other medical conditions in 72.4% (540) articles opinion of medical professional was obtained. Similarly daily and Sunday broadsheets were significantly more likely to seek the opinion of a professional (76.5% and 70.3% respectively) in contrast to 56.8% in the tabloid newspapers (Chi^2 18.07, df 2, p 0.000).

When comparing with English papers, opinion of medical professional was obtained slightly more commonly for Irish articles, 63.2% than English, 60.9% (Chi^2 0.0448, df 1, p 0.8324). Overall 62.7% articles obtained opinion from a medical professional.

Use of photographs other than of the author was least common in the daily broadsheets as compared to the tabloids and Sunday broadsheets for both psychiatry related articles and other medical conditions.

For psychiatric conditions overall 43.1% (154) article authors were male, 45.1% (161) articles by females and 11.8% (42) articles by both or it was not mentioned. In comparison for other medical conditions 32.1% (240) article authors were male, 57.0% (426) articles by females and 11.0% (82) articles by both or it was not mentioned.

Predominantly for articles related to mental illnesses tone of *heading* was neutral in daily and Sunday broadsheets and dramatic in daily tabloids, (Chi^2 37.8, df 6, p 0.000) and the result was statistically significant for tabloid (Z = -2.95 for neutral heading and 4.29 for dramatic heading). The tone of *article* was neutral for broadsheets and dramatic for tabloids(Chi^2 26.8, df 6, p 0.000) Z = -2.90) for neutral article and (Z = 3.43) for dramatic articles in tabloids. Overall 35.85% (128) articles had neutral headlines and this can be seen in tables 6 and 7. Z values > 1.96 are significant. Positive value mean the observed value is greater than the expected value.

For articles related to other medical conditions tone of heading was neutral in daily and Sunday broadsheets and dramatic in daily tabloids (Chi^2

Tone of Heading	Broadsheet (daily)	Tabloid(daily)	Broadsheet(Sunday)
Positive	12.6% (28)	15.4% (8)	14.5% (12)
Neutral	41.7% (93)	11.5% (6)	34.9% (29)
Critical	15.2% (34)	5.8% (3)	20.5% (17)
Judgemental	1.8% (4)	0.0% (0)	6.0% (5)
Dramatic	24.7% (55)	61.5% (32)	20.5% (17)
Factual	4.0% (9)	5.8% (3)	3.6% (3)

***Table 6**: Predominant tone of headline by newspaper type.*

Tone of articles	Broadsheet (daily)	Tabloid(daily)	Broadsheet(Sunday)
Positive	15.7% (35)	17.6% (9)	10.8% (9)
Neutral	38.1% (85)	11.8% (6)	44.6% (37)
Critical	22.0% (49)	23.5% (12)	25.3% (21)
Judgemental	0.9% (2)	0.0% (0)	3.6% (3)
Dramatic	17.5% (39)	41.2% (21)	12.0% (10)
Factual	5.8% (13)	5.9% (3)	3.6% (3)

***Table 7**: Predominant tone of article by newspaper type.*

62.0, df 8 p 0.000) and the result was statistically significant (Z = -3.51) for neutral headings and (Z = 5.74) for dramatic headings in tabloids, whereas tone of article was critical in daily and Sunday broadsheets and dramatic in daily tabloids (Chi^2 65.6, df 8 p 0.00). Overall 28.28% (211) articles had neutral headlines and almost 26% had critical headlines. During this time the cancer services in Ireland were criticised a lot, so the content of most articles was critical in broadsheets.

In comparison the tone of heading and article was neutral for both Irish and English articles. Irish newspapers had more dramatic headings than the

Tone of Heading	Broadsheet (daily)	Tabloid (daily)	Broadsheet (Sunday)
Positive	17.6% (86)	13.5% (15)	14.5% (21)
Neutral	31.0% (152)	10.8% (12)	32.4% (47)
Critical	25.5% (125)	21.6% (24)	31.7% (46)
Judgemental	1.0% (5)	0.0% (0)	2.8% (4)
Dramatic	20.0% (98)	51.4% (57)	17.2% (25)
Factual	4.9% (24)	2.7% (3)	1.4% (2)

***Table 8**: Predominant tone of heading by newspaper type.*

Tone of articles	Broadsheet (daily)	Tabloid (daily)	Broadsheet (Sunday)
Positive	15.7% (77)	13.5% (15)	13.1% (19)
Neutral	29.6% (145)	10.8% (12)	35.2% (51)
Critical	32.4% (159)	27.0% (30)	36.6% (53)
Judgemental	0.8% (4)	0.0% (0)	1.4% (2)
Dramatic	14.7% (72)	43.2% (48)	11.0% (16)
Factual	6.7% (33)	5.4% (6)	2.8% (4)

***Table 9**: Predominant tone of article by newspaper type.*

English papers which had slightly more positive headings. (Chi^2 42.78, df 5, p 0.00049). Irish newspapers gave more factual information than English papers. (Chi^2 48.11, df 5, p 0.000499).

A range of topics were covered of which general articles relating to psychiatric illness/treatment were the most common. Articles about the general information were more common in the daily broadsheets, 22.1% (79) articles focused on the patients, 53.5% (191) articles were about the illness itself, and 15.1% (54) articles focused on the services provided to the patients.

For other medical conditions general articles relating to medical services were the most common in broadsheets whereas articles about medicines/ illness were more common in the daily tabloids (Chi^2 41.50, df6 p 0.000). 22.5% (168) articles focused on the patients, 37.4% (279) articles were about the illness itself, and 32.2% (240) articles focused on the services provided to the patients (Chi^2 15.03, df8 p 0.058)

Articles regarding illness and treatment were more common in Irish papers, whereas services were more a topic in English papers (Chi^2 38.95, df 3, p 0.000497). 25.6% (75) articles focused on the patients, 51.2% (150) articles were about the illness itself, and 13.7% (40) articles focused on the services provided to the patients.

Conclusions

News items were the most common type of articles in the daily broadsheets and in the tabloids, 60.78% (217) for psychiatric conditions and 72.3% (539) for other medical conditions and both had a similar pattern in relation to features and letters, while features predominated in the Sunday papers. These findings are very similar to the one in the previous study[13]. In the English newspapers the pattern was similar in psychiatry but there was an increased focus on the features (43.47%) than the Irish papers (26.45%).

We noted with interest that only a fraction of the articles published about psychiatric (and medical) issues was written by a health professional. Had they done so, perhaps more of the articles would have been facutal and more measured in tone (and less sensationalist and dramatic). Certainly organisations such as the Science Media Centre (www.sciencemediacentre.org) are trying to encourage more health care professionals to be placed on a database so that journalists can contact them when a story that is related to their field of expertise is required. Their aim is to provide 'accurate and evidence-based information about science and engineering through the media, particularly on controversial and headline news stories when most confusion and misinformation occurs'[24]. There is also a similar databse held by the Medical Journalists Association[25].

Regarding the hypotheses we found that Irish print coverage is no different in tone from that in Britain. As expected, we found a difference between broadsheet or tabloid newspapers in the tone of coverage of psychiatric issues with broadsheets faring better. We however did not find the coverage of physical illness is more favourable than that of mental illness. Many of the articles read about physical health stories were about doctors misdiagnosing a medical condition (such as meningitis) and was often critical about the care and services received. In contrast, some of the articles about mental illness depicted a personal journey of someone affected and how psychiatrists, and services had helped, and was therefore positive in nature.

The limitations to the study are that 6 months of the year were studied, and the results may be skewed by one large story that was written frequently in the press. It would be preferable to repeat the study over a longer period of time. Also 2 different researchers were involved in reading the articles, one for the Irish print, and one for the British print. As there is a degree of subjectivity involved in making judgements about the tone of the article, this could have varied between the 2 researchers. However attempts were made to minimise this by defining the parameters as clearly as possible.

Reference

1. Byrne P.Psychiatry and the media. Advances in Psychiatric Treatment. 2003. Vol 9, 135-143.
2. Chopra AK, Doody GA. Schizophrenia, an illness and a metaphor: analysis of the use of the term"schizophrenia"in the UK national newspapers. Journal of Royal Scottish Medicine. 2007.100 (9), 423-426.
3. Maqliano L, Read J, Marassi R. Metaphoric and non Metaphoric use of the term "Schizophrenia" in Italian newspapers. Soc Psychiatry psychiatr Epidemiol. 2011.Oct:46 (10):1019-25.
4. McHall, M. and Stocking, S. Between scientists and the public. American Psychologist. 1982. 37, 985-993.
5. Wahl, O. and Roth, R. Television images of mental illness: results of a metropolitan Washington media watch. Journal of Broadcasting. 1982. 26, 599-615.
6. Day, D.M. and Page, S. Portrayal of mental illness in Canadian newspapers. Canadian Journal of Psychiatry. 1986. 31, 813-817.

7. Matas, M. El-Guebaly. N. and Harper, D. Mental illness and the Media: Part II. Content Analysis of press coverage of mental health topics. Canadian Journal of Psychiatry. 1986. 31, 813-817.
8. Stuart H. Stigma and the daily news:evaluation of a newspaper intervention. Canadian Journal of Psychiatry. 2003. 48 (10), 651-656.
9. Nunally, J.C. Popular conceptions of mental health: their development and change. 1961.New York: Reinhart and Winston.
10. Stark C, Paterson B, Devlin B. Newspaper coverage of a violent assault by a mentally ill person. 2004. Journal of psychiatric mental health nursing. 6, 635-643.
11. Hillert, A., Sandmann, J., Ehmig, S.C. *et al*. The general public's cognitive and emotional perception of mental illness; an alternative to attitude research. In the image of Madness; The Public Facing Mental Illness and Psychiatric Treatment EDS. 1999. Guimon,J., Fischer, W. and Sartorius, N. Basel; Karger.
12. Scott, J. What the paper say. Psychiatric Bulletin. 1994.18, 489-491.
13. Meagher, D., Newman, A., Fee, M. and Casey, P. The coverage of psychiatry in the print media. 1995. Psychiatric Bulletin. 19, 642-644.
14. Stone J, Colyer M, Feltbower S. *et al*. "Psychosomatic" A systematic review of its meaning in newspaper articles. 2004. Psychosomatics 45:4, 287-290.
15. Vahabzadeh A, Wittenauer J, Carr E. Stigma, Schizophrenia and the media: exploring changes in the reporting of schizophrenia in major U.S. newspapers. Journal of psychiatric practice. 2011 Nov; 17(6):439-46.
16. Browne, V. Protecting the rights of the most valuable. Irish Times. Aug. 11th 1999.
17. Lawrie S.M. Newspaper coverage of psychiatric and physical illnesses. Psychiatric Bulletin. 2000. 24,104-106.
18. Salter M, Byrne P. The stigma of mental illness. How can you see the media to reduce it? Psychiatric Bulletin. 2000; 24; 281-3.
19. Irish Division of the Royal College of Psychiatrists and National Union of the Journalists. Oct 1999. Guide for Journalists and Broadcasters reporting on Schizophrenia. Eli Lily, Ireland.
20. World Psychiatric Association. "Open The Doors". Global programme to reduce stigma and discrimination because of schizophrenia.2005.
21. O'Connor, Casey, P. What it says in the papers: an audit. Irish Journal Psychological Medicine. 2001. 18(2): 68-71.
22. Statistical Package for the Social Science. 1998. SPSS inc. Chicago.
23. Ramadas S, Kuttichara P.The Development of a Guideline and its impact on the media reporting of suicide. Indian Journal of Psychiatry. 2011 Jul: 53 224-8.
24. Science Media Centre. Online. Available on http://www.sciencemediacentre.org/about-us/ last accessed on 8/2/13.
25. Medical Journalists' Association. Online. Available on http://www.mjauk.org/ last accessed on 8/2/13

Review Article
DAUIN 20140060

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Music and Healing: The Role of Positive Affect

Dr Kaye E*; Dr Susan Rutherford **

Institution
**Royal Oldham Hospital, Rochdale Rd, Oldham, Manchester OL1 2JH*

***Martin Harris Centre for Music and Drama-SO4L.2, School of Arts, Languages and Cultures, University of Manchester, M13 9PL*

WJMER, Vol 8: Issue 1, 2014

Abstract
Music produces a vast array of responses: emotional, intelligent, physiological and motor. In this paper the relationship between the emotional response to music and possible therapeutic applications is analysed. Literature describing the theories behind interpretation, production and uses of musical emotion is studied. It appears that music can elicit positive affect (emotional experience) through a manner of mechanisms: both psychological and neurological. Positive valence is caused by memory recall; association, visual imagery and consonance levels; emotional contagion and mirroring. Activation of the limbic system specifically, dopamine release in the striatum causes additional positive affect. Music's therapeutic qualities are considered in reference to literature on the promotion of health via positive affect. Here, the implications of neuroendocrine and immune factors, along with health behaviours are considered. It appears that there is definite evidence for a therapeutic opportunity presented by music and improved sense of well-being, along with their relationship to one another, yet far more research is needed in both areas.
1 Samuel 16:16b 'He will play soothing music and you will soon be well again.'
New Living Translation (1996)

Key Words
Music, Therapy, Health, Emotion, Art

Corresponding Author:
Dr Kaye E, E-mail: emily.kaye@doctors.org.uk

Introduction:

Every human being dances to the rhythm of his/her own pulse; the tempo increases with exhilaration or fear and slows as we rest and sleep. Music captivates its listeners. It can make feet tap, quicken the pulse or conjure up a smile. This suggests physical and emotional responses. This paper questions what enables music to produce such a reaction, and whether it can be applied therapeutically. The research in this area is sparse with limited sample sizes. Anecdotally however, music appears to touch many people's lives.

Organised music therapy is relatively new and its results controversial. It includes a range of methods with varying aims. Music is used as: an expressive language; basis for a relationship; vehicle to another world; and the therapeutic achievement itself[1]. Therefore, patients are able to control their treatment within music therapy, creating a highly personalised treatment. Music appears to involve all who experience it, facilitating communication between listener, performer and composer[2].

Music and emotion:

Music is used universally to influence emotion: mothers sing lullabies to babies, whereas, businesses use music as a consumer aid[3a]. DeNora[2] describes a phenomenon called 'musical entrainment' where musical elements such as tempo and rhythm cause various subconscious physical (foot tapping) and emotional reactions. Through the interactive quality of music, 'aesthetic agency' is created: the listener may take control of music's effect and *use* it. There are still however, large gaps in understanding music's exact effects on emotion.

Semiotic theory suggests that cues exist within musical architecture that represent human kinesics[3b-c]. From these, the listener perceives an emotion and then 'mimics' it through "emotional contagion"[4]. Juslin's super-expressive voice theory states that a

musical instrument can both portray and go 'beyond' vocal expression through timbre, dynamics and tempo[4]. Alternatively, Davies argues that humans 'mirror' emotions by displaying a reciprocal emotion – not empathising exactly[3d].

Memories and music are closely intertwined[3c,4]. Evaluative conditioning is where affective valence (negative or positive associations) is applied according to past experience. Davies 1978[3d] described the "Darling they're playing our tune again" phenomenon (episodic memory): the recall of a complete event involving similar music. In both these circumstances, emotion is elicited by the *memory* not the music; therefore memory has an extrinsic relationship to musical emotions[3c].

Episodic memory can also be linked to visual imagery[4]. Bonny used music as a metaphorical vehicle, transporting the listener along a musical journey[1]. Priestley[1] categorised countertransference in music therapy: empathic countertransference, where the patient's unconscious emotions 'flow through' the music to the therapist; and complementary countertransference, where the patient projects a close associate's persona onto the therapist.

Perhaps music could be compared to a Picasso piece, where it presents ideas and cues to the listener, yet the listener's current life experiences and mood control which elements are noted, how they are construed and thus what emotions are perceived. This would make the inspiration of emotions by music more of an interpretative experience.

Further extrinsic factors lie in the realm of personal preference. Many scientific studies have attempted to convert musical subjectivity to a more objective focus, using affective valence: is the stimulus pleasant or unpleasant? Blood *et al*[5] been found that the level of melodic dissonance is inversely related to the perceived pleasantness of the piece. This however, does not account for the influence of context on the perception of music as pleasant/unpleasant. Jungaberle's 'metaphorical circle'[1] states that musical context involves both the extramusical environment and intramusical components like cadence.

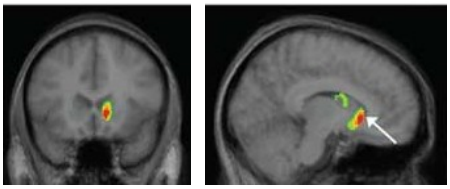
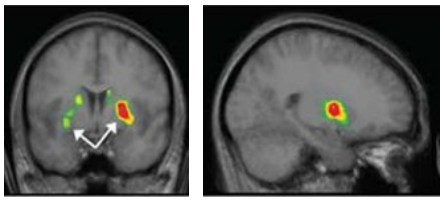
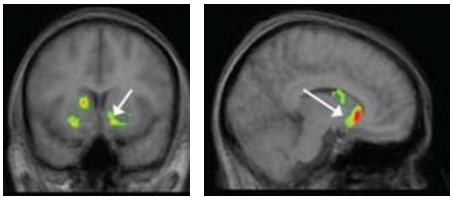
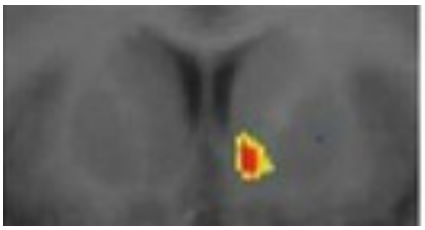
Blood[5] does not explain whether the studied pieces ended with cadence (resolution). Cazden[6] explained that the interpretation of dissonant moments is proportional to how urgently the listener feels that the music must move on to resolve. Extramusically, Cazden states that musical perception conforms to music's 'cultural service'[6].

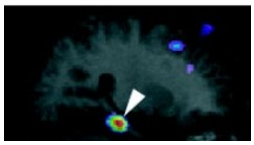
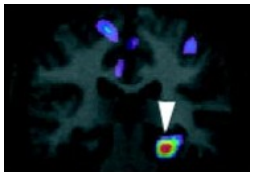
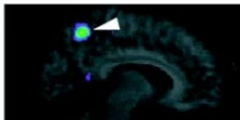
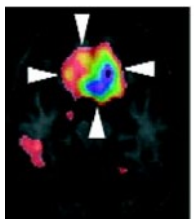
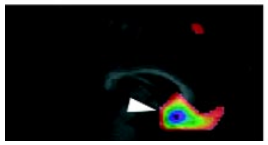
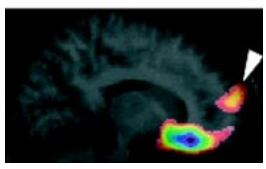
The effect of dissonance on valence could be due to the brain stem detecting dissonance as a sign of danger[4]. Dissonance stimulates arousal, an extreme emotion, which may either result from or produce a high level of sympathetic nervous activation due to brainstem reflexes[4, 7-8]. Conversely, Bonny[1] described consonant music (along with other relaxing qualities) as 'sedative music' and emphasised its use in therapy. Arousal has been measured in studies involving physiological autonomic effects, for example heart rate[7-8]. Research postulates that dissonant music can increase heart rate[8].

Conversely, a small study[9] used autonomic activity ('chills') to note subjects' 'peak' pleasure experiences in their favourite songs. It was found that the number of 'chills' felt was proportionate to the degree of pleasure experienced. Brain imaging discovered that dopamine was released from the caudate just prior to the 'chill' and in the nucleus accumbens during. This suggests evidence for Juslin's theory of musical expectancy[3c,4]: familiarity of musical structure allows prediction of melody, causing intrinsic emotion or tension to build. Perhaps music does not have to relax the listener in order for it to have a positive effect. More research is needed here as this study was limited by its sample size.

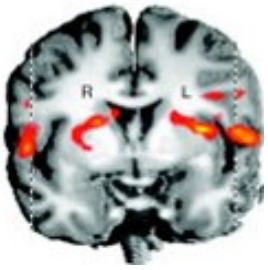
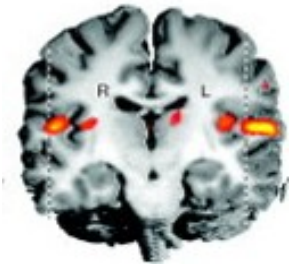
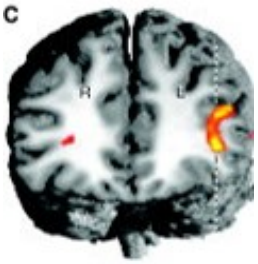
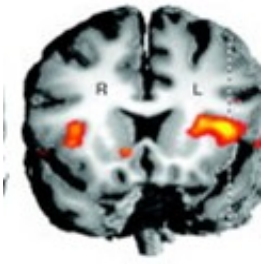
World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Summary of Various Neurological Musical Studies (R = Right, L = Left)[5, 7, 9-10]

Sample	*Stimulus*	*Areas Most Activated*	*References*
28 subjects, mixed musical backgrounds	Pleasurable music	Caudate  Putamen  Nucleus Accumbens 	9
	Peak emotional response	 Nucleus Accumbens	

Summary of Various Neurological Musical Studies (R = Right, L = Left)[5, 7, 9-10]			
Sample	*Stimulus*	*Areas Most Activated*	*References*
10 right handed non-musicians	Increasing *dissonance*	R Parahippocampal Gyrus   R Precuneus region  Superior Temporal Gyri	5
	Increasing *consonance*	Bilateral Orbitofrontal Lobes  Medial Subcallosal Cingulate  R Frontal Frontal Polar Cortex  Superior Temporal Gyri	
12 Non Musicians	Harmony perception/	R Hemisphere	7
12 Musicians	Harmony perception	L Hemisphere	

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

11 Non Musicians, R handed	Pleasant music	Bilateral Rolandic & Frontal Opercular  Heschl's Gyri  Inferior Frontal  Insula  Strongly *deactivated* Amygdala	10
	Unpleasant music	L Hippocamp-us L Para-hippocamp-al Gyrus L Amygdala R Temporal Poles	

The neurological effects of music appear diverse, yet more research with larger sample sizes is required. Results show consistent activation of areas involved in emotional processing – especially of affective valence and memory. Interestingly, these patterns of activation are similar, yet *different* to those of everyday emotion: perhaps this suggests that musical emotions are separate from emotions with objects and goals[5]. This notion is comparative to Davies[3d] argument against emotional contagion: empathic rather than sympathetic responses to music.

The Rolandic operculum is implicated in laryngeal motor function but is activated when listening to pleasant (consonant) music[10]. Could this suggest that pleasant music prompts us to want to sing? Emotional contagion could underlie this phenomenon, causing internal mimicry of the music[4]. Furthermore, it has been suggested that singing elicits positive emotions[11].

Brown[12] studied the use of music in psychogeriatric care and discovered that it produced a positive atmosphere, promoted memory in some patients, *and* aided group cohesion. Surely this unifying quality of music must be of therapeutic benefit.

Emotion and Health: The Positive Affect

Positive affect encompasses an enjoyable emotional experience due to a pleasurable occurrence[13]. It has been demonstrated that happier individuals have the lowest levels of cortisol[14,15]. Cortisol causes glycaemia and immunosuppression – particularly effecting leukocytes[14]. Therefore, reduced cortisol could enhance immunity. Positive affect appears also to decrease systemic inflammation thus inflammatory markers[14]. High levels of inflammatory activity are implicated significantly in coronary heart disease risk[13, 14]. Positive affect appears to allow the immune system to work more beneficially. This has been demonstrated with administration of the rhinovirus, where positive emotionality (assessed over 2 weeks) appeared to decrease susceptibility to the common cold[15].

A meta-analysis[13] that collated the results of 70 studies with follow-up times ranging from 2-44 years revealed a positive correlation between psychological well-being and increased longevity. Other physiological events associated with positive affect include improved sleep patterns, decreased blood pressure and heart rate, and increased heart rate variability. This could be due to parasympathetic activity[13,14], perhaps representing decreased arousal. Therefore, could Bonny's 'sedative music'[1] elicit this effect, and thus promote health?

There are many problems related to the study of positive affect: confounding factors are abundant[14]. The discussed studies have attempted to control and adjust results in order to account for controllable variables, such as: BMI; smoking status; social-economic status; gender; ethnicity and age[13-15]. Unfortunately, however, there may be other factors present that affect the results. For example, cortisol levels peak during waking then decline throughout the day and thus, random cortisols may not be reliable. In addition to this, it is not possible to decipher which factor is the independent or dependent variable. More favourable health behaviours could lead to an improvement in emotional well-being (perhaps via the release of endorphins) or, a positive emotional state could provide motivation to partake in positive lifestyle choices[13-14].

Due to the subjective nature of these studies, a range of methods for collecting data on emotional states have been developed. Retrospective assessment produces more negative results, suggesting that emotions are *reflected* on more negatively than they are experienced[14]. Therefore, if there are variations in results based on methods of collection, it is not possible to compare studies reliably. Nevertheless, neuro-physiological research appears promising and warrants further investigation – especially with larger sample sizes.

Setting the above complexities aside, it is clear that positive affect promotes health. The precise mechanisms involved here are still uncertain, yet physiological studies appear to be approaching an answer related to neuroendocrine and immune mediators. Literature surrounding this area is abundant, with this review merely touching the surface.

Music and Health

This paper has focused on the possible psychosomatic benefit of music. Further evidence for this is that a meta-analysis concluded music to be a useful adjunct in pain relief by decreasing opiate requirements and increasing efficacy of analgesic treatment[16]. It was noted however, that the extent of analgesia produced by music *alone* was not significant enough to provide a clear clinical benefit.

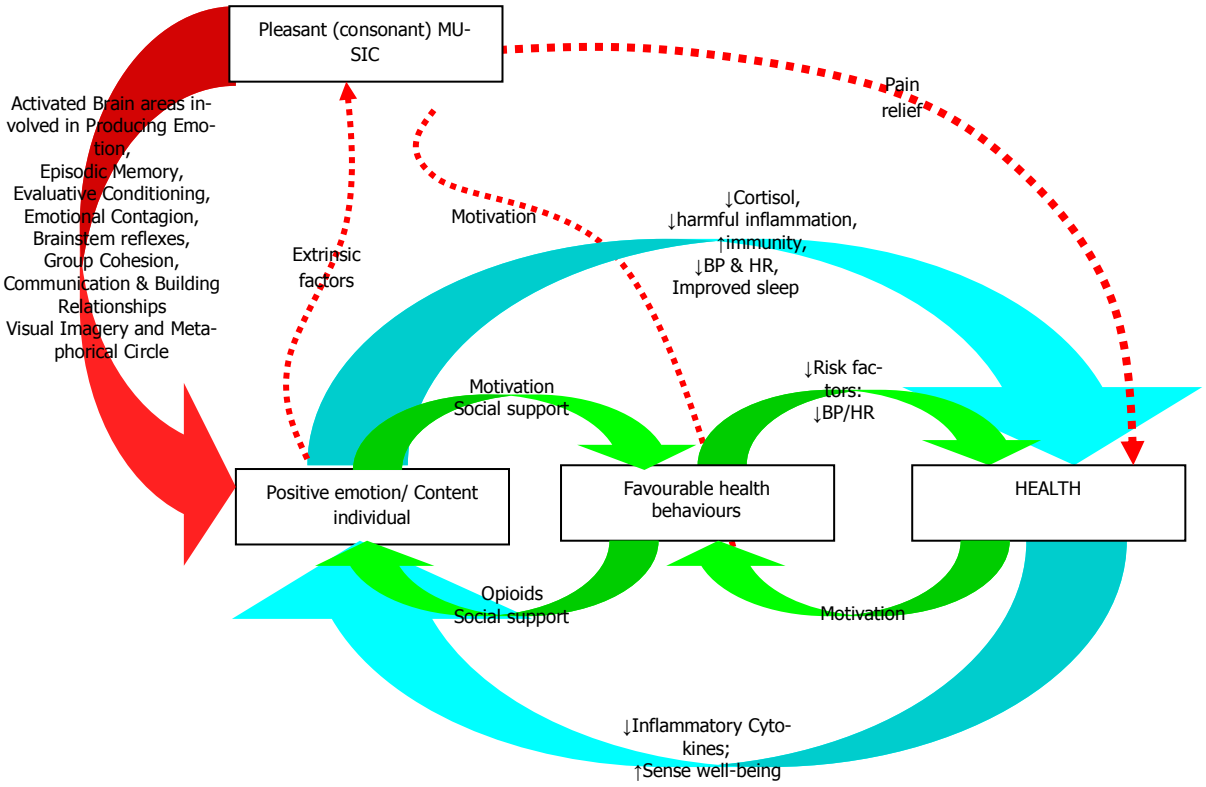
Apart from the apparent symptomatic relief and positive affect afforded by music therapy, it is possible that this therapy produces other benefits. During a music therapy session, emphasis is placed on accepting the patient just as they are. Whether

the patient interacts with the music by performing or listening, the therapist focuses on the potential that the patient has and how his/her capabilities can be used. The patient can accept actively, the music's agency[2]: allowing him/herself to be 'moved' by the music and, if the patient wishes, he/she has the power to employ it for his/her own devices. The therapist has no expectations or requirements of the patient[1]: he/she awaits a response and the patient can choose to give it. Therefore, the patient does not feel pressured or inhibited and can be freed to lose his/herself in the music. This idea of losing one's self in the music is compatible to Winnicott's 'holding-environments'[17], pertaining to parent-infant relationships. Here, he describes where a babe-in-arms is completely dependent upon his mother, yet simultaneously feels in control. The babe is at one with himself and understands that his mother will do anything for him: there are no pressures, just the knowledge that he exists and can 'be'. In this way, a subconscious bubble is created, through which nothing that requires a reaction can impinge. Bonny's 'sedative music' can cocoon the patient with feelings of serenity, where nothing can surprise or 'annihilate'[1, 17].

Conclusion

There is substantial evidence for the therapeutic benefits of music. Possible practical applications of this type of therapy are abundant. Brown[12] explained how singing to and performing music together can enhance group cohesion and positive affect. Bonny's "sedative music" could be utilised in the anaesthetic room or during other anxiety provoking procedures in order to relax the patient[1,17]. In addition to this, music may aid analgesia[16] thus lower doses, reducing side effects and cost.

Confounding factors within the aforementioned studies are noted. Disparities in preference, musical background[7], familiarity (studies have found that repeated exposure to a piece of music can alter preferences[3c, 8, 11]), and culture[6] produce potential for error. Music and emotions are subjective and it



Postulated Mechanisms for the Therapeutic Benefit of Music Covered in this Paper[1-15]
HR = Heart Rate; BP = Blood Pressure
Red dotted lines are possible mechanisms, but are areas of research that are not focused on in this paper.

is therefore very difficult to generalise any finding related to either. These differences are very difficult to control, and when they are controlled, sample sizes suffer (hence the undersized studies discussed). Everyday music is extremely diverse thus it is near impossible to generalise *any* findings. In addition to this, it is exceedingly difficult to isolate human emotion, as we are complex, interdependent beings influenced by many factors. Isolation is required in order to perform a completely fair scientific investigation.

An interesting question to consider is: Do all hearing humans hear the same sound? It is impossible to understand how exactly each individual hears and processes a piece of music. Our sensory perception may differ as much as emotional response and preference, yet this will remain an unsolved mystery. Which is the variable in the neural interpretation of music: is it the cortical location of sound interpretation or the pattern of neural activity? Another quandary is if the positive affect on health pertains more to *feeling* better than actually *being* better[15].

In recent times, we have become used to the separation of Arts and Sciences. Does this therapeutic use of music question the separation and does it point to the necessity of treating the patient as a whole – an interactive, sentient being with a spirit, a soul and emotions, along with physical anatomy? We are subjective not objective beings. Science attempts to be objective, whereas emotions are subjective: consequently, it is very difficult to analyse music's effect on health using the scientific method. Despite this, it appears that the *personal* experience of music as a therapeutic agent seems to prevail.

Reference

1. Wigram T, Pedersen IN, Bonde LO. *A Comprehensive Guide to Music Therapy*. Philadelphia: Jessica Kingsley Publishers, 2002. p. 93-113
2. DeNora T. *Music in Everyday Life.* Cambridge: New York Cambridge University Press, 2000. p. 46-79
3. Sloboda JA ed, Juslin PN ed. *Music and Emotion: Theory and research.* Oxford: Oxford University Press, 2001:
   - Peretz I p. 105 – 134
   - Cook N & Dibbon N. p. 44 – 70
   - Sloboda JA & Juslin PN. p. 71 – 104
   - Davies S. p. 23-44
4. Juslin PN, Västfjäll DN. Emotional responses to music: The need to consider underlying mechanisms. *Behavioural and Brain Sciences.* 2008;31:559–621
5. Blood AJ, Zatorre RJ, Bermudez P, Evans AC. Emotional responses to pleasant and unpleasant music correlate with activity in paralimbic brain regions. *Nature Neuroscience.* 1999;2:382-387. doi:10.1038/7299 (accessed 29/01/2011).
6. Cazden N. The Systemic Reference of Musical Consonance Response. *International Review of the Aesthetics and Sociology of Music.* 1972;3 (2):217-245. http://www.jstor.org/stable/836715 (accessed 15/02/2011)
7. Evers S, Dannert J, Rödding D, Rötter G, Ringelstein EB. The cerebral haemodynamics of music perception: A transcranial Doppler sonography study. *Brain.* 1999;122:75–85. http://brain.oxfordjournals.org/content/122/1/75.full.pdf (accessed 01/02/2011)
8. Witvlieta CVO, Vranab SR. Play it again Sam: Repeated exposure to emotionally evocative music polarises liking and smiling responses, and influences other affective reports, facial EMG, and heart rate. *Cognition & Emotion.* 2007;21:1-25. doi: 10.1080/02699930601000672 (accessed 01/02/2011)
9. Zatorre R J, Salimpoor V, Benovoy M, Larcher K, Dagher A. Anatomically distinct dopamine release during anticipation and experience of peak emotion to music. *Nature Neuroscience.* 2011;14(2):257-262 http://www.nature.com/neuro/journal/v14/n2/full/nn.2726.html (accessed 30/01/2011)
10. Koelsch S, Fritz T, Cramon DY, Müller K, Friederici AD. Investigating emotion with music: An fMRI study. *Human Brain Mapping.* 2006;27 (3):239-250 doi:10.1002/hbm.20180 (accessed 28/01/2011)
11. Wendrich F, Brauchle G, Staudinger R. Controlled Induction of Negative and Positive Emotions by Means of Group Singing. *Music and Medicine.* 2010;2(3):144-149.http://mmd.sagepub.com/content/2/3/144.full (accessed 02/02/2011)
12. Brown S, Ekman SL, Götell E. Caregiver-assisted music events in psychogeriatric care. *Psychiatric Mental Health Nursing.* 2000;7(2):119-25. doi:10.1046/j.1365-2850.2000.00271.x (accessed 04/02/2011)
13. Chida Y, Steptoe A. Positive psychological well-being and mortality: a quantitative review of prospective observational studies. *Psychosom Med.* 2008;70(7):741-56. doi:**10.1097/PSY.0b013e31818105ba (accessed 03/02/2011)**
14. Steptoe A, Dockray S, Wardle J. Positive Affect and Psychobiological Processes Relevant to Health. *J Pers.* 2009;77(6):1747–1776. doi:10.1111/j.1467-6494.2009.00599.x. (accessed 04/02/2011)
15. Cohen S, Doyle WJ, Turner RB, Alper CM, Skoner DP. Emotional Style and Susceptibility to the Common Cold. *Psychosomatic Medicine*

2003;65:652-657. http://www.psychosomaticmedicine.org/cgi/content/full/65/4/652 (accessed 05/02/2011)
16. Cepeda MS, Carr DB, Lau J, Alvarez H. Music for pain relief. *Cochrane Database of Systematic Reviews.* 2006;(2)1-55 doi:10.1002/14651858.CD004843.pub2.
17. DW Winnicott. *The Maturational Processes and the Facilitating Envronment.* London: Karnca Books Ltd 1960 p. 37-55

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Qualitative Research
DAUIN 20140061

Identifying the Perceptions of Hospital Consultants with Regard to Faculty Development in the UK: A Qualitative Study

Agius S PhD*; Duffy K R.G.N., MA Ed*; Jones A MD, FRCS*; Garden A FRCOG**; Hayden J FRCP, FRCGP, DRCOG, DCH*

Institution
**North Western Deanery, Three Piccadilly Place Manchester*

***Lancaster University, Bailrigg, Lancaster, United Kingdom*

WJMER, Vol 8: Issue 1, 2014

Abstract

Purpose: In the UK, Modernizing Medical Careers has resulted in a highly structured, curriculum-based approach to postgraduate medical education. Combined with the impact of the European Working Time Regulation, this has resulted in the need for more effective and efficient delivery of education. Medical educator development has gained considerable momentum, driven by the profession's regulatory body. Postgraduate deaneries are accountable to the General Medical Council for ensuring that all clinicians are sufficiently prepared for their educator role.

Method: The authors conducted a qualitative study based on semi-structured interviews with a purposive sample of 18 hospital consultants in a single region, using a grounded theory approach to explore their perceptions of faculty development.

Results: The authors found evidence of individual and collective negotiation of the educator role, mediating processes in faculty development, and the factors involved in structuring transformative practice.

Conclusions: The centrality of faculty development in ensuring a well-trained, safe and productive medical workforce cannot be underestimated. Strengthening our understanding of hospital consultants' perceptions of educational Continuing Professional Development (CPD) can inform the commissioning and provision of faculty development activities.

Key Words

Medical education, Modernizing medical careers, Faculty development, Educational supervisor, Continuing professional development

Corresponding Author:
Agius S, E-mail: s.agius@nwpgmd.nhs.uk

In the UK, Modernising Medical Careers[1], building upon earlier reforms[2], has resulted in a shorter, structured, curriculum-based approach to postgraduate medical education. Combined with the impact of the European Working Time Regulation[3], this has resulted in the need for more effective and efficient delivery of education. Recent inquiries and reviews of medical training and the NHS workforce [4,5,6] have added further impetus to this trend, casting focus on medical educators and their preparedness for the role.

Introduction

In 2008, the Postgraduate Medical Education and Training Board (PMETB) published its *Standards for Trainers*[7], including mandatory requirements which had to be implemented by early 2010. The Academy of Medical Educators was then commissioned by the UK Departments of Health to help define training requirements for educational supervisors in secondary care, and to explore options for their future accreditation and performance review[8]. The General Medical Council (GMC) has now merged with PMETB and the standards, which are set out in Table 1, have been incorporated into the GMC *Generic standards for specialty including GP training*.[9] In order to achieve these standards, Local Education Providers (LEPs) and training programmes need to make sure that all clinicians, both trainees and hospital consultants, are sufficiently prepared for, and supported in, their educator role. Postgraduate deaneries are responsible for ensuring that the standards are met.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

GMC standards for trainers	
1	Trainers must provide a level of supervision appropriate to the competence and experience of the trainee.
2	Trainers must be involved in, and contribute to, the learning culture in which patient care occurs.
3	Trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and time to develop trainees.
4	Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees.

Steinert *et al* have conducted a systematic review on designing faculty development programmes[10]. They propose a series of recommendations, including understanding institutional and organisational culture, determining appropriate goals, conducting needs assessments to ensure relevant programming and accommodating a diversity of educational methods. Work has also been done on devising a framework for developing excellence as clinical educators[11]. Previous empirical studies have tended to focus upon specific elements of faculty development, such as identifying the core content[12] or impact[13] of programmes.

In 2008, we initiated an empirical study of the faculty development needs of hospital consultants to provide evidence of hospital-based medical educators' (HBME) perceptions of their role. By gathering and analysing such qualitative data the research team sought to achieve a greater understanding of faculty development and insight into how it might be enhanced.

Methods

A purposive sample of hospital consultants working as educational supervisor (ES) in a single deanery was identified. We used a grounded theory approach to the collection and analysis of data[14]. A purposive sample of hospital consultants working in a variety of specialties in NHS trusts, i.e. the LEPs, across the region was identified. In accordance with good practice in the grounded theory approach, the research team reserved the right to increase the sample size, as data were collected and analysed, in order to secure saturation of themes. We sent a letter of invitation to the identified participants and a time to conduct a telephone interview was arranged. Over a 4 month period in 2008, the semi-structured interviews were conducted using a guide that had been designed to identify perceptions of faculty development. The guide focused on four specific areas: (i) initial preparation required for the educator role; (ii) personal experience of faculty development; (iii) the form and content of faculty development which should be routinely available; and (iv) stake holder support for faculty development. Questions were kept sufficiently open and general to give participants the opportunity to expand upon their perceptions[15].

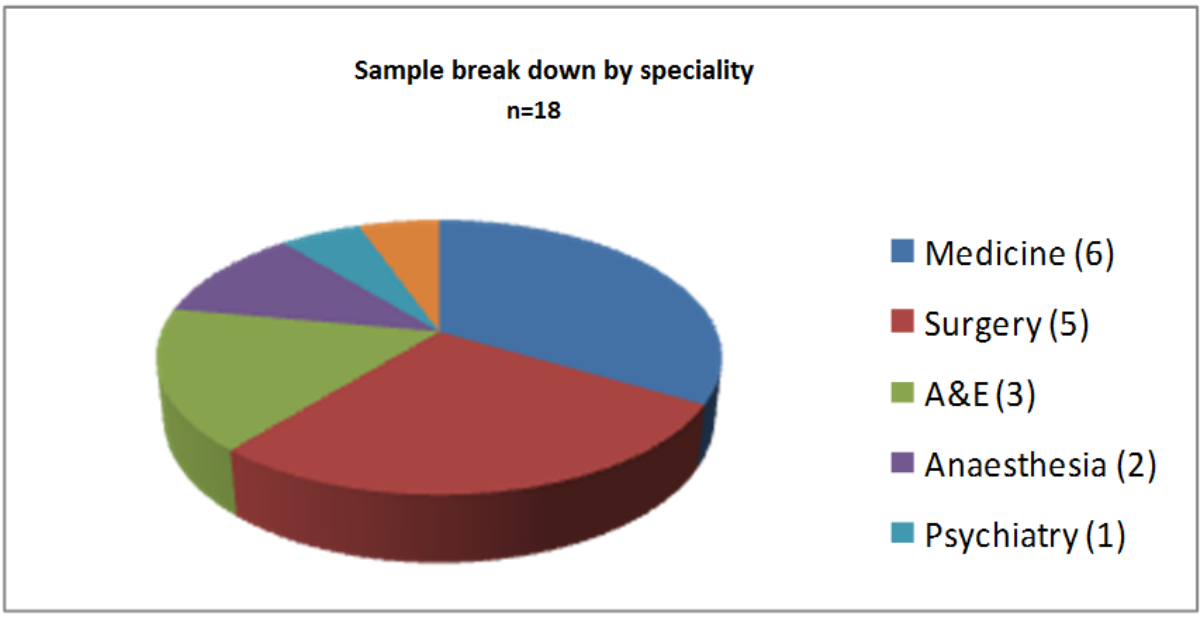
One of the researchers (SA) conducted the interviews, with each lasting approximately 45 minutes. The interviews were digitally recorded and subsequently transcribed verbatim and then carefully checked for accuracy by SA. Transcripts were analysed for recurring discourses and themes, as well as contradictions in the ways that the participants discussed these issues. Data collection and analysis were carried out in tandem, repeatedly referring back to each other. The research team collectively devised a coding framework following initial independent scrutiny of the transcripts. The resulting codes were constantly compared by the team, and relationships between them were established, in order to produce a set of themes. These themes, which are set out in the results section, are based on the primary discourses which our sample of hospital consultants expressed whilst describing their perceptions of faculty development.

Ethical approval was obtained for the study from Tameside and Glossop NHS Local Research Ethics Committee via the UK National Research Ethics System. All participants were given written assurances of anonymity at the time the data were recorded and their interviews and other information were made anonymous prior to data analysis.

Results

The final sample comprised 18 hospital consultants with educational supervisor responsibilities who were categorised by specialty as set out in Figure 1.

The saturation of themes was achieved by the time 18 members of the sample had been interviewed. By this stage new data were no longer illuminating the themes. Because of this, the research team did not consider it necessary to recruit additional subjects to the sample. There was a high level of consensus



Theme 1		**Individual & collective negotiation of the educator role**
Constituent codes:	*a* *b* *c* *d* *e* *f*	*Faculty development as a continuum: from medical school to continuing professional development (CPD).* *Adaptation to an evolving system of education.* *Exposure to theoretical and practical knowledge to enhance educational practice.* *The service v. training dichotomy: dealing with conflicting priorities.* *Reviewing the leadership role in medical education.* *The power of influence: guiding paradigm shifts in medical education.*
Theme 2		**Mediating processes in faculty development**
Constituent codes:	*a* *b* *c* *d* *e* *f*	*Identifying and nurturing the instinctive educators.* *Establishing career pathways in medical education.* *Developing formative appraisal & personal development planning for educators.* *Creating an infrastructure which supports frontline educators.* *Information flow: providing timely and effective communications.* *Peer networks: accessing social support and experiential knowledge.*
Theme 3		**Structuring transformative practice: the faculty development programme**
Constituent codes:	*a* *b* *c* *d* *e*	*Plurality of provision: from short courses to accredited academic programmes.* *The centrality of the workplace in CPD provision.* *The core content of educator development programmes.* *Commissioners and providers: defining expectations and maximising expertise.* *Utilising technology in development programmes.*

Each of the themes, summarising the empirical data relating to the constituent codes and including illustrative quotes, is described below.

1. Individual and collective negotiation of the educator role

a. Faculty development as a continuum, from medical school to CPD

We identified a perception that preparation for the educator role should commence in medical school and continue through to CPD for independent practitioners:

Learning about the educational role should start at medical school. To some extent, it's an appropriate time because at that point they recognise the importance of educational expertise and that would be the most appropriate time. And also, they are the people who, in their day-to-day life, are experiencing good teachers and bad teachers; they can see the difference probably clearer than those of us who have passed long beyond that stage. [HBME 4]

Including educator development in undergraduate and postgraduate programmes must be done carefully if it is not to overload an already heavy curriculum. Whilst students and trainees are perceived to be particularly engaged with medical education as a subject, all clinicians need knowledge and skill in the principles and practice of education.

b. Adaptation to an evolving system of education

It was suggested by a number of participants that it may be more difficult for established consultants than their recently appointed colleagues to engage with the increasingly formal requirements of medical education because they are less familiar with structured training programmes and appraisal:

People who have come through a world of RITAs [Record of In-Training Assessment] and CPD and so on, are very accepting…whereas I think education for people who are in the system already has gone from a largely didactic world to a world where there are a lot more modern assessment tools, a lot more need for feedback, engagement with learners and so on. I think there are issues about how people are helped to evolve, who already know the old system, into what is now quite a different approach, I suppose, to supporting learning. [HBME 17]

Doctors who experienced more traditional systems of medical education may need to be supported in developing their knowledge and skills. Specific expertise is required in giving feedback, undertaking workplace-based assessments (WBA), appraisal and completing education reports.

c. Exposure to theoretical and practical knowledge to enhance educational practice

Our sample suggested that there exist pressures of change, including to attitudes and behaviours, in relation to having to teach/train a multi-layered team of medical students and junior doctors. Supporting the development of both theoretical and practical knowledge can help consultants negotiate such pressures. Consultants may have limited experience of educational theory and this should be addressed. However, the provision of theoretical knowledge should be closely followed by practical application:

We need to be careful that what comes to the individuals who are actually doing the delivery is enough knowledge to allow them to effectively impart the subject matter expertise they have rather than turning them into expert educators who spend their entire life worrying about pedagogical paradigms as opposed to actually imparting the knowledge they have. [HBME 7]

d. The service v. training dichotomy: dealing with conflicting priorities

We identified a perceived need to further evolve the trust framework for the stewardship of postgraduate education. Clinical commitments can often present problems for attendance at educator development sessions.

The main difficulty is finding the time for the teaching…. in a clinical setting… Clearly there is a potential impact on the actual amount of clinical work that is being done… Some will sacrifice the clinical activity in order to be able to provide more in-depth teaching, others will be able to provide very good teaching and get through a pile of work and others will say 'I can't possibly spend any time teaching or talking to you because I've got far too many patients to see'.[HBME 2]

Participants reported that a major issue for consultants is having sufficient time for educational activities in a planned and prepared way. Education is very difficult to fit in, given all the other pressures.

e. Reviewing the leadership role in medical education

Trust-based medical education leaders are perceived to be too often tied up with administrative duties to engage in frontline support and development for consultant educators. It would be useful if they could be more pro-actively involved in giving advice and feedback on educational techniques:

If I look around our trust there are an awful lot of people that have got some sort of a title, with regard to medical education, be it tutors or whatever, but I'm not sure I can remember the last time any of them came and sat in my office and said 'How can we practically help you as a consultant? How can we help you with

your education?' [HBME 14]

f. The power of influence: guiding paradigm shifts in medical education

It was suggested by participants that employers need greater encouragement to recognise the educator role. Deaneries might take a harder line, including with trust management, in requiring consultants to attend educator development activities. Deaneries and the Royal Medical Colleges also might influence the normal educator contribution to be expected within Supporting Professional Activities (SPAs).

Perhaps we should integrate ourselves a little more, in other words the deanery and the trusts have a sort of integrated process and policy about the whole issue of education… and be a bit stricter on consultants attending the programme. [HBME 7]

2. Mediating processes in faculty development

a. Identifying and nurturing the instinctive educators

We identified the perception that 'good and enthusiastic' teachers should have their job plans tailored to accommodate their interests and skills. It should be recognised that some people are naturally more adept as educators than others:

One can't pretend that all consultants are educators to the same level. Therefore some may want to be research orientated and some may want to go into hospital management; some may want to do more direct involvement in education. There are different levels of commitment to education. It's a heterogeneous group you are dealing with and the expectation should vary. [HBME 7]

As this quote suggests, some interviewees perceived that it may be difficult to force people to be educationalists if they have no wish to follow this path. It was agreed that all consultants should have a basic educational role, i.e. clinical supervisor, but some suggested that not everyone should be required to develop it to a high level, instead focusing on other roles.

b. Establishing career pathways in medical education

We encountered a desire for career progression routes in medical education to be developed, defining what modules must be completed, and level of qualifications required for taking on such roles as clinical supervisor, educational supervisor and educational leaders such as programme director and director of medical education.

A lot of trainees are actually taking a Master's in Medical Education as they go through, which I find very interesting, as that's something that in my time you wouldn't have dreamt of doing… We just expected to make the best of what was available, now there is a much higher expectation of the trainees to…actually learn more about the education process, and then stick with it as they go further on…It's also an extra qualification that makes them more appointable as consultants especially in a teaching hospital. [HBME 12]

Participants had observed that more trainees are pursuing qualifications in medical education, which is gaining a higher profile as a potential career path, unlike previous generations who developed competence as educators as they went along.

c. Developing formative appraisal and personal development planning for medical educators

Participants suggested that appraisal of the educational aspects of a clinician's role should be introduced as a quality assurance mechanism and to encourage educational development planning.

I have never at any point been assessed by the trust in my teaching ability … it hasn't been suggested to me in the appraisals process or anything else that I might wish to develop my educational portfolio. I think the trust just think, you're a consultant; it's your job; get on with it. [HBME 14]

Few in the sample had experienced any form of educational appraisal within their trust and participants suggested that it should be at least incorporated into the annual NHS appraisal. A personal development planning process should identify precisely what education CPD is needed. There was a perception that it would be very useful to have a structured observation and feedback system for consultants from trained adult educators.

d. Creating an infrastructure which supports frontline educators

Trusts are viewed as supportive of consultants with an education management role (e.g. directors of medical education), but this is less apparent for their colleagues who are the frontline educators.

Support for education is often very good at trust level, the postgraduate centres, but can fall down at directorate level, when consultants, or its often specialty trainees, run teaching programmes almost single-handedly with minimal support, administrative or otherwise. [HBME 6]

Infrastructure is seen as effective in terms of supporting education leads within trusts but much less so in enabling the educational activities of the wider consultant body working in their departments on a day-to-day basis.

e. Information flow: providing timely and effective communications

We heard that lines of communication can be problematic and that often information only goes to (and can stop at) education leads within trusts.

I don't think they pass on down to the consultants who are not directly involved in education. A lot of information on processes, appraisals, everything that would come into education, there is sort of a block between those who are directly involved in education and those who provide it but don't feel that they are part of the deanery. [HBME 2]

It was suggested that the quality of information about CPD provision should be improved, including what can be accessed and where. Similarly, knowledge of national bodies involved in developing education policy appears to be minimal. They are seen as too academic for most consultants who need practical faculty development information.

f. Peer networks: accessing social support and experiential knowledge

We found that a lack of facilitated networks for information sharing may hinder the development of medical educators by limiting the sharing of good practice. The networks that do exist, including those established by postgraduate deaneries and the Royal Medical Colleges, are valued.

Networking and finding out how people do it, floating ideas of how you can make things work, sharing experiences: I've found that enormously helpful and supportive and stimulating, you know you just think 'oh god I could give up today it's just so miserable' and then you get with a group of people who have got the same problems as you, I've found that helpful. [HBME 1]

3. Structuring transformative practice: the faculty development programme

a. Plurality of provision: from short courses to accredited academic programmes

We identified support for sustained, credit-bearing academic programmes. Modular programmes are the preferred option, as the progressive accumulation of levels of qualification gives a sense of achievement without being daunting for a busy clinician. There is a market for both short courses, from which consultants can pick and mix, and for accredited courses leading to an educational qualification aimed at consultants with a more pronounced career interest in medical education:

Maybe you could sort of graduate it so that some of the initial modules are those which would be applicable to any consultant who has got responsibility for training and then you can build it up to the more advanced levels as you go along, which would then progress up to a master's degree. [HBME 14]

b. The centrality of the workplace in CPD provision

There was a general perception that CPD should be delivered, where possible, within locality, including half-day sessions and spread throughout the year so as to improve the ability to attend. Ideally, CPD should be 'based on the day job', and largely achieved in relation to workplace activities. It also should be relevant to real-life education and training situations.

CPD should be anchored in what we actually do, so that what we do attracts credits and also attracts support… The distinction between education and quality improvement is a very artificial one. [HBME 15]

c. The core content of faculty development programmes

It was suggested to us that there are different CPD requirements depending on the nature of the educator roles held by individuals within trusts. Of particular importance was that CPD should encompass supervision, assessment and teaching. Participants believed that there should be a focus on how to use curricula at all training levels, managing underperforming trainees and careers counselling.

Train the trainers, recruitment and selection, equality and diversity should be covered. I mean those are almost requirements to be appointed as a consultant these days. So it's really trying to build on that… and the first thing they need to know is how to use the curriculum… in the widest sense not just the syllabus, but more importantly the assessment tools…Also, how to deal with trainees who don't want to engage with training, for whatever reason.[HBME 9]

d. Commissioners & providers: defining expectations & maximising expertise

We identified a perception that commissioners should draw upon expertise in the wider higher education (HE) sector, particularly academic departments/faculties of education, in determining appropriate CPD providers. There is some unease at funding expensive external consultancies to provide CPD, when it might be better done in-house or collaboratively with HE institutions.

I think there's an awful lot of commercial companies who are making an awful lot of money out of running courses where it would be much better if, because there is a significant mass, the NHS were able to do those things in house in some way, either through deanery or through individual trusts taking on parts of the role. But I do resent the large flow of money to these consultancies. [HBME 11]

e. Utilising technology in development programmes

We encountered a general perception that interactive web-based teaching and other technologies should play a major part in CPD. E-

learning modules allow considerable flexibility and can test understanding with automatic logging and validation of CPD.

E-learning modules are absolutely ideal. They can be done at the time and place of the consultants' choosing and they can be manufactured in such a way that they actually include tests of understanding…and also when you've done it you can actually prove that you have successfully done it. You immediately get your CPD logged and validated. [HBME 14]

They are labour-intensive to manufacture, but can be made available to a large number of people. Distance learning can be highly effective but does require great discipline and should form only part of the CPD provision that is available to consultants.

Discussion

Through detailed analysis of qualitative data drawn from interviews with consultants, we identified perceptions of faculty development. Given that hospital consultants are the primary deliverers of teaching and training at trust level, their narratives about the structures, processes and activities involved in their development as educators can contribute to a richer understanding of its effectiveness.

Individual & collective negotiation of the educator role

Different perceptions of the timing of faculty development within the medical education continuum illustrate the nuanced nature of role perception. Whilst many participants agreed with the principle of commencing faculty development in medical school, and continuing through postgraduate training and beyond, we identified some concerns about overloading an already heavy curriculum. We also found conflicting views on the value of theoretical knowledge to enhance educational practice, with some participants believing this should be the preserve of the career educator whilst others upheld its intrinsic importance for all[16].

We found evidence of a recognised need for adaptation to an evolving system of medical education. The introduction of professional standards promotes such evolution, whilst the establishment of the Academy of Medical Educators in 2008, and a rapid growth in its membership, is indicative of the increasing prominence of the faculty development agenda. This evolution also appears to be influencing perceptions of the traditional leadership roles in medical education, specifically within trusts. Traditionally a managerial and administrative function, translating national and regional policy for local consumption and quality managing education, we identified a desire to see such leaders become more visible, hands-on role models for their educators, observing practice and providing constructive guidance on improving performance.

We also found evidence amongst our sample of a desire to see the power of influence brought to bear more forcibly on employing trusts, particularly by the Royal Medical Colleges and postgraduate deaneries. Such bodies are seen as occupying the vanguard position within medical education, and without their guidance and, if necessary, punitive action, there is a danger that some trusts may fail to fully support and enable the paradigm shift in faculty development. This suggests that the interviewees' may experience a degree of powerlessness in relation to the assertion of their educational role. It would appear that the lynchpins in this situation are the clinical leads, some of whom appear to put service ahead of education albeit not in all specialties and not in all trusts.

In faculty development, a number of tensions are apparent. Perhaps the most pervasive is the structural tension between service and training, at both an individual and organisational level[17]. The multi-faceted role of a hospital consultant: clinician, manager, researcher, educator, has inherent tensions which are compounded by such external forces as government targets and regulatory measures. These contradictions, sometimes intensified as a consequence of disjointed policy making, may be mirrored with added complexity at trust level.

Mediating processes in faculty development

Tensions between service and training commitments can be an effective force for adaptation, if effectively mediated. An example is the formalisation of workplace-based training opportunities and assessment measures, emphasising the symbiotic relationship between service and training in an NHS where both must be delivered to increasingly rigorous standards in a reduced working week[18].

We encountered differing expectations in relation to engagement with the educator role. There was evidence of a widely-shared belief that all consultants had a duty to teach their junior colleagues as enshrined in the GMC's *Good Medical Practice.* It was suggested, however, that not all consultants had either the propensity or talent to develop as fully-fledged educators. We found evidence of a pragmatic belief that forcing all doctors into enhanced educator roles may not

work and it might be better to identify, nurture and support the instinctive educators, leaving their colleagues to focus on alternative areas of interest, be they clinical, managerial or academic[19]. This suggests that local discussions are needed to ensure effective job plans are shaped to support all roles within a clinical team or department.

Our data suggest that the systematic review of consultants' educational role may not yet be embedded in the annual NHS appraisal process: a situation which employers will need to address. We certainly encountered a belief in the value of personal development planning in order to identify education CPD. Nurturing a culture that supports structured observation and feedback for consultants from educationalists may further advance faculty development. The culture of education within trusts also requires an appropriate infrastructure to support frontline educators in departments as well as organisations' lead educators.

We found evidence of support for the emergence and gradual formalisation of career pathways for educators[20], with both consultants and doctors in training pursuing academic qualifications at varying levels. The desire for clarity and guidance around the knowledge and skill-set required for specific educational roles was made clear, which is something the GMC should be responsive to.
Our data suggest that there is potential for premature stalling in information flow, preventing frontline educators from receiving (or more commonly filtering out) key communications and accessing development opportunities. The uncertain connectivity between the leaders of cutting edge developments in the field and frontline educators is noteworthy and not entirely surprising: a problem which may be overcome by translating the shibboleths of academia and drawing out practical lessons for educators. Stakeholder organisations engaged with educator development should ensure that *appropriate* communication with all educators is optimised.

Another communication–related factor which we encountered was a professed desire within our sample to engage with peer networks of educators[21]. This was perceived as an effective means of accessing social support, knowledge exchange and innovation. Stakeholders might encourage and facilitate peer networks where they may be beneficial in furthering faculty development.

Structuring transformative practice: the faculty development programme
We identified a pragmatic desire for plurality of provision which has the capacity to cater for clinicians with varying levels of engagement with the educator role. The centrality of the workplace as a medium for effective CPD, a desire for formalised curricula, role-related standards and the facilitation of their attainment by employing organisations, all are voiced as necessary developments.

Continued availability of preferably LEP-provided focused workshops and education meetings which are quality assured, combined with the growth in provision of postgraduate credit-bearing programmes in clinical teaching, will help to meet these varying needs. In addition, participation in a variety of educational activities may well, over time, enable a community of educators to be established in localities or across deaneries.

The optimal content of faculty development programmes is well-evidenced[12] and our sample displayed a clear understanding of the centrality of curriculum delivery, supervision, assessment, teaching methods and dealing with underperformance. We also found evidence of a recognised need for increasing utilisation of technology to support the delivery and assessment of education[22].

Limitations
There are several limitations to our study. We conducted interviews with a small number of hospital consultants within one postgraduate deanery. By using purposive sampling involving the main medical specialties in several hospital trusts we attempted to reduce the possibility of unrepresentative perceptions as a result of area- and specialty-specific variables. During interviews, social desirability may have led respondents to self-censor their actual views. We attempted to limit this possibility by placing emphasis on the assured anonymity of participants.

Conclusion
Exploring the perceptions of hospital consultants in relation to faculty development enabled us to examine a multiplicity of factors, each contributing both independently and symbiotically to the whole.
It is important to note that we collected the interview data in 2008, prior to the publication of detailed training requirements for educational supervisors by the Academy of Medical Educators and the GMC's training standards. To understand how these influential policy documents are impacting upon faculty development will require further investigation.

Our study was focused on obtaining a greater understanding of faculty development based on the self-reported perceptions of hospital consultants. This is a crucial perspective but, in order to secure a more comprehensive understanding of faculty

development, follow-up work with, for example, trainees would be useful in generating a richer narrative with which to describe and understand the development needs of medical educators.

Faculty development is in a constant state of evolution, with occasional bursts of revolution[23]. The centrality of this activity in ensuring a well-trained, safe and productive medical workforce cannot be underestimated. As the NHS experiences a period of major economic constraint, the implementation imperative to constantly improve the effectiveness of medical education and training will become increasingly challenging[24]. Understanding the development needs of medical educators, and utilising this knowledge to focus expertise and resources most effectively, may make the challenge less daunting.

Disclosures

Acknowledgements: The authors gratefully acknowledge all the busy hospital consultants who generously gave up their time to speak to them.
Funding/support: None
Ethical approval: Ethical approval was obtained for the study from Tameside and Glossop NHS Local Research Ethics Committee via the UK National Research Ethics System.
Disclaimer: None
Previous presentation: None

Reference

1. Department of Health. *Modernising Medical Careers*. London: Department of Health, 2003.
2. Working group on specialist medical training. *Hospital doctors: training for the future*. London: Department of Health, 1993.
3. Health and Safety Executive. The Working Time Regulations http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm Accessed October 21, 2011).
4. Tooke J. *Aspiring to excellence: Final report of the independent inquiry into Modernising Medical Careers*. London: MMC Inquiry, 2008.
5. Darzi A. *A High Quality Workforce: NHS Next Stage Review*. London: Department of Health, 2008.
6. Temple J. *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*. Medical Education England: London, 2010.
7. Postgraduate Medical Education and Training Board. *Standards for Trainers*. PMETB: London, 2008.
8. Academy of Medical Educators. *Educational Supervisors in secondary care: Stage 1 Report*. London: Academy of Medical Educators, 2009.
9. General Medical Council. *Generic standards for specialty including GP training*. London: General Medical Council, 2010.
10. Steinart Y, Mann K, Centeno A, Dolmans D, Spencer J, Gelula M, Prideaux D. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. *Med Teach.* 2006; 28(6):497-526.
11. Hesketh EA, Bagnall G, Buckley EG, Friedman M, Goodall E, Harden RM, Laidlaw FM, Leighton -Beck L, McKinlay P, Newton R and Oughton R. A framework for developing excellence as a clinical educator. *Med Educ.* 2001*;* 35: 555-64.
12. Wall D and McAleer S. Teaching the consultant teachers: Identifying the core content. *Med Educ.* 2000; 34: 131-8.
13. Knight AM, Carrese JA, Wright SM. Qualitative assessment of the long-term impact of a faculty development programme in teaching skills. *Med Educ.* 2007; 41(6) 592-600.
14. Strauss A and Corbin JM. *Grounded Theory in Practice*. Thousand Oaks, Ca: Sage Publications, 1997.
15. Denzin NK and Lincoln YS. *Handbook of Qualitative Research*. 3rd ed. Thousand Oaks, Ca: Sage Publications, 2005.
16. Hewson MG. A Theory-based Faculty Development program for Clinician-Educators. *Acad Med. 2000;* 75(5): 498-501.
17. Tsouroufli M, Payne H. Consultant medical trainers, modernising medical careers (MMC) and the European time directive (EWTD): tensions and challenges in a changing medical education context. *BMC Med Educ.* 2008; 8:31.
18. Modernising Medical Careers Programme Board Task and Finish Group on Quality. *Maintaining quality of training in a reduced training opportunity environment.* London: MMC, 2009.
19. Bligh J and Brice J. Further insights into the roles of the medical educator: the importance of scholarly management. *Acad Med*. 2009; 84 (8):1161-5.
20. Association for the Study of Medical Education. *Careers in Medical Education: Report of the ASME conference held on 8 December 2005*. Edinburgh: ASME, 2006.
21. Steinert Y, Macdonald ME, Boillat M, Elizov M, Meterissian S, Razack S, Ouellet MN, McLeod PJ. Faculty and student support: Faculty development: if you build it, they will come. *Med Educ*. 2010; 44(9): 900–7.
22. Choules AP. The use of e-learning in medical education: a review of the current situation. *Postgrad Med J. 2007; 83:212-6.*
23. Skeff K, Stratos G, Mount J. Faculty Development in Medicine: A Field in Evolution. *Teach Teach Educ. 2007;* 23(3): 280-5.
24. Department of Health. *Equity and excellence: Liberating the NHS*. London: Department of Health, 2010.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Audit: The Prescribing of Escitalpram and Citalopram in the Later Life

Dr Hankir A MBChB; Dr Tharaken V MBChB, MRCPsych; Dr Ratcliffe J MBChB MRCPsych

Institution
**National Institute for Health Research Academic Clinical Fellow in Psychiatry, Manchester University. Harvard Medical School Global Clinical Scholars Research Training Program, Harvard Medical School, Boston, USA.*

***Consultant Old Age Psychiatry, Tameside Hospital, Greater Manchester, England.*

****Consultant Old Age Psychiatry, Manchester Royal Infirmary, Manchester, England.*

Key Words
Audit, Old age, Depression, SSRIs, Citalopram, Escitalopram

Corresponding Author:
Dr Hankir A, E-mail: ahmedzakaria@doctors.org.uk

WJMER, Vol 8: Issue 1, 2014

Background

Episodes of mood disorders in the elderly occur more frequently and last longer than they do compared to that of the general population. Moreover, studies suggest that mood disorders in the elderly have a worse prognosis and there may also be a tendency towards chronicity[1].

The prevalence for clinically significant depression is 10 % for those > 65yrs, with 2-3 % being severe[1]. The rates of depression differ depending on the setting: 10-15 % in the community; 25-30 % of clinical inpatients and 15-30 % of those in long-term care settings (i.e. residential and nursing homes) [2].

The first line treatment of depressive illness in the elderly is a selective serotonin reuptake inhibitor (SSRI) due to decreased side-effects and relative safety in overdose. It must be borne in mind that the elderly can be on SSRIs for a longer duration than the general population are (maintenance periods can last up to 2 years) and hence are subject to the adverse effects of medications for more protracted periods[1].

Citalopram is a SSRI antidepressant that is widely used in clinical practice[3]. Castro *et al* conducted a cross sectional study of electronic health records to quantify the impact of citalopram and other selective serotonin reuptake inhibitors on corrected QT interval (QTc) which is a marker of risk for ventricular arrhythmia, in a large and diverse clinical population based in the US[4]. Normal values for QTc range from 350 to 450 ms for adult men and 360 to 460 ms for adult women, but up to 10-20 % of otherwise healthy persons may have QTc values outside this range [5, 6, 7]. The main outcome measure of the study was the relationship between antidepressant dose and QTc interval in linear regression, adjusting for potential clinical and demographic confounding variables. This study confirmed a modest prolongation of QT interval with citalopram and escitalopram[4].

Zhang *et al* conducted a meta-analysis of the literature to investigate the correlation between the QT interval and mortality endpoints[8]. Abnormal prolongation of the ECG QT interval (whether genetically determined or acquired) predisposes to malignant ventricular arrhythmias and sudden cardiac death [9, 10]. Zhang *et al* found consistent associations between prolonged QT interval and increased total risk of, cardiovascular, coronary, and sudden cardiac death. They conclude by stating that

QT interval length is a determinant of mortality in the general population and that at a population level, these associations are substantial and comparable in magnitude to the effect of other traditional cardiovascular risk factors[11].

Aims

The aim of this audit was to ascertain whether we were adhering to the MHRA guidelines on the prescribing of SSRIs in older people for a particular later life consultant psychiatrist's caseload in the Manchester catchment area.

The MHRA guidelines were introduced in December 2011 recommending that the maximum dosage of Citalopram and Escitalopram be reduced to 20 mg and 10 mg respectively in the elderly (>65yrs). We wanted to establish if we were adhering to the MHRA guidelines which included the following:

1. For the group of patients already started on Citalopram/Escitalopram before December 2012, whether the dosage was (A) reduced (B) there was a switch in the anti-depressant being prescribed or (C) whether there was discussion and documentation with the patient that they were on the above recommended dosage, that they were informed of the adverse risks of this and that an ECG was requested for at the point of discussion (and subsequently performed imminently and on a 6 monthly basis.)
2. For the group of patients who were instigated on Citalopram/Escitalopram after December 2012, were they initiated on Citalopram/ Escitalopram as per MHRA guidelines (i.e. were they within the range of 20mg and 10mg respectively).

For both groups we also recorded whether they were on any medicines that might have an effect on the QT interval (we obtained a list of drugs that can prolong QT interval by conducting a word search on PubMed Central. We obtained a table from the following issue of a journal indexed in PubMed Central: Heart. 2003 November; 89 (11): 1363-1372.)

Standards

The standard was to be in 100 % compliance with the MHRA guidelines on the prescribing of SSRIs in older patients (>65 yrs).

Methodology

We conducted an audit on all the elderly patients of a particular Later Life Consultant Psychiatrist's caseload in the central Manchester catchment area who were diagnosed and receiving treatment for depressive illness with Citalopram or Escitalopram. These patients could broadly be divided into two groups:

1. A group of patients who were initiated on Citalopram/Escitalopram prior to December 2011
2. A group of patients who were initiated on Citalopram/Escitalopram after December 2011.

We accessed the letters and other information for each case on the electronic database AMIGOs. We were then able to confirm if the patient was on Citalopram/Escitalopram, when they were started, if there was any change in the dosage in accordance with the introduction of the MHRA guidelines in December 2012 and whether other aspects of the guidelines were adhered to.

In order to expeditiously and efficiently collect the data, we created a pro-forma. The pro-forma, once filled out, would contain all of the relevant information that was necessary to undertake and complete the audit. Upon completion of the acquisition of data, we entered this information onto a Microsoft spread-sheet. Having done this, we were then able to analyse the data.

In order to calculate the sample size, we used a sample size calculator (http://www.raosoft.com/ samplesize.html) provided by the department's the Quality Improvement Officer. The population size is the number of patients under the care of the consultant from which we obtained our sample. The parameters were as follows:

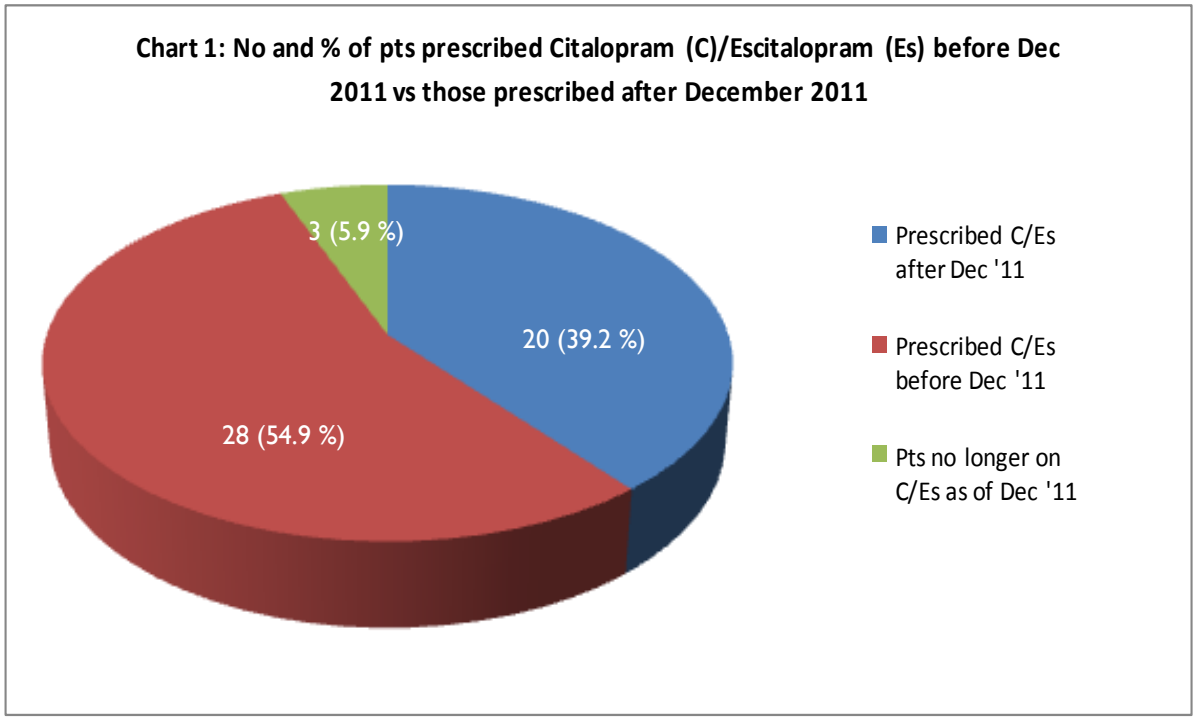
Population Size: 242
Margin error: 10 %
Confidence interval: 90 %
Response distribution: 50 %
Using the aforementioned calculator with the above parameters, the recommended sample size was calculated to be **54.**
The population size of later life psychiatry in general is 1680 (i.e. patients listed in AMIGOS with an outpatient consultant of specialty Old Age Psychiatry).

Findings and Results

The total number of cases in the sample was 51 of which 3 were excluded due to discontinuation of Citalopram/Escitalopram prior to December 2011.

Out of the remaining patients who were on treatment as of December 2011, 28 (54.9 %) were prescribed Citalopram/Escitalopram before December 2011 and 20 (39.2 %) were prescribed Citalopram/Escitalopram after December 2011.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

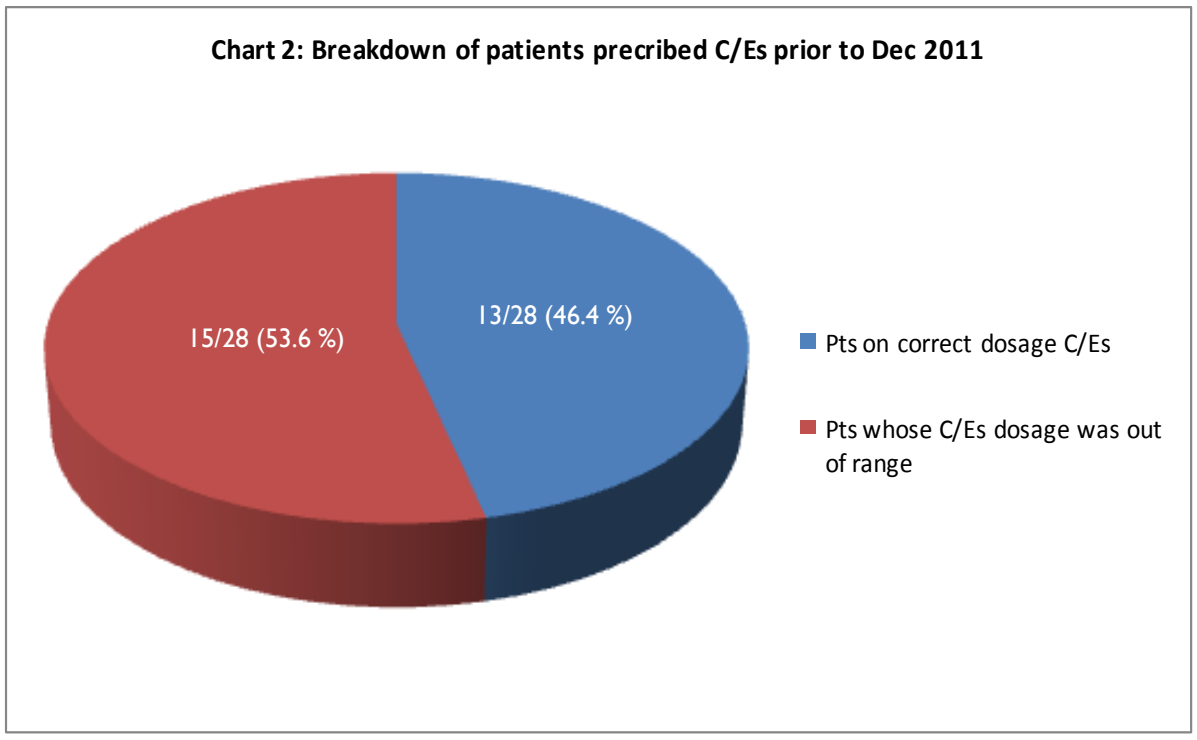


Patients on Citalopram/Escitalopram after December 2011

Of the 20 patients on Citalopram/Escitalopram after December 2011, 20 of them (100 %) had the dosage in range. 4 (20 %) had medications that can prolong QTc, of which.

Patients on Citalopram/Escitalopram before December 2011

This group was comprised of 28 patients. We found it easier to analyse the results of this group by splitting them into those who were on the correct dosage and those who were not:



Patients on the correct dosage of Citalopram/Escitalopram:
13 out of 28 patients (46.4 %) were on a dosage that was within the recommended range.

Of these 13, 9 had an ECG prior to or during the course although this is not part of the guidance.

1 patient was on a medicine that can prolong QTc. An ECG was done on this patient and the Citalopram/Escitalopram was subsequently changed to an alternative anti-depressant.

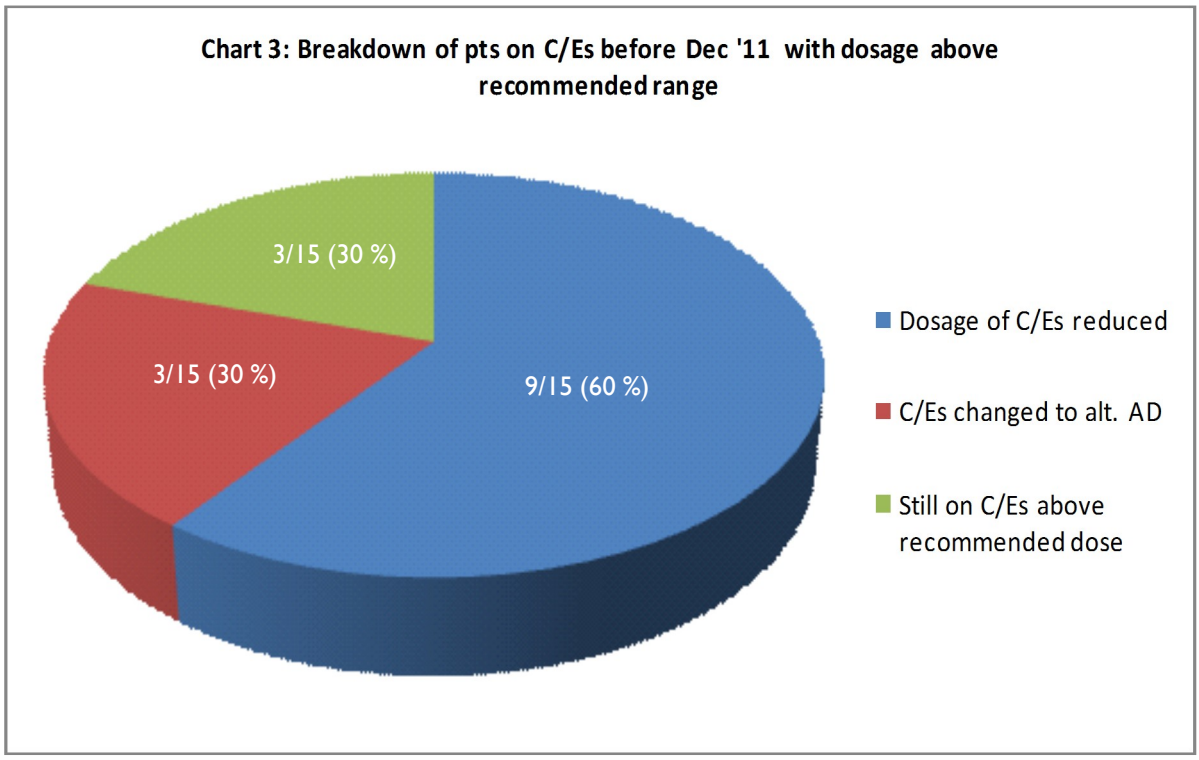
Patients not on the correct dosage of Citalopram/Escitalopram:
15 out of the 28 (53.6 %) who were on Citalopram/ Escitalopram before December 2011 were on a dosage above the recommended range.

9 out of these 15 cases (60 %) had the dosage of Citalopram/Escitalopram reduced in accordance with the recommendation, all of which were preceded by a discussion with the doctor.

3 out of 15 of these cases had their Citalopram/ Escitalopram changed to an alternative anti-depressant. 2 out of these 3 had a documented discussion with a doctor.
In the remaining 3 out of these 15 cases there is no record that the dosage Citalopram/Escitalopram was reduced.

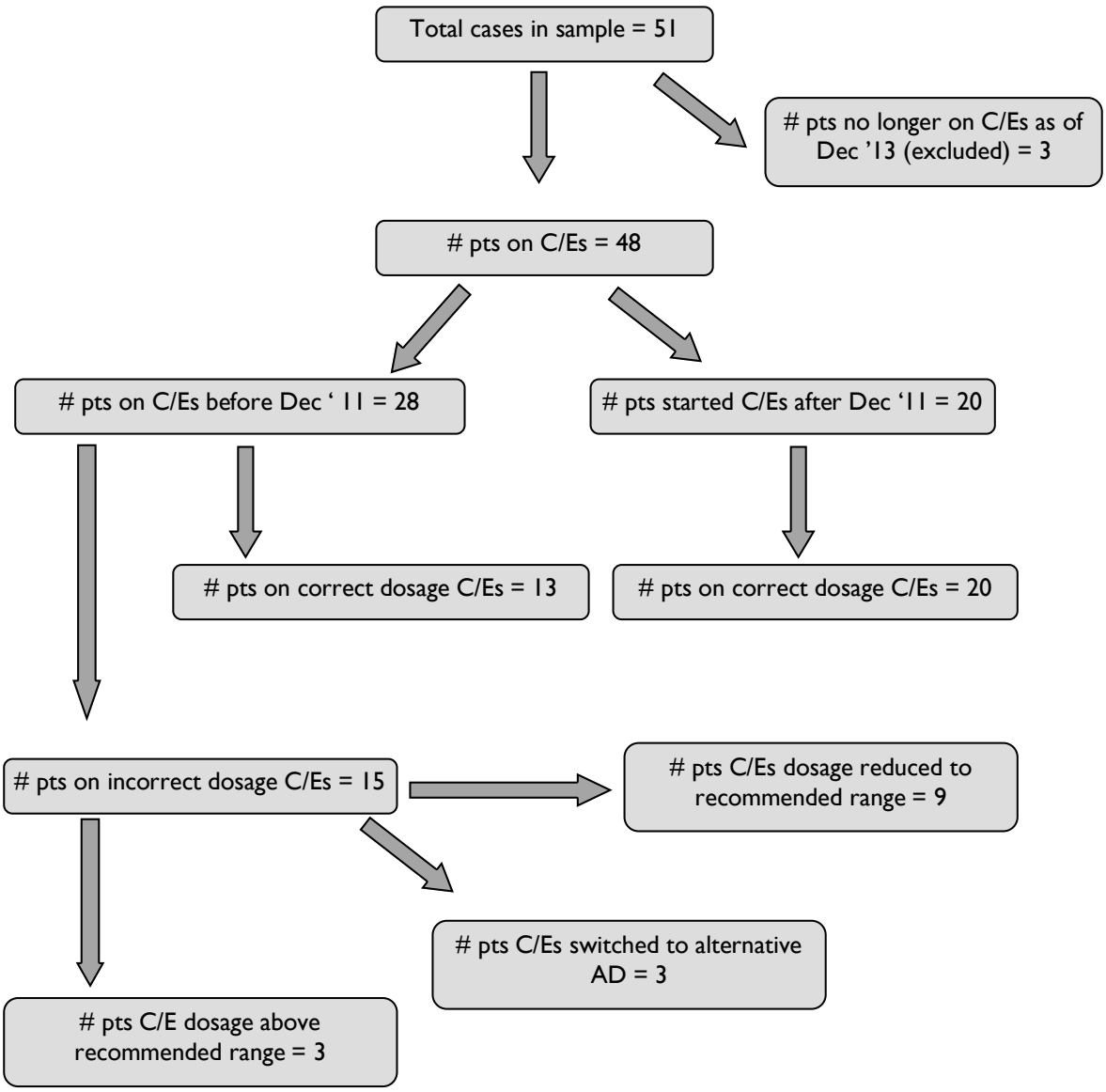
3 out of these 3 (100%) patients had documentation that the dosage of Citalopram/Escitalopram was above the recommendation. 3 out of these 3 (100%) patients had documentation that there was a discussion that he/she is being treated above the recommended limits.

All 3 (100%) of these patients had ECGs prior to or during treatment. 3 out of 3 (100%) had documented 6 monthly ECG recommendation.
2 of the 15 were on medications that can prolong QTc and both had an ECG.



World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Flowchart of Patients on Citalopram/Escitalopram



Service Strengths
This audit enabled us to identify the strengths of our service as well as areas that require further development. The strengths of our service are as follows:

- We were adhering to the MHRA guidelines for the prescribing of Citalopram and Escitalopram in 100 % of our patients.
- 100 % patients initiated on citalopram/ escitalopram after December 2012 were on a dosage that was in accordance with the MHRA guidelines.
- 100 % of patients who had prolonged QT interval were identified and instigated on an alternative antidepressant.

Service Recommendations
The audit revealed that we were in compliance with the standard with which we measured ourselves against in 100 % of our service users.

Although 3/51 patients in our sample were on a dosage above the recommended range, this was documented and discussed with the patient.

We recommend that baseline ECGs be performed on all patients who are about to be initiated on citalopram/escitalopram. The rationale of our recommendation is that if we were to perform an ECG on a patient whom we are about to start on citalopram/escitalopram and we incidentally detected an abnormal QT interval this would prevent us from possibly making the situation worse (i.e. by placing them at increased risk of ventricular arrhythmia) which would be a possible consequence of proceeding and prescribing one of these medicines. The ECG would provide us with further information that would guide our decision making to include considering an alternative anti-depressant in patients who may be at increased risk of developing a cardiac arrhythmia (we note that the NICE guidelines recommend that all patients who are about to be initiated on acetylcholine esterase inhibitors have an ECG prior to starting treatment due to the increase risk of developing cardiac arrhythmias with this class of drug).

Outcomes and Benefits
This audit has enabled us to identify patients whom we are not complying with the MHRA guidelines whom may otherwise may not have been identified for a potentially substantial time period (follow up appointments can be arranged on a 6 monthly basis in some patient groups). The benefits obtained include being able to review these patients sooner rather than later and intervening accordingly. Not identifying these patients and allowing them to continue on a dosage or medicines that can prolong QT interval places them at increased risk of developing ventricular arrhythmia and this could potentially become a governance issue (mortality due to a preventable cause).

Action Plan
We intend to present our findings in local (and national) meetings in order to educate and/or remind the relevant mental healthcare providers of the MHRA prescribing guidelines on citalopram/ escitalopram and the associated dose-dependent risk of prolongation of QT interval and the possible adverse effects of this.

We will seek to roll out our audit across Manchester Mental Health and Social Care Trust so we can identify patients with whom we are not in compliance with the MHRA guidelines and take the relevant action to ensure 100 % compliance rates.

We will also develop a list of medicines that can prolong the QT interval and distribute that list to the relevant mental healthcare providers (i.e. other services in the Manchester Mental Health and Social Care Trust, GP surgeries etc).

Reference
1. Semple, D; Smyth, R. *The Oxford Handbook of Psychiatry*, Old Age Psychiatry Chapter pp. 520-521 Oxford University Press, 2013.
2. L.S. Schneider, C.F. Reynolds III, B.D. Lebowitz, A.J. Friedhoff (Eds). *Diagnosis and treatment of depression in late life: Results of the NIH Consensus Development Conference* (pp. 9-19). Washington D.C.: American Psychiatric Press
3. Cooke, MJ; Waring WS. *Citalopram and Cardiac toxicity* Eur J Clin Pharmacol. 2013 Apr;69(4):755-60. doi: 10.1007/s00228-012-1408-1. Epub 2012 Sep 21.
4. Castro VM, Clements CC, Murphy SN, Gainer VS, Fava M, Weilburg JB, Erb JL, Churchill SE, Kohane IS, Iosifescu DV, Smoller JW, Perlis RH. *QT interval and antidepressant use: a cross sectional study of electronic health records*. BMJ. 2013 Jan 29;346:f288. doi: 10.1136/bmj.f288.
5. Viskin S. *The QT interval: too long, too short or just right*. Heart Rhythm. 2009;6(5):711–5. [PubMed]
6. Mason JW, Ramseth DJ, Chanter DO, Moon TE, Goodman DB, Mendzelevski B. *Electrocardiographic reference ranges derived from 79,743 ambulatory subjects*. J Electrocardiol. 2007;40(3):228–34. [PubMed]
7. Johnson JN, Ackerman MJ. *QTc: how long is too long*? Br J Sports Med. 2009;43(9):657–62. [PubMed]
8. Zhang, Y; Post,W,S; Blasco-Colmenares, E;

Dalal,D; Tomaselli,GF; Guallar, E. *Electrocardiographic QT interval and mortality: a meta-analysis*. Epidemiology. 2011 September; 22(5): 660 –670.doi: 10.1097/EDE.0b013e318225768bPMCID: PMC3150395 NIHMSID: NIHMS305907

9. Sauer AJ, Moss AJ, McNitt S, Peterson DR, Zareba W, Robinson JL, Qi M, Goldenberg I, Hobbs JB, Ackerman MJ, Benhorin J, Hall WJ, Kaufman ES, Locati EH, Napolitano C, Priori SG, Schwartz PJ, Towbin JA, Vincent GM, Zhang L. *Long QT syndrome in adults*. J Am Coll Cardiol. 2007;49 (3):329–37. [PubMed]
10. Montanez A, Ruskin JN, Hebert PR, Lamas GA, Hennekens CH. *Prolonged QTc interval and risks of total and cardiovascular mortality and sudden death in the general population: a review and qualitative overview of the prospective cohort studies*. Arch Intern Med. 2004;164(9):943–8. [PubMed]
11. Dekker JM, Schouten EG, Klootwijk P, Pool J, Kromhout D. *Association between QT interval and coronary heart disease in middle-aged and elderly men*. The Zutphen Study. Circulation. 1994;90 (2):779–85. [PubMed]

The Post-graduate Psychiatry Training Programme in Malta

Dr Aquilina FF M.D

Institution

Foundation Year 2 Doctor Materdei Hospital & Mount Carmel Hospital, Malta.

WJMER, Vol 8: Issue 1, 2014

Abstract
Post-graduate psychiatry training in Malta has undergone considerable reform over recent years in order to keep up to date with developments in psychiatry training worldwide. The burgeoning increase in the rates of mental illness has meant that the demand for psychiatrists is also on the rise. With the advent of neuro-imaging, there has been a boom in the scientific progress of psychiatry and this, as well as other factors, has resulted in more medical graduates expressing an interest in pursuing a career in this exciting and dynamic medical specialty. This article outlines the psychiatry training programme offered in Malta to doctors who have successfully completed their foundation training. The article outlines psychiatry training at both core and specialist training levels.

Key Words
Training, psychiatry, Malta, Core training, Specialist training.

Corresponding Author:
Dr Aquilina FF: wjmer@doctorsacademy.org.uk

Introduction

The post graduate training programme offered for psychiatry in Malta was only recently launched. This started being offered to foundation doctors willing to take up a career in psychiatry as from the year 2011 onwards. This programme is offered under the guidance of the co-ordinator Dr John Mifsud, consultant psychiatrist and president of the Malta college of psychiatrists.

Psychiatry is a humanitarian branch of medicine. Thus, this programme endeavors to analyse the etiology, prevention, diagnosis, management and rehabilitation of disorders affecting mental functioning, with the ultimate goal being to promote a positive mental health.

The programme in Malta spans over a period of five years of training. It aims to assist the psychiatry trainees to become competent professionals in this speciality and therefore manage a variety of clinical situations and problems in various ethical settings. It also aims at offering a sound knowledge of the basic sciences applicable to psychiatry. In fact, it reflects advances made in the field of neuroscience, molecular biology and genetics, thus rendering the trainee competent at delivering the most appropriate treatment modalities suitable for the individual patient.

Additionally, the programme also aims at providing the adequate training for doctors to become balanced clinicians with strength in both psychotherapeutic and biological aspects of psychiatry. This is only possible when the trainee learns to analyse critically the practice of evidence based psychiatry so as to ultimately acquire life long learning skills. Thus, the programme does not only aim at producing good clinical psychiatrists but leaders in the field with an ability to carry out research, teaching, administration and clinical services offers in Malta and overseas. It is for this reason that having a leadership role in a multidisciplinary team is never emphasized enough. The training ultimately satistifies the requirements set by 'Union Européene des Médecins Spécialistes'.

The Teaching Programme

This divides into two parts. The first part is carried out over a span of three years and corresponds to basic specialist training while the second part is of two years duration and is equivalent to higher specialist training. Each of these two parts consists of a theoretical and competence training part. The former involves formal work experience which is organized and regularly assessed by an assigned clinical supervisor as per diagram below. Each part of this schedule is carefully planned, organized and run by the Director of Training and his Specialist Committee.

A Scheme of 'Part I' (Three year duration)

		Minimum of:
Obligatory	General Adult Psychiatry (in and out patients) ---------- ----------	18 months
Obligatory	*Emergency Psychiatry (including night duties)----------	33 months
Obligatory	Consultation-Liaison Psychiatry ----------	3 months
Obligatory	Developmental Psychiatry (Either Child & Adolescent Psychiatry or	3 months
Obligatory	Old Age Psychiatry ----------	3 months
Obligatory	Psychotherapy----------	2 years
Recommended	Forensic Psychiatry ----------	3 months
Recommended	Substance Abuse/Addictions Psychiatry ----------	3 months
Recommended	Chronic Care/Rehabilitation Psychiatry ----------	3 months

*Emergency psychiatry involves the on call duties both if scheduled for the morning or for the night. The vast majority are carried out at our main psychiatric hospital i.e: Mount Carmel Hospital in Attard. However, the duty work which takes the form of urgent consultations may also be carried out at the emergency department at Mater Dei Hospital in Msida,which is our principal medical hospital. Other such scenarios may also occur in health centres and during the consultation- liason psychiatry placement offered at Mater Dei Hospital. The latter is supervised by the trainee's Consultant Psychiatrist/Clinical supervisor.

Theoretical teaching

Basic Psychology ……	3 months
Social Psychology ……	3 months
Cognitive Psychology ……	3 months
Human Development ……	3 months
The Personality and its Problems ……	3 months
Research methods, Statistics, Epidemiology and Evidence-based practice ……	3 months
History taking and psychiatric examination, Mental Status, Formulation. Psychological tests & lab. investigations Diagnosis & classification ……	3 months
Basic Neurosciences (Neuroanatomy, Neurophysiology) ……	3 months
Basic Neurosciences (Neurochemistry, Genetics) ……	3 months
Psychiatry overview & Emergency Psychiatry ……	3 months
ECT ……	3 months
Philosophy, Ethics, Religion & Psychiatry ……..	3 months
Case conferences, Seminars ……	27 months
Journal Club, Research Presentations ……...	27 months
Psychotherapy ……	27 months
History of Psychiatry, Social Science & Socio-cultural Psychiatry ……...	3 months
Neurobiology & Clinical Psychopharmacology ……	9 months
Child and Adolescent Psychiatry ……	6 months
Learning Disability ……	3 months
Mental Health Problems and Mental Illness ……	9 months
Addictions and Addictive Behaviour ……..	6 months
Old Age Psychiatry ……	6 months
Consultation Liaison, Clinical Topics Interfacing Medicine & Psychiatry ……	6 months
Forensic Psychiatry ……	6 months
Sex, Marital and Couple problems ……	3 months
Clinical Neurology, Neuropsychiatry, EEG, Neuroimaging……	6 months
Perinatal Psychiatry ……	3 months
Eating Disorders ……	3 months
Leadership and Management ……	3 months
Chronic care & psychiatric rehabilitation ……	3 months

The topics above are thought modules which take the form of seminars, tutorials, case presentations, journal clubs, videos, research and research presentations. These are all deemed necessary for a solid understanding and training of the practice of psychiatry and adherence to the scheduled meetings is essential.

A Scheme of Part 2 (Two year duration)

Competence training

General Adult Psychiatry (in and out patients) ----------	minimum of: 6 months
*Emergency Psychiatry (including night duties)----------	minimum of: 6 months
Child and Adolescent Psychiatry ----------	minimum of: 3 month
Old Age Psychiatry ----------	minimum of: 3 months
Consultation-Liaison Psychiatry (including emergencies)----------	minimum of: 3 months
Forensic Psychiatry ----------	minimum of: 1 month
Chronic Care/Rehabilitation Psychiatry ----------	minimum of: 1 month
Substance Abuse/Addictions Psychiatry ----------	minimum of: 1 month
Perinatal Psychiatry, ----------	minimum of: 1 month
Learning Disabilities, ----------	minimum of: 1 month
Neurology----------	minimum of: 1 month
Neuroradiology----------	minimum of: 1 month
Psychotherapy----------	2 years

*This takes the form of the emergency setting as described in the previous note.

The competence training is based on the same concepts as that for the first part of the programme. However, the length of the placement depends on a number of factors. Most importantly; an expressed interest of the trainee in a particular subspeciality together with a recommendation from the clinical and educational supervisors of the particular trainee. The decision is ultimately made by the Director of Training while taking into consideration these factors.

Theoretical training

In-depth mental health problems ……	18 months
Advanced psychopharmacology……	6 months
Special topics including recent developments and telemedicine	6 months
Case conferences, Seminars……	18 months
Journal Club, Research Presentations ……	18 months
Psychotherapy ……..……	18 months

The above modules take the form described in the theoretical training as described for part 1. However, the teaching modules are more detailed and delve into in-depth mental health problems.

Method of trainee evaluation
This consists of:

1. Attendance : a minimum of 80% attendance of the theoretical teaching is required. This is normally recorded on a sign in log book present during the teaching site. Persistent and regular attendance to clinical and educational supervision is also vital.
2. Competence : regular assessment is carried out by the Clinical Supervisor on a monthly basis

which is then handed to the Director of training as a mark sheet. Competence in presentation of research, articles and also lecturing is included. An annual examination is carried out in which the trainee is presented with a psychiatric clinical vignette and must take a history and ultimately give a diagnosis and management.

3. End of rotation : the trainee must submit both a written report to the director of training outlining the valuable experiences gained throughout the placement. An evaluation of the trainee's work by the director of training is then carried out. In fact, a logbook should be kept by each trainee to verify whether one is up to date with the necessary requirements of the programme. A workbook should also be updated in which detailed case histories covering a wide spectrum of psychiatry are included.
4. Theoretical :
   - Modules are assessed by seminar attendance and also success in the annual examinations held at the end of each academic year. Pass marks in assignments is also required.
   - Research must be well evidenced by presentations and projects created by the trainee. These are assessed by the supervisor in charge of the trainee.
   - CPD includes case presentations, seminars and special topic lectures carried out by the trainee him/herself. These are yet again supervised by the clinical supervisor in charge.

At the end of the 5 year programme the trainee is to present an original research work in the form of a thesis. If the latter is completed and the above also obtained the trainee will finally be awarded with a certificate of completion together with the qualification in General Psychiatry. Specialization in a particular area ex : child and adolescent mental health will require a further 12 months of training. The details of the rotation would be proposed and approved by the Specialist Accreditation Committee.

Ultimately, the training is aimed at producing versatile specialists able to take up roles of psychiatric clinical decision-makers, communicators, collaborators, managers, health advocates, scholar and professionals. Above all, by the end of the five year programme the trainees should become compassionate and professional psychiatrists.

Reference

John Mifsud, Coordinator of PGPsych Malta, President of Malta College of psychiatrists, Malta - 2014 personal communication

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Addressing the dual needs of substance misuse and Attention Deficit Hyperactivity Disorder: an audit and a literature review

Ragsdell B*, Theodosiou L BSc Hons, MBChB, MSc, PGCE**

Institution

**5th year Medical Student, University of Manchester, UK*

***Consultant Child and Adolescent Psychiatrist, Central Manchester University Hospitals NHS Foundation Trust*

Key Words
ADHD, Substance misuse, Alcohol, Adolescents, Mental health

Corresponding Author:
Theodosiou L: louise.theodosiou@cmft.nhs.uk

WJMER, Vol 8: Issue 1, 2014

Introduction

The Emerge 16 – 17 Community Mental Health Team was launched in 2007. The multi-disciplinary team accepts all new referrals of young people with mental health needs across Manchester and Salford while the core CAMHS (Child and Adolescent Mental Health Services) accept referrals of children below 16 and keep their existing case until they reach 18. Emerge accepts referrals from a wide range of agencies including adolescents themselves. From April 1st 2013 to March 31st 2014 Emerge received 722 new referrals (505 to the Manchester arm, and 212 to the Salford arm). As in previous years, the numbers of female service users was higher than males (251:469) with two young people declaring formally that they were exploring their gender identity. The predominant presenting issues for the young people referred were concerns about low mood / depression and self harm. The number of GP referrals had increased for the 3rd year in a row, from 40.7% in 2011 – 2012 to 50.9% in 2012 – 2013 to the present year where 58.3% of referrals came from GPs.

Attention Deficit Hyperactivity Disorder (ADHD) is one of the commonest mental health conditions in young people in the UK[1], with a prevalence of between 3-9%. The condition is characterised by hyperactivity, impulsivity and inattention and must be pervasively present (e.g. home and school) for diagnosis. ADHD can be managed through a multidisciplinary approach. The National Institute of Health and Clinical Excellence (NICE) notes that treatment involves education programmes, behavioural strategies, Cognitive Behavioural Therapy (CBT) and stimulant medication[1].

In young adults, inattention and impulsivity are often the most challenging features reported[2]. This can lead to an increase in risk-taking behaviour, particularly during the experimental phase that is adolescence. Consequently, young people with ADHD have increased risk of teenage pregnancy, forensic involvement and reduced education outcomes[2]. It is estimated that 45% of young people involved in the Youth Offending Service (YOS) suffer from ADHD[2]. Furthermore, many studies have also identified a correlation between ADHD and substance misuse[3].

Studies suggest that up to 30% of young people with ADHD have concurrent SUD[4]. Comorbid SUD both worsens the prognosis of ADHD and increases the risks associated with the symptoms[5]. Young people with ADHD may be more likely to make impulsive decisions, including experimentation with drugs and alcohol[6].

It is acknowledged that a high proportion of patients with ADHD will also have some form of learning difficulty[7]. This, coupled with the increased likelihood of school exclusion and peer rejection can lead to poorer outcomes at school[8] which can in turn impact on self-esteem. Low adolescent self-esteem in an adolescent is an independent risk factor for substance misuse[9] which could be an

additional risk factor in the initiation of substance use.

Wilens *et al* identified that, compared to a control group, 36% of young people with ADHD, acknowledged that they used substances as a form of self-medication; 33% sought to change their mood while 3% sought help with sleep[5]. Carroll and Rounsaville investigated the effect of ADHD on cocaine abusers and suggested that much of the cocaine use appeared to be clinically consistent with self- medication[10].

A key factor predicting the risk of an adolescent with ADHD developing a concurrent substance use disorder is a co-morbid diagnosis of Conduct Disorder (CD)[11]. CDs are defined in the NICE guidelines as being: 'characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations[12]'. Research suggests that both ADHD and CDs have independent risk for substance use disorder, where there is a co-diagnosis of both problems these risk factors are compounded[12]. Further studies have investigated the relationship between ADHD, CD and SUD. Molina *et al.* identified that CD was the only factor that increased a young person's risk of substance misuse and that a co-morbid diagnosis of ADHD gave significant increase in this risk[13]. Barkley found young people with a sole diagnosis of ADHD had no further increase in risk of SUD compared with the control population[13, 14]. However, this has been refuted by other studies which report that ADHD is an independent risk factor for SUD if other factors, including conduct disorder, are adjusted for[15].

Carroll and Rounsaville identified that if a patient with a SUD had concurrent ADHD then the severity of the SUD was more likely to be worse. This paper, along with other research, also reported that a young person with ADHD and SUD was more likely to present earlier with their addiction, compared with a sufferer of SUD without ADHD[10].

Method

This is a retrospective audit of 200 randomly chosen patients referred to Emerge. To allow for a sample size of 200 patients every third referral was selected starting with the first referral from April 2013. Once the patient was selected the data needed was taken from the patient's notes and referral information. A data collection pro forma (Appendix 1) was produced to ensure all data needed was collected and in an efficient manner.

If a patient's notes could not be found, data collection continued with the next third person to be selected. Once the data was collected on the pro forma it was transferred onto a statistics package: IBM SPSS Statistics 20.

Results

Roughly 50% of case notes contained some history regarding drug and alcohol use. The suggested that 54.5% of service users abstained from drinking alcohol. With regards to tobacco, 25.5% of services users were found to smoke on a regular basis. The audit identified that 45.2% of people in which a cannabis history was asked admitted to smoking cannabis in varying frequency. Of the 45.2% of patients 22.6% of these admitted to only trying cannabis once. The remaining 22.6% smoke either occasionally or regularly.

Discussion

Emerge works with young people in a range of difficult circumstances, including young mothers, homeless young people, young people awaiting trial or moving back into the community from a young offenders institute, unaccompanied asylum seekers and young people with significant anxiety presentations that can impact on their engagement. Phone numbers, addresses and circumstances can all change quickly which impacts on initial attendance at a service, engagement during appointments and ongoing attendance. All of these factors can in turn impact on the completion of drug and alcohol histories.

These factors can also impact on the development of peer relationships and the peer groups chosen which can in turn partially explain the patterns of drug use.

It has been estimated that more than 25% of young people who have a substance use disorder have undiagnosed ADHD[17]. Thus it has been proposed that young people presenting with problematic substance use should be screened for potential ADHD. However, diagnosing ADHD when there is active substance use is a clinical challenge; the substance problem can mimic the features of ADHD[17]. A period of abstinence would enhance assessment but this may be unrealistic. Therefore, it is important to take a detailed history from the patient and a carer or parent to elucidate function before the SUD. Information from education sources is also key[17].

It is acknowledged that a non-pharmacological approach to this dual diagnosis can be of benefit; CBT is a mode of treatment effective in both conditions. CBT for ADHD can reduce the symptoms and severity of concurrent substance misuse if the programme is tailored to their condition e.g. shortened sessions and removal of

components that need more concentration[18]. However, this would require therapists to have specialist training on how to tailor the sessions appropriately. CBT could either be delivered on a one-to-one basis or through group work.

NICE[1] recommends the use of standard pharmacological treatment for ADHD when there is comorbid SUD. It is argued that by treating the ADHD, the precipitating and perpetuating factors for the substance misuse are reduced, as well as allowing the patient to participate more fully in the psychotherapy for the SUD[19]. The Royal College of Psychiatry Practice standards for young people with substance misuse problems offers guidance on the treatment of young people with mental health problems and concurrent substance use[20]. NICE[1] notes that there is an argument that the use of methylphenidate increases the likelihood of subsequent drug misuse (sensitization theory) although the guidance notes that the evidence is limited. [21]. Mannuzza *et al* designed a prospective follow up study to identify possible correlations and identified that the later ADHD treatment was commenced, the higher the risk of SUD developing [22]. This evidence is further supported by Groenman *et al*. who found no difference between the control group and the group taking stimulant medication to the relationship of forming a SUD[21].

Many clinicians have raised concerns that if Methylphenidate were to be initiated, it may compound the SUD and lead to the medication being abused. There is uncertainty in this area because many of the studies looking at the efficacy of pharmacological management of ADHD have excluded patients with a concurrent diagnosis of substance misuse[23].

Clinicians are often wary of initiating Methylphenidate in someone with a previous substance problem. There have been case reports in the literature that report abuse of Methylphenidate in patients with a previous dual diagnosis of ADHD and SUD[24]. However, the concern seems to be more of a theoretical risk. Studies have been developed to elucidate whether there is an increased risk of abuse with Methylphenidate in patients with ADHD and SUD. A double blind randomised control trial examined the effects of Methylphenidate in a population of ADHD patients with a comorbid cocaine dependency[25]. It aimed to assess both the safety of the use of the drug in this population and whether there were any benefits. The study reported a positive benefit to symptoms subjectively when Methylphenidate was used in comparison to the placebo and did not find that Methylphenidate exacerbated the cocaine use of the patients[25]. This has been supported by earlier preliminary studies that showed that with close supervision there is a safe and effective role for the use of Methylphenidate for ADHD and SUD[26, 27].

Mental health services must strive to meet the needs of all young people accepted, and to assess the risk of self harm, abuse and further development of mental illness in all young people referred. However the authors would like to highlight the needs of young people with ADHD and substance use. Both conditions impact on economic opportunities, physical health and relationships. Both are potentially treatable.

References

1. NICE. Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults. 2013;CG72. September 2008.
2. Harpin VA. The effect of ADHD on the life of an individual, their family, and community from preschool to adult life. Archives of disease in childhood. 2005;90 Suppl 1:i2-7. Epub 2005/01/25.
3. Wilens TE. Attention deficit hyperactivity disorder and substance use disorders. The American journal of psychiatry. 2006;163 (12):2059-63. Epub 2006/12/08.
4. Hovens JG, Cantwell DP, Kiriakos R. Psychiatric comorbidity in hospitalized adolescent substance abusers. Journal of the American Academy of Child and Adolescent Psychiatry. 1994;33(4):476-83. Epub 1994/05/01.
5. Wilens TE, Adamson J, Sgambati S, Whitley J, Santry A, Monuteaux MC, *et al*. Do individuals with ADHD self-medicate with cigarettes and substances of abuse? Results from a controlled family study of ADHD. The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions. 2007;16 Suppl 1:14-21; quiz 2-3. Epub 2007/04/25.
6. Graziano PA, Reid A, Slavec J, Paneto A, McNamara JP, Geffken GR. ADHD Symptomatology and Risky Health, Driving, and Financial Behaviors in College: The Mediating Role of Sensation Seeking and Effortful Control. Journal of attention disorders. 2014. Epub 2014/04/20.
7. Mayes SD, Calhoun SL, Crowell EW. Learning disabilities and ADHD: Overlapping spectrum disorders. J Learn Disabil-Us. 2000;33(5):417-24.
8. Simkin DR. Adolescent substance use disorders and comorbidity. Pediatric clinics of North America. 2002;49(2):463-77. Epub 2002/05/08.
9. Richter SS, Brown SA, Mott MA. The impact of social support and self-esteem on adolescent

substance abuse treatment outcome. Journal of substance abuse. 1991;3(4):371-85. Epub 1991/01/01.
10. Wilens TE, Biederman J, Mick E, Faraone SV, Spencer T. Attention deficit hyperactivity disorder (ADHD) is associated with early onset substance use disorders. The Journal of nervous and mental disease. 1997;185(8):475-82. Epub 1997/08/01.
11. Flory K, Milich R, Lynam DR, Leukefeld C, Clayton R. Relation between childhood disruptive behavior disorders and substance use and dependence symptoms in young adulthood: individuals with symptoms of attention-deficit/ hyperactivity disorder and conduct disorder are uniquely at risk. Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors. 2003;17 (2):151-8. Epub 2003/06/20.
12. NICE. Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management 2013 March 2013; CG158. Available from: http:// publications.nice.org.uk/antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-intervention-cg158.
13. Molina BS, Bukstein OG, Lynch KG. Attention-deficit/hyperactivity disorder and conduct disorder symptomatology in adolescents with alcohol use disorder. Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors. 2002;16 (2):161-4. Epub 2002/06/25.
14. Barkley RA. Attention-deficit hyperactivity disorder : a handbook for diagnosis and treatment. 3rd ed. New York: Guilford Press; 2006. xiv, 770 p. p.
15. Szobot CM, Rohde LA, Bukstein O, Molina BS, Martins C, Ruaro P, *et al*. Is attention-deficit/ hyperactivity disorder associated with illicit substance use disorders in male adolescents? A community-based case-control study. Addiction. 2007;102(7):1122-30. Epub 2007/06/15.
16. Szobot CM, Bukstein O. Attention deficit hyperactivity disorder and substance use disorders. Child Adolesc Psychiatr Clin N Am. 2008;17(2):309-23, viii. Epub 2008/02/26.
17. Mariani JJ, Levin FR. Treatment strategies for co -occurring ADHD and substance use disorders. The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions. 2007;16 Suppl 1:45-54; quiz 5-6. Epub 2007/04/25.
18. van Emmerik-van Oortmerssen K, Vedel E, Koeter MW, de Bruijn K, Dekker JJ, van den Brink W, *et al*. Investigating the efficacy of integrated cognitive behavioral therapy for adult treatment seeking substance use disorder patients with comorbid ADHD: study protocol of a randomized controlled trial. Bmc Psychiatry. 2013;13:132. Epub 2013/05/15.
19. Wilens TE, Morrison NR. Substance-use disorders in adolescents and adults with ADHD: focus on treatment. Neuropsychiatry. 2012;2(4):301-12. Epub 2012/10/30.
20. Practice Standards for young people with substance misuse problems (2012) Royal College of Psychiatrists http:// www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf
21. Groenman AP, Oosterlaan J, Rommelse NN, Franke B, Greven CU, Hoekstra PJ, *et al*. Stimulant treatment for attention-deficit hyperactivity disorder and risk of developing substance use disorder. The British journal of psychiatry : the journal of mental science. 2013;203(2):112-9. Epub 2013/07/13.
22. Mannuzza S, Klein RG, Truong NL, Moulton JL, 3rd, Roizen ER, Howell KH, *et al*. Age of methylphenidate treatment initiation in children with ADHD and later substance abuse: prospective follow-up into adulthood. The American journal of psychiatry. 2008;165(5):604 -9. Epub 2008/04/03.
23. Perez de los Cobos J, Sinol N, Perez V, Trujols J. Pharmacological and clinical dilemmas of prescribing in co-morbid adult attention-deficit/ hyperactivity disorder and addiction. British journal of clinical pharmacology. 2014;77(2):337 -56. Epub 2012/12/12.
24. Rizkallah E, Legault L, Pampoulova T, Levesque S, Belanger M, Stavro K, *et al*. A case report of Concerta misuse in a patient with comorbid substance use disorder and attention deficit hyperactivity disorder. The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions. 2011;20(5):478-9. Epub 2011/08/16.
25. Schubiner H, Saules KK, Arfken CL, Johanson CE, Schuster CR, Lockhart N, *et al*. Double-blind placebo-controlled trial of methylphenidate in the treatment of adult ADHD patients with comorbid cocaine dependence. Experimental and clinical psychopharmacology. 2002;10(3):286-94. Epub 2002/09/18.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

26. Levin FR, Evans SM, McDowell DM, Kleber HD. Methylphenidate treatment for cocaine abusers with adult attention-deficit/hyperactivity disorder: a pilot study. The Journal of clinical psychiatry. 1998;59(6):300-5. Epub 1998/07/22.

27. Castaneda R, Levy R, Hardy M, Trujillo M. Long-acting stimulants for the treatment of attention-deficit disorder in cocaine-dependent adults. Psychiatr Serv. 2000;51(2):169-71. Epub 2000/02/02.

Appendix 1 – Data Collection Tool

Initials	
Gender (circle)	Female Male
Age (Circle)	16 17 18 18+
Date of Birth	
Ethnicity (Circle)	Afro-Caribbean Asian White British Chinese Dual Heritage Middle Eastern Unknown Other……..
Looked After Children (LAC) Status (Circle)	Yes No Unknown
Youth Offending Service (YOS) Status (Circle)	Yes No Unknown
Not in Education, Employment or Training (NEET) Status (Circle)	Yes No Unknown

Referred by	
Presenting Complaint	

Was a substance use history taken? (Circle)	Yes No Partially
Alcohol	Yes No Quantity……..
Smoking (Nicotine)	Yes No Quantity……
Cannabis	Yes No Quantity……
Other	…… Quantity……

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Review Article
DAUIN 20140065

From the 'C' word- Cancer, to the 'M' word- mental Illness; How Negative Attitudes are Shaped and Overcome

Dr Hadjidemetriou C MBChB, BSc (Hons)

Institution

University of Manchester, United Kingdom

WJMER, Vol 8: Issue 1, 2014

Abstract
Stigma is the inevitable result of inequalities in our society. There are many forms of stigma especially against many chronic disease sufferers. Cancer and Mental illness sufferers experience stigma in a different manner. The reasons behind how stigma develops and affects negative attitudes being formed in society are briefly explored as well as the major role the media play in forming positive or negative attitudes in society. Methods of how people can change this unfairness in society are also briefly explained. Stigma is increasingly difficult to overcome but not impossible.

Key Words
Stigma, Mental illness, Cancer, Training, Media, Society

Corresponding Author:
Dr Hadjidemetriou C, E-mail: christiana.h@doctors.org.uk

Introduction

Billions of people around the world suffer from a chronic illness; whether it is hypertension, cancer or schizophrenia it never ceases to deter the person enduring it every day. It is not people's choice not to be 'healthy', but whatever their illness they always seem to find a way to deal with their preoccupations and the fact that they may never recover completely; nonetheless, they have come to terms with their future, however daunting or bright it may seem. What counterfeits their psychologically victorious fight against their disease is their misplacement in society. It is not just about feeling at ease with yourself, it is also all about how you feel in the place society pretenses you. Every single person functions optimally in an environment where they are comfortable and feel at ease with their surroundings.

The 'C' Word

Cancer, one of the most dreadfully unspoken words, yet it is the first utterance that comes to mind when someone is unwell, affects millions of people every year worldwide. The general public associates it with doom and death; health professionals regard it as more of a common, fairly treatable condition. In recent times, people have been sensitized to the word cancer through campaigns to increase cancer awareness (each cellular type of cancer is being separately promoted), through advertisements, positive media portrayal of cancer patients and educational programs, all aimed to decrease the fear and distress associated with the disease. As a result, people donate vast amounts of money to cancer charities (GBP 500 million yearly) the most popular being Cancer Research UK[1] and feel empathy for a person as soon as they find out that they have a history of cancer. This is not all to imply that cancer patients are treated impartially in society. Stigma surrounding the disease itself makes people react differently, they feel uneasy and try to pretend that they understand the effects the disease has on patients and try to provide encouragement even if patients themselves feel fine. This leads to a vicious cycle of social isolation, being labeled and being looked at differently. "Attributing superhuman bravery to cancer patients"[12] is not the solution. As soon as a cancer diagnosis is being announced to the patient and the relatives, proceeding shock is despondency, resulting in family members being precipitately withdrawn from the patient as they are expecting death to hit their door. Where is the patient going to receive support from if the people nearest to him/her are reserved more and more each day?

Younger generations of this modern era have benefitted and still are, from the ongoing work to diminish the stigma and negative emotions

associated with cancer. A greater understanding of the pathologic processes involved in tumor formation and migration as well as advances in investigational methods, means that cancer is picked up earlier and therefore treated more aggressively, successfully. The notion that the earlier cancer is discovered the longer the survival, has been so well engrained in our society, that most people visit their GP as soon as a lump appears anywhere on their body. This has resulted to a greater number of cancer cases being acknowledged but also to better control of the disease. Psycho-oncology issues are being tackled, especially with educating doctors and health professionals how to break bad news in a way that will make those receiving them a bit less hopeless.[7] Educating the patient as well as the relatives is paramount in sustaining positive attitudes towards the disease, discussing about the treatment, side effects and prognostic characteristics usually leaves the patient and family with a glimmer of hope in the horizon.

The 'M' Word

Compared to a wide range of other disease, attitudes towards cancer patients are more positively shaped, with empathy being the ubiquitous sentiment. On the other end of the spectrum lies an umbrella term identified as mental illness. It was recognized from ancient times as the state of being demonized by the gods and in modern times in some parts of the world it is still regarded as a state in which evil has possessed the soul. The pervasive stigma and prejudice surrounding mental illness is so harsh that people prefer to close their eyes and ignore the hostility posed by society towards people affected by it. Whilst most people go with no hesitation to their doctor if they suspect that they might physically have something sinister (cancer), almost no one asks for a professional opinion regarding mental health, leading to more people suffering in silence and despair, while their mental health status is deteriorating.

Numerous scientists researched the attitudes of the public towards mental illness. One of the biggest studies in the UK[8] relevant to attitudes towards mental illness, set out to investigate whether the attitudes of people (n=6000) changed between the years 1994- 1997, 2000 & 2003 in England and Scotland. Interestingly, what was suggested was that public attitudes towards mental illness not only remained predominantly negative, but answers to some questions were answered in a more negative manner in 2003 that they were answered in 1994. A large majority of people reported that: "People with mental illness do not deserve our sympathy". They also disagreed with the statement presented to them that "We need to adopt a far more tolerant attitude toward people with mental illness in our society". It is also noteworthy that while attitudes in England were more negative as time progressed, attitudes in Scotland were not as negative. Why be so judgmental and ferocious against people that are ill? Similarly shocking results were published in other countries (in 1994-1996) such as the USA and Hong Kong. Studies in Germany and Greece around the same time actually showed improved attitudes toward mentally ill individuals[8].

There are approximately 400 000 people with a mental disorder in the world with as many as 1:4 people living in Europe, experiencing mental health problems at some point in their life[3]. Mentally ill people are victims of an absentminded society who has exercised stigmatized behavior against them for hundreds of years. This in result has caused their self-stigmatization. Subconsciously, they have internalized[5] all the negative attitudes from the people around them and they are embarrassed and shameful of what is happening to them. They are labeled, set apart and isolated, having the little potential left of independent functioning crashed and taken away from them. They are terrified of seeking help because of labeling. Even if they are willing to find help, they are apprehensive about what the cruel, vindictive psychiatrist will think of them. What if they are tagged as neurotic and dysfunctional by their own doctor? As if the rest is not adequate, they have to convince the rest of the world that they are not dangerous, unintelligent, and dysfunctional or developmentally disabled people[6].

Why stigma develops

A number of suggestions as to the origin of stigma have been offered. (Refer to *figure 1* for a more comprehensive outline). Devaluating individuals has a psychological advantage of boosting one's self-esteem[5]. It is the product of living within a society where inequalities between people flourish. Most people less fortunate than others are always undermined with a certain degree of prejudice. The symptoms of mental illness can be threatening to people around the person affected. Anxiety, anguish and tension tend to remind startlingly the observer that one might not be in control of his/her own mind forever. A sense of stability that every individual needs to function normally is endangered. As a result, ignorance and prejudice help preserve one's feeling of integrity in society. This is clearly indicated by the fact that only a few million pounds are donated to mental health charities each year for research and support, mostly for neurodegenerative disorders (e.g. Alzheimer's) as opposed to the earlier onset disorders (e.g. Schizophrenia), which could help many more people[1]. In addition, through

evolution we are programmed to instinctively avoid and be socially distant to those who have different values, expectations and norms as they are perceived as a threat to one's picture of the world.

The Media

The role of the media in perpetuating and even expanding this negative perception regarding mental illness has been recognized for years. The negative portrayal of mentally ill people as violent and unpredictable is the major collaborator in propagating the stigmatization of mental illness. The theory of cognitive economy suggests that negative characteristics identified in one person of one group in society, tends to generalize for all the members of that particular group. This is how stereotypes are formed. Television has a very potent way of forming stereotypes for a lot of groups of people[3]. Cultivation theory explains how people think that the television view of mental illness is the real world view of mental illness, and social learning theory suggests how television teaches individuals how to treat mentally ill patients in a social context. Magazines and newspapers offer a sensational article concerning the 'Schizophrenic who killed his children' in the headlines, and tend to feed on news stories concentrating on the failures of psychiatric rehabilitation or with the exciting, yet mysterious dissociative symptoms of schizophrenia. Moreover, they tend to inaccurately use psychiatric terms such as obsessive-compulsive disorder to describe an obsessive personality trait and focus on treatments of depression and anxiety with no scientific basis[2]. All this contributes to the incomplete, irrational and unjust world view of mental illness. They omit to print that the proportion of people with schizophrenia being violent to another person is minute or that many people suffer from anxiety but do not seek help because they will be labeled as 'strange' and 'crazy'[3].

Conflict within medicine?

Within the term mental health, psychiatrists and in general health professionals in this field of medicine, are continuously underestimated by their 'anti-psychiatrist' [5]colleagues and try to treat a mental illness according to their own volition, leading to the production of more bias against the profession by qualified health professionals, whom people trust and seek advice. So it is not only the general, ignorant members of the public that depict negative attitudes toward mental illness, but also people who should be helping in the fight of stigma against mental health not perpetuating the myths learned from television and culture. It is devastating enough that mental health professionals are portrayed as cruel power-seeking men or loveless, unsatisfied women, the last thing hindering their commitment and hard work is their colleagues from other specialties expressing their own personal, negative views about mental health and how it should be dealt with.

The end result of social stigma even in a person who might have had a brief history of mental illness a long time ago is social separation, distress, unemployment, increased insurance premiums, less housing opportunities and many more, even in the complete absence of any disability. Put simply, they are grouped as less deserving of anything society has to offer.

What can WE do to change this unfairness?

How can the obscurity described above change? Firstly, by encouraging everybody in our proximity who has a positive view toward mental illness to undertake an active role in making society a better place for mentally ill individuals. Education is vital both at the time of diagnosis of a condition and long term. It is up to health professionals in the field to let the world know that mentally ill people are not violent and criminals. Education is central to understanding the 'strangeness' of the disorders. Once people are educated, there should be more contact with mentally ill people. In Germany[2] a mental health education program aimed at high school students, encouraged the personal encounter between students and people who were mentally ill and found that students' attitudes towards mentally ill people were more positive than negative. This could be implemented in all countries all over the world.

Non-Governmental organizations need more support for the great work they are conducting across the country in increasing awareness and decreasing the stigma associated by supporting sufferers and their families. MIND is one such example in the UK, set up to increase schizophrenia awareness. According to the first study mentioned on negative attitudes in England and in Scotland, it has been speculated that the Scottish public's negative attitude was not increased as much as England's did, due to the 'See me'[8] campaign launched in 2002 targeting the media and dispersing leaflets and posters at GP practices, prisons, libraries and at most public places. The corresponding 'Changing Minds'[8] campaign by the Royal college of psychiatrists in England from 1998-2003 did not prove that successful.

Changing how media portray mental illness is not easy as the economic needs and values of journalists and others in the field have to be taken into account. Basically they will publish whatever at whatever cost; this is their job and this is why they are hesitant to change their strategies. Stories concerning mental illness seem to have that surreal,

intriguing quality that helps to sell. A short mental health course could be suggested to be included in the curriculum of training young reporters on how they could cover mental illness in the news without sending any negative and discriminatory signals to the public (contagion). This has been implemented for suicide and it has proven successful[10].

A fundamental approach to changing such attitudes is by proposing an alteration of social policies[5]. Laws on discriminating against mentally ill individuals should be revised and changed. If people that the public admires and looks up to have a positive attitude towards psychiatric patients then the general public will change their attitude in essence. A top to bottom approach is often the most successful.

Recently in Japan[7, 11], the name of schizophrenia (mind-splitting) was changed to 'Integration disorder', and what they found was that the misconceived notion that connected schizophrenia with criminality was largely decreased, proving that even a name change of a disorder has the potential to decrease prejudice and discrimination.

Last but not least, psychiatrists should make sure they have better understanding of most conditions, and revise their skills and training practices, so that they encourage people to seek help. They could alongside practicing medicine, adopt a more politically activist role to diminish stigma. Bottom line is, if psychiatrists are apathetic and passive regarding stigma in society, why should anyone else try to make a difference? They should be openly expressing their concerns if a situation demonstrating discrimination appears and they should become more available to the public, through lectures not only directed towards medical students, but also speaking to people working in public services, going to schools and engaging more with the general members of the public.

There is still hope

Yes it is difficult to change preformed attitudes of hundreds of years but if we all help individually and together even by little to diminish this burden on society we could make the lives of thousands/ millions of people more tolerable.

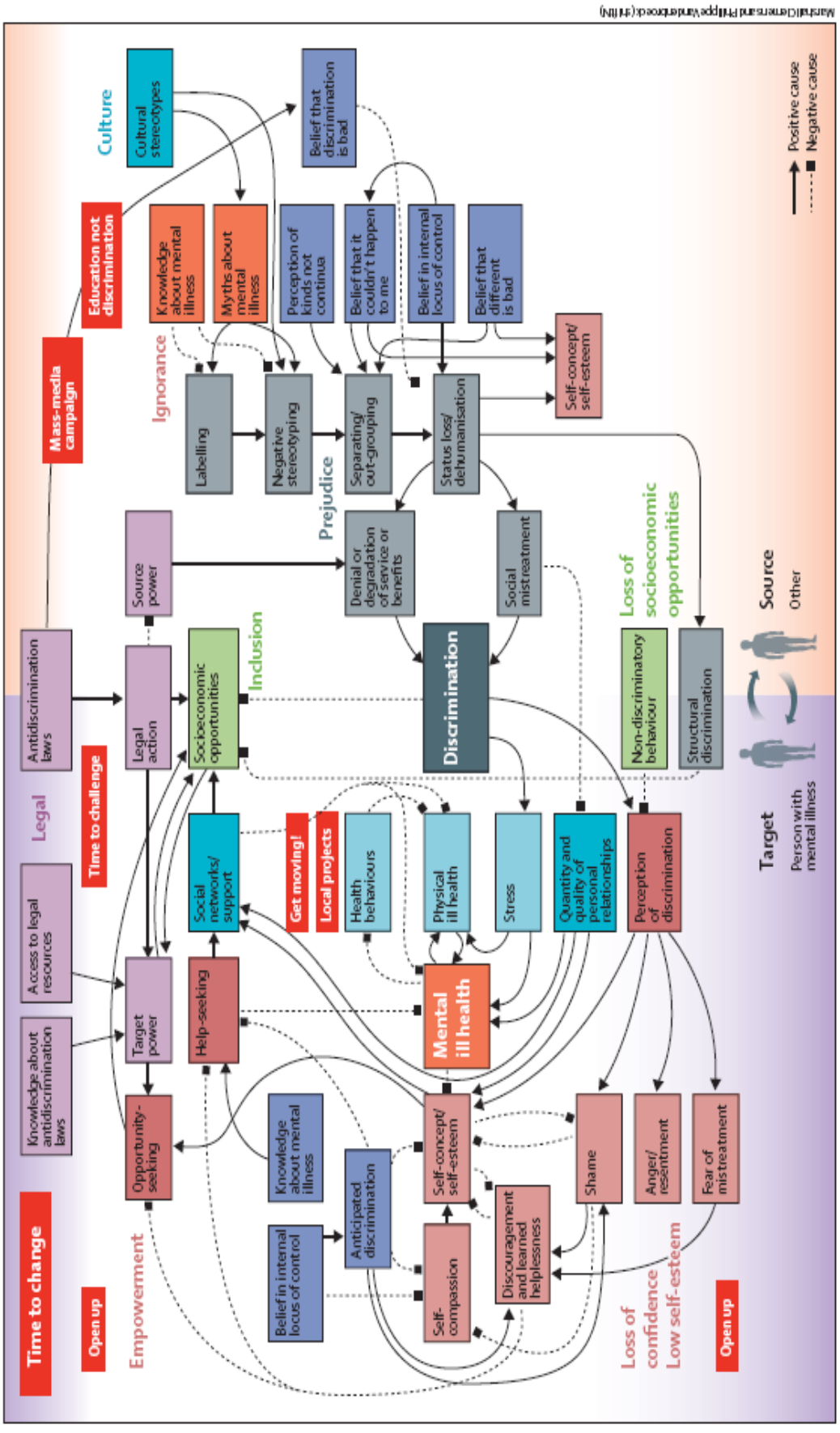


Figure: Systemic model of contributing factors to stigma and discrimination
Red boxes=Time to Change components. Adapted from reference 9.

Figure 1: 'Systemic model of contributing factors to stigma and discrimination'[6].

References

1. 'A decade for psychiatric disorders', Nature, 2010; 463(7277):9.
2. Angermeyer MC, Richter-Werling M. 'A mental health education program: the school project "Crazy? So What!" initiated by "Irrsinnig Menschlich (Madly Human) e.V. Leipzig"' MMW Fortschr Med. 2003 Mar 10;145(12):38, 40-1.
3. Baumann A.E. 'Stigmatisation, social distance an exclusion because of mental illness: The individual with mental illness as a 'stranger''. International review of psychiatry,2007;19 (2):131-135.
4. Henderson C., Thornicroft G. 'Stigma and discrimination in mental illness: Time to change.' The lancet,2009; 373:1928-1930.
5. Hinshaw S., Stier A.,'Stigma as related to mental disorders'. Annu. Rev. Clin. Psychol., 2008; 4:367-493.
6. Klin A., Lemish D., 'Mental disorders stigma in the media: Review on studies on production, content and influences'. Journal of health communication, 2008; 13(5):434-449.
7. Levin T.T., 'Newer conceptualizations of schizophrenia demand a name change'. Schizophrenia research,2009; 115: 374.
8. Mehta N., Kassam A., Leese M., Butler G., Thomicroft G. 'Public attitudes towards people with mental illness in England and Scotland 1994-2003'. *The British Journal of Psychiatry*, 2009; 194: 278-284.
9. Sartorius N. 'Stigma: What psychiatrists can do about it'. The lancet, 1998; 352: 1058-1059.
10. Stout P.A., Villegas J., Jennings N.A., 'Images of mental illness n the media: Identifying gaps in the research'. Schizophrenia Bulletin, 2004; 30 (3): 543-561.
11. Takahashi H., Ideno T., *et al* 'Impact of changing the Japanese term for Schizophrenia for reasons of stereotypical beliefs of schizophrenia in Japanese youth'. Schizophrenia Reseach,2009; 112 (1-3): 149-152
12. Wilson K., Luker K.A. 'At home in hospital? Interaction and stigma in people affected by cancer' Social science and medicine, 2006;62: 1616-1627.

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Review Article
DAUIN 20140066

The Right to Mental Health and Parity

Prof Bhugra D FRCP, FRCPE, FRCPsych, FFPH, MPhil, PhD*; Dr Campion J MRCPsych**; Prof Sue Bailey FRCPsych, HonFC Psych(SA)***

Institution

**Professor of Mental Health and Cultural Diversity, PO25, Health Service & Population Research Department, Institute of Psychiatry (King's College), De Crespigny Park, London SE5 8AF*

***Visiting Professor of Population Mental Health University College London, 1-19 Torrington Place, London WC1E 7HB*

****President Royal College of Psychiatrists, Professor of Child Mental Health University of Central Lancashire, Consultant Child and Adolescent Psychiatrist, Greater Manchester West NHS Mental Health Trust, Manchester, M25 3BL*

WJMER, Vol 8: Issue 1, 2014

Abstract

Mental disorders are common affecting up to 10% of the world's population. Furthermore, mental disorder is responsible for 22.8% of global disease burden of disease which results in annual global costs of US$2.5 trillion. However, despite such impacts and costs, only a minority with mental disorder receive treatment mostly from primary care despite the existence of effective treatment which can result in economic savings even in the short term. Far fewer with mental disorder receive intervention for either health risk behaviour or their physical health with even less coverage of interventions to address risk factors to prevent mental disorder. This public mental health intervention gap is underpinned by a systematic failure to respect the right of access to effective interventions to both treat and prevent mental disorder as well as associated health risk behaviour and physical illness. A number of reasons contribute to this failure including lack of knowledge about numbers affected, associated impacts or evidence based interventions as well as systematic discriminatory attitudes towards mental disorder. In this short paper, we outline why a right to health should include access to interventions to both treat and prevent mental disorder.

Key Words

Mental well-being, Mental disorders, Parity gap, Human rights

Corresponding Author:

Prof Bhugra D, E-mail: dinesh.bhugra@kcl.ac.uk

Mental disorder and mental wellbeing

Mental disorders include mental illness such as anxiety and depressive disorders (common mental disorder) and psychosis as well as alcohol and drug use disorders, personality disorder and eating disorder.

Both mental disorder and wellbeing comprise of various dimensions including biopsychosocial, spiritual and anthropological. Mental disorder and wellbeing are also influenced by a range of biological, physical, psychological, social, cultural and spiritual factors. Mental wellbeing is both a social and a personal construct and value laden – values being dictated by a number of factors. Although mental disorders are defined by diagnostic criteria, social and value laden personal constructs usually override these so that stigma, discrimination and ignorance results in lack of access to evidence based interventions.

Rights to health

Rights incorporate civil, social and health dimensions. Regarding the right to health, the WHO (1946)[1] constitution made it clear that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures'. The Universal Declaration of Human Rights (1948)[2] also reads: 'Everyone has the right to a standard of living adequate for the health of himself and of their family, including food, clothing, housing and medical care and necessary social services'. Subsequently, the Alma Alta declaration of 1978 reiterated the

fundamental right to the enjoyment of the highest attainable standard of health and is widely recognised in many human rights declarations (ICEAFRD, 1965[3]; CEAFDAW, 1979[4]; CORC, 1989[5]; European Social Charter, 1965[6]; African Charter, 1981[7]; American Convention, 1988[8]). These charters and amendments are often used as the basis of legal framework but regrettably not all the time.

The Universal Declaration of Human Rights has at its core three key aspects important to health care:

1. Preserve, extend and improve the life of the people in need based on equality (for treatment and cure irrespective of gender, race, language, religion and opinions and socio-economic conditions);
2. Quality (high quality, up-to-date interventions)
3. Social responsibility (health and well-being of citizens as well funded priority and effective in health promotion and prevention of ill health).

In looking at human rights based parity across all health – be it physical or mental or psychosomatic – policy makers must bear these three facets in mind.

Hogerzeil[9] points out that human rights are legally guaranteed by international, regional and national human rights law through which individuals are protected especially against actions which may interfere with human dignity and fundamental freedoms. The right to a disability free life and to health is closely associated with the right to life, and these rights are indispensable for the exercise of most other human rights. Freedom from discrimination is at the core of all rights.

Evolution of rights

It is important to acknowledge that these frameworks and associated changes take a considerable period of time to be implemented. Higgins[10] notes that the international recognition of rights gathered pace after the Nazi atrocities and mass migration which took place after the Second World War. Furthermore, although equality has often been referred to, there has been very little progress on this in some parts of the world. While Hogerzeil[9] emphasises that the principle of 'progressive realization' carries with it limits of available resources. However, two immediate obligations include the guarantee that the right to health will be exercised without discrimination and deliberate targeted steps are taken towards the full realization.

Human rights have also evolved over the centuries although the legal and philosophical developments of rights did not always occur in parallel. The idea of natural law emerged from religion and philosophy while attitudes to mental disorder were strongly influenced by prevalent knowledge, religion and understanding of causative factors. However, mainstream Anglo-American conceptions of rights have tended to confine themselves to individualistic civil and political rights to the exclusion of rights relating to collectivist social, economic[10] and health. This tension between individual and collectivist or community rights lies at the core of the relationship between those providing treatment for illness including mental disorder.

Rights in the context of the mental health intervention gap

Mental disorders are common affecting up to 10% of the world's population[11] although 31.2% of the European population each year (136.2 million people)[12]. Furthermore, mental disorder is responsible for 22.8% of global disease burden of disease and 29.2% of burden of disease in Europe when examining the twenty leading causes of years lost due to disability (YLD)[13]. The large burden of mental disorder is due to a combination of high prevalence, early onset in the life course and broad range of impacts[14]. These impacts result in annual global costs of US$2.5 trillion and €532.2 billion in the European Union[15].

The majority of people with mental disorder can be effectively managed in primary care using a mixture of psychological and pharmacological therapies while a very small proportion require secondary mental health services mostly as outpatients. However, despite mental disorder resulting in such large impact and the existence of effective treatments, only 10% of people with mental disorder in Europe receive notionally adequate treatment[12] mostly from primary care while coverage is far less in low and middle income countries[13]. Even fewer with mental disorder receive intervention for either health risk behaviour or physical health while coverage of interventions to address risk factors to prevent mental disorder is extremely low even in high income countries. This is in contrast to areas such as cancer and cardiovascular disease which invest in action to address associated risk factors.

A number of reasons account for such a large intervention gap[14] which include that the proportion of health budgets spent on treatment of mental disorder does not match size of the burden of mental disorder. In the UK, 11.2% of the health budget is spent on treatment of mental disorder despite it being responsible for at least 23% of burden of disease[14] although the UK has one of the highest proportion spend on treatment of mental disorder in Europe[16]. Other reasons include lack of intelligence about the size, impact and cost of the intervention gap[17], poor recognition of mental disorder by both health professionals and the

population, as well as stigma and discriminatory attitudes towards treatment of mental disorder. Debate about definitions of mental disorder despite diagnostic criteria further contributes to inaction.

Lack of mental health policy in 40% of countries [18] despite the prevalence and impact of mental disorder also contributes to the implementation gap, In countries with a mental health policy, this often focuses on detention of people with mental illness despite this being required for only a very small proportion of people with mental illness.

A rights approach to address the mental health gap

Rights to health include universal access to effective treatment for illness which should include mental disorder. Since the majority of lifetime mental disorder arises before adulthood, the rights of children and adolescents to treatment and prevention of mental disorder is particularly important.

As noted above, the relationship between mental disorder and human rights has various elements: The first at an individual level involves the rights of people to lives which will support their mental health and well-being and prevent mental disorder; the second involves rights to access early treatment for mental disorder and associated consequences such as health risk behaviour and physical illness; and the third, to access education, employment and other aspects of social and economic life without discrimination [19]. In defining a human rights approach to mental health, it is absolutely critical that people with mental disorder are not seen as a product of their disorder but instead as having a condition which requires early recognition and treatment as is the case for physical illness.

The legal framework should go beyond quality of care to include a rights approach which enables early access to effective treatment and prevention according to need. Implications of this right in itself means that not only are their needs assessed but they are met at all levels including individual, familial and social. In particular, such a rights approach recognises that particular groups are at several fold higher risk of mental disorder and therefore need a proportionately targeted approach to both treatment and prevention which need to be part of the overall planning of health care[20]. Such groups include women, children with learning disability and in the care of the state, those with a learning disability, certain Black and minority ethnic groups, lesbian, gay, bigender and transexual, migrants etc. Such an approach improves coverage and also reduces discrimination at all levels.

Yamin and Rosenthal [21] argue that a human rights framework is critical and quality of care must form a part of this framework with a focus on ending discrimination against those with disorder. Once treatment and prevention of mental disorder is seen as a central and integral part of health, health care delivery becomes more acceptable. In order to do this, it is helpful to have normative framework within international law [22] which can provide an oversight of human rights particularly for more vulnerable groups.

Since the coverage and standards of care are extremely variable even within the same country, a rights-based international acknowledgement and agreement on minimum basic standards is required.

Parity and rights

A rights based approach supports the achievement of parity between treatment for physical illness and mental disorder. Additional issues related to achieving rights based parity include research, policy, delivery and outcome indicators. Embedded within policy development and delivery are transparency and accountability: civil and political rights are indivisible and these play a powerful normative role in health care development and delivery [23].

Hogerzeil[9] suggests that the WHO Essential Medicines Programme has much to offer with its consistent focus on sustainable universal access to essential medicine which includes those for mental disorder. This can be achieved through the development of national medicines policies in line with human rights principles of non-discrimination and care for those at higher risk of physical illness and mental disorder including the poor and disadvantaged. Careful evidence based selection of essential medicines and making these available cheaply and reliably particularly for those at higher risk of illness is part of the good governance by the state. In the case of early intervention for mental disorder, this can also results in substantial net savings even in the short term[24] as well as reduced risk of subsequent physical illness.

A rights approach also supports parity between prevention of physical illness and prevention of mental disorder. Since the majority of lifetime mental disorder has arisen by the mid-twenties[25], addressing risk factors and particular social determinants during childhood and adolescence is particularly important to prevent mental disorder although early intervention for mental disorder arising during adolescence can also prevent a proportion of adult mental disorder[26]. The local levels of risk factors for mental disorder including

inequalities can be locally assessed to inform required interventions to address such factors to prevent mental disorder [17]. Public health and social care have important roles in addressing risk factors to prevent mental disorder such as through early detection and intervention of child abuse[17].

A rights based approach is crucial in research. Amon *et al*[27] suggest that the balance between protecting the state or protecting individuals is crucial in research. Risks in human rights investigations are related to potential conflict. Carrying research out and setting policy development in place when security is at risk can raise specific ethical issues. Consequences of reporting human rights abuses need to be remembered, especially from vulnerable individuals

How to achieve parity?

Achievement of parity for mental health will be supported by a human rights based approach which affirms the right to effective interventions to treat mental disorder, prevent mental disorder and promote mental health.

The Royal College of Psychiatrists[28] has recently made several recommendations to achieve parity between physical and mental health including leadership, policy change, addressing stigma and discrimination, improving physical health and reducing premature mortality in those with mental disorder, commissioning of appropriate levels of services according to need, addressing comorbidity, public health, funding and research.

Parity for mental health can be supported by appropriate monitoring of the parity gap; public mental health intelligence includes the local size, impact and costs of the intervention gap for treatment of mental disorder, prevention of mental disorder and promotion of mental health including for higher risk groups[17]. Such information enables transparent decisions about coverage of public mental health interventions and also enables monitoring of associated outcomes. Local members of the community are able to access such intelligence, challenge low coverage of treatment and advocate for parity[29]. In this context, the role that social media is likely to play also becomes significant in highlighting the impact and cost of this gap. Regular feedback and transparency highlights level of unmet need and facilitates improved outcomes through appropriate commissioning.

Although much public mental health intelligence is available[20], it is often missing for higher risk groups which highlights the lack of parity of measurement for some and the need for collection of such information to address their needs. Such data collection, according can make stakeholders aware of the need and accuracy of the data[9].

Achieving parity requires transparency and accountability for the framework for rights. Clear targets, indicators and outcomes must be identifiable and must be used to monitor the progressive realisation of the changes. This includes regular assessment of the proportion of those with different mental disorder including from higher risk groups who receive appropriate intervention[17]. Safeguards in the structures and also the possibilities of redress are required if and when human rights are violated including from lack of access to effective interventions to both treat and prevent mental disorder. The legal and policy framework must take into account and emphasise the obligations incumbent upon the government.

Policy and legal frameworks which enable action towards the goal of parity must also focus on a nation state's relationships outside its external boundaries. These frameworks can also help develop and regulate interactions across international agencies. These frameworks can offer protection both to the state and to the individual. In addition, these frameworks offer a mechanism for ensuring the success of multi-sector action and activities in any given sector, especially in the treatment and prevention of mental disorder.

Conclusions

Despite the large impact of mental disorder and the existence of effective treatments, the majority of people with mental disorder receive no intervention which represents a violation of their right to health. This intervention gap can be addressed in a number of ways which are underpinned by a rights approach. Avoiding discrimination in mental health service planning and delivery is at the heart of human rights based parity in psychiatry. Transparency and accountability within the legal framework and clear indicators and outcomes are essential if parity is to be achieved.

Reference

1. World Health Organization: Constitution. 1946 http://www.who.int/governance/eb/who_constitution_en.pdf. Accessed online 25 July 2013.
2. Universal Declaration of Human Rights (1948): http://www.un.org/en/documents/udhr/
3. ICEAFRD (1965): International convention on the elimination of all forms of racial discrimination. Article 5 (e) iv.
4. CEAFDAW (1979): Convention on the elimination of all forms of discrimination against women. Articles 11.1 (F) and 12.
5. CORC (1989): Convention on the rights of the

child. Article 24.
6. European Social Charter (1965): Article 1.
7. African Charter on Human and People's Rights. 1981, article 16.
8. American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. 1988, Additional Protocol. Article 10.
9. Hogerzeil H V (2006): Essential medicines and human rights: what can they learn from each other? Bull WHO 84 (5), 371-375.
10. Higgins W (2012): Human rights development: provenance, amit and effect. In M Dudley, D Silove and F Gale (eds) *Mental Health and Human Rights: Vision, Praxis and Courag*e. Oxford: Oxford University Press, pp 55-68.
11. Whiteford, H., A, L. Degenhardt, J. Rehm, *et al*., Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet, 2013.
12. Wittchen HU, Jacobi F, Rehm J *et al* (2011) The size and burden of mental disorders and other disorders of the brain in Europe 2010. European Neuropsychopharmacology 21: 655-679
13. WHO (2013) Mental Health Atlas -2011 country profiles. http://www.who.int/mental_health/evidence/atlas/profiles/en/
14. Campion J, Bhugra D, Bailey S, Marmot M (2013) Inequality and mental disorder: opportunities for action. The Lancet 382: 183-184
15. Olesen J, Gustavsson A, Svensson M *et al* (2012). The economic cost of brain disorders in Europe. *Eur J Neurol*; 19:155-162
16. Samele, C., Frew, S. and Urquia (2013) Mental Health Systems in the European Union Member States, Status of Mental Health in Populations and Benefits to be Expected from Investments into Mental Health. A report prepared on behalf of the Institute of Mental Health, Nottingham for the EU Executive Agency for Health and Consumers. http://ec.europa.eu/health/mental_health/docs/europopp_full_en.pdf
17. Campion J (2013) Public mental health: The local tangibles. The Psychiatrist 37:238-243.
18. WHO (2011) Mental health: Mental health policy and financing. Data by country. http://apps.who.int/gho/data/node.main.MHPOLFIN?lang=en
19. Walters C (2012): Mental health and illness as human rights issue: philosophical, historical and social perspectives and controversies. In M Dudley, D Silove and F Gale (eds) *Mental Health and Human Rights: Vision, Praxis and Courage*. Oxford: Oxford University Press, pp 66-79.
20. Campion J, Fitch C (2012) Guidance for the commissioning of public mental health services. Joint Commissioning Panel for Mental Health http://www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/
21. Yamin A E, Rosenthal E (2005): Out of the shadows: using human rights approaches to secure dignity and well being for people with mental disabilities. *Plos Medicine***2** (4), e71.doi 101371.
22. UNCESCR (2000): General Comment 14: The right to the highest attainable standard of health. www.unhchr.ch/tbs.doc.nsf/(symbol).E.C.12,2000.4En? Open document.
23. London L (2008): What is a human rights based approach to health and does it matter? *Health and Human Rights***10**, 65-80.
24. Knapp M, McDaid D, Parsonage M Eds (2011) Mental health promotion and mental illness prevention: the economic case. Department of Health
25. Kessler RC, Amminger GP, Aguilar-Gaxiola S *et al* (2007). Age of onset of mental disorders: a review of recent literature. Current Opinion in Psychiatry 20(4): 359-364
26. Kim-Cohen, J. Caspi A, Moffitt TE *et al* (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. Archives of General Psychiatry 60: 709-717
27. Amon J J, Baral S D, Beyrer C, Kass N 2012): Human rights research and ethics review: protecting individuals or protecting the state? Plos Medicine **9** (10):e1001325. doi 10.1371/journa.lpmed.1001325.
28. RCPsych (2013): Whole person care: from rhetoric to reality. London: Royal College of Psychiatrists.
29. Campion (2013a) Ten questions for your council. The Mental Health Challenge http://www.mentalhealthchallenge.org.uk/wp-content/uploads/2013/08/LA_Challenge_10_questions.pdf

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

The Making of a Student Psychiatry Society

Dr Kaye E MBChB*; Dr Halder N, MBChB, MRCPsych, MSc, CT Dip. PG Cert. Med. Ed.**

Institution

**FY1, Former chair of the Manchester Psychiatry Society Royal Oldham Hospital, Rochdale Rd, Oldham, Manchester OL1 2JH*

***Consultant Psychiatrist, Alpha Hospital, Buller Street, Bury, BL8 2BS.*
Senior Honorary Lecturer, School of Medicine, The University of Manchester, Oxford Road, Manchester M13 9PT, UK.

Key Words
Psychiatry, Student, Society, Leadership, Teamwork

Corresponding Author:
Dr Kaye E: emily.kaye@doctors.org.uk

WJMER, Vol 8: Issue 1, 2014

Abstract
Manchester Psychiatry Society is an undergraduate-led society run for and by those interested in mental health and promoting psychiatry at that level. This is a personal account of how it was set up and run from the time the author was the president. Included are examples of events that were successful and challenges faced. It is hoped to be valuable to those who are interested in setting up Psychiatry societies in their facilities, or improve on ones that already have one.

While at medical school, I (EK) have been lucky enough to be part of the formation of the Manchester Psychiatry Society (also known as Psych Soc). Currently, the group has over 700 members and we are affiliated with the Royal College of Psychiatrists. The society was set up by 6 students (including myself), a patron consultant and two psychiatry specialist registrars. The aim of the society was for students to meet, discuss and promote the importance of mental health awareness. In addition to this, we aimed to give those interested in specializing in psychiatry or related fields a chance to gain career information or network.

As a society, we developed a programme of interesting events including educational lectures with speakers such as Professor Dinesh Bhugra, former president of the Royal College of Psychiatrists. We provided students with the opportunity for topical debates, for instance "This House Believes that Psychiatrists are Not Real Doctors". We held film nights and our Psych Soc hosted one of the first 'Medfests', an annual nation-wide film festival run by UK psychiatric trainees with the aim to examine how health & medicine are explored through film. In addition to this, the society developed a blog (http://mancpsychsoc.blogspot.co.uk/), Facebook group (https://www.facebook.com/groups/mancpsychsoc/) and a Twitter account (https://twitter.com/ManchPsychSoc), in order to increase awareness of the society, publicize events and discuss topical mental health issues.

Along with increasing interest in Psychiatry, we hosted the North West Psychiatry Summer School; several days of lectures by eminent psychiatrists in the North West, which provided advice and information regarding psychiatry as a career.

A further aim of the society was to supplement the medical school's psychiatric teaching. We held revision lectures by a senior honorary lecturer at the university and biannual OSCE practices for the medical students with psychiatry trainee examiners.

These events prove to be tremendously popular every year, receiving very positive feedback.

I was able to work on the committee for three years and eventually became president of the society in my fourth year of medical school. I undertook a wide variety of roles within the committee including:

- Recruitment and organization of committee members: president; vice-president; treasurer; secretary; events' organizers and promoters.
- Liaison with psychiatrists, other mental health practitioners and students.
- Management of meetings; setting objectives, discussing ideas and collating minutes.
- Organisation, advertisement and coordination of events.

The above roles have helped me to become more confident in my ability to organize both events and committee members, while also enabling me to feed my passion for Psychiatry. Alongside this, my discussion and public speaking skills have improved. Liaison with psychiatrists and students has allowed me to network with some fascinating people and gain contacts, along with furthering my communication skills. In addition to this, I have developed my teamwork and leadership skills. In particular, I have learnt how to delegate jobs, in order to spread out what would be an intimidating, large work load for one person, to the team. Leadership and team-work in medicine are very important skills to develop as all clinical settings are run by multi-disciplinary teams. As president of the society, I have had the opportunity to work amongst and utilise the varied skills set of committee members. This has enabled the society to work well as a team, where each member brought with them diverse abilities and passions, allowing different visions and viewpoints to be put forward and amalgamated into events.

Although I have enjoyed my time on the committee, there have been several challenges faced along the way. Consultants are busy due to the nature of their job and therefore, establishing contact and recruiting speakers for appropriate dates often proved difficult. In addition to speakers, it proved difficult to find dates for committee meetings where the whole team could attend. Despite this, perseverance and good communication resulted in events organised successfully. Initially, it was difficult to fund events, such as paying for the venues and refreshments, but this problem was resolved by asking for a small entry fee or one-off payment for society membership.

In the society's early stages, committee member roles were not particularly clear and therefore work delegation was not as equal as it should have been. As the committee matured, so did our grasp of the importance of specific roles and therefore fair job delegation.

I feel that a University society needs the following in order to be successful:

- Achievable and relevant goals.
- Reliable and enthusiastic committee to members.
- A president who coordinates and delegates jobs equally, utilizing all members of the multidisciplinary team and not trying to do everything by his or her-self!
- Regular elections for new committee members (optimizing the opportunity for other students to join) with comprehensive handover from those stepping down. In terms of continuity, it proved helpful to have a vice-president who became president the following year.
- The ability to collect and respond to feedback.

My work within the Psych Soc committee has enabled me to build a large amount of useful contacts within psychiatry, along with building my confidence in liaising with my seniors. Time spent in the world of psychiatry and with so many entertaining psychiatrists, all so passionate about their jobs, has further enhanced my excitement to begin a career alongside them. It has been a thoroughly enjoyable experience that has presented many great opportunities.

I would like to thank Dr. Ross Overshott, Dr. Neel Halder and Dr. Roshelle Ramkisson, three consultant psychiatrists, who made the society the success that it is today, through all their incredible efforts in the coordination of many of our events. Many thanks also to all the Psych Soc committee members, past and present, for all their hard work and commitment, it has been a pleasure to work with you.

References

1. Meechan C: Manchester Psychiatry Society (psychiatry/ psychology/ philosophy). *Blogspot* 2011. url: http://mancpsychsoc.blogspot.co.uk/. No doi number available. (accessed 10/06/2014)
2. Manchester Psychiatry Society Facebook Group. *Facebook* 2010. url: https://www.facebook.com/groups/mancpsychsoc/. No doi number available (accessed 10/06/2014)
3. Manchester Psychiatry Society Twitter account. *Twitter* 2012. url: https://twitter.com/ManchPsychSoc. No doi number available (accessed 10/06/2014)
4. Ahmed K. Medfest's official website. Created 2010. url: http://www.medfest.co.uk/. No doi number available (accessed 11/06/2014)

Review Article
DAUIN 20140068

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Day in the life of…..a psychiatrist working in learning disabilities and forensics

Dr Halder N, MBChB, MRCPsych, MSc, CT Dip. Med Ed

Institution

Consultant in Learning Disabilities working in a forensic secure hospital

WJMER, Vol 8: Issue 1, 2014

Abstract
The fields of learning disabilities and forensic psychiatry involve utilizing a varied set of skills. The workload is interesting and rewarding, and no two days are the same. This article gives a personal account of what life is like in this branch of psychiatry. Part of the article below was published in the Guardian newspaper and served to help the public to understand more about these lesser known fields of psychiatry.

Key Words
Learning disability, Forensic, Career, Work, Job

Corresponding Author:
Dr Halder N: neel.halder@alphahospitals.co.uk

When speaking with medical students at career's fairs, I am enthused by the strength of interest in learning disability, but surprised that many did not know it was a branch of psychiatry. One of my main passions is to help as many other people understand the complex, interesting and rewarding work undertaken by learning disability psychiatrists. I have written in newspapers and have worked closely with the media. As one of the lesser-known fields in psychiatry, I was particularly pleased that the Guardian expressed an interest in giving coverage about what a typical working life was in this field. I have replicated my interview with the journalist Anita Sethi published in the Guardian newspaper below (available at http://www.theguardian.com/lifeandstyle/2010/apr/27/doctor-neel-halder-my-week).

"I work in learning disabilities, with adults who have conditions such as autism, brain damage or intellectual difficulty. When it comes to diagnosis it is challenging, as there's an added communication barrier. In some cases you play the role of detective, working with what family tell you, team members and clinical acumen.

This week I've been on call. I start my on-call shift at 5pm and it doesn't finish until 9am – that's after a full day at work. Lots of coffee is one way to deal with it, but the main thing is to ensure that it doesn't interfere with clinical decision-making. I've been a psychiatrist for 11 years, and your body becomes resilient to not sleeping as much.

Every Monday morning we have an outpatients clinic. This week, a lovely middle-aged woman with severe learning disabilities was referred to me as she was distressed, banging her head a lot. I had to assess her. In this case, little things make a big difference; carers tried to give the lady choices. They gave her cereal packets and let her touch the box she wanted. She clearly understood what we were asking; and the frequency of her disturbed behaviour decreased after being given a choice. The main reason she felt distressed was because she didn't have any autonomy in what was happening to her. It demonstrated that we shouldn't jump in with medications first, but look at simple solutions. We need to let the patient have some responsibility, no matter how poor their communication.

In the afternoons I do home visits. This week I saw somebody who needed round the clock support. You can imagine the toll it takes on family members. But his father said: "A lottery winner may be rich, but he'll never be as rich as us in terms of the happiness we get from looking after our son."

One man in his 20s who I saw this week was isolating himself – things he used to enjoy he now wasn't interested in. We look for those markers to guide us as to whether they might be depressed. We also try to get collateral history: information from other sources, such as family members. We assess behavioural differences and then come up with a plan – medication or psychological

interventions. This time, we initiated an antidepressant treatment.

We have ward rounds every Wednesday, where people involved in inpatients' care – social workers, psychiatrists, nurses – discuss what would be in the best interests of the patient. There is a lady with bipolar illness, for instance, who we thought needed intensive care where we could monitor her food intake and keep a close eye on any risk issues. What other people may see as low points, I see as challenges, such as liaising with people to ensure everyone is working in harmony.

Like a lot of doctors I divide my time between clinical and non-clinical work. I'm a medical education fellow, and teaching is one of my great pleasures. On Thursdays I get a research day, which is another very important part of being a doctor – trying to advance knowledge.

One of my main aims is to reduce the stigma attached to mental illness in psychiatry, not only among the public, but also among potential patients. They think it's like One Flew Over the Cuckoo's Nest; we have to explain it's not. It's incredibly rewarding and humbling and puts everything in perspective. That's why I have a very positive outlook on everything I do."

I received many responses from others as a result of the above article, including those who hadn't started medical school, which is where I think is where we need to target the interested or curious. Since the interview, I have moved into the specialised field of working with those with learning disabilities in a low secure forensic setting. Many of my patients have autistic spectrum disorder, brain injuries, schizophrenia, depression amongst other diagnoses. They have also committed some serious offenses, and are thought to be a current risk to the community (hence a locked door on the ward). All patients are detained under the mental health act, which means they have additional safeguards to their detention, and quite rightly, are scrutinised regularly by an independent panel at manager's hearings and tribunals. Much of my work involves working with a team of highly skilled professionals such as occupational therapists, psychologists, speech and language therapists, nurses, support workers, social workers. Our job involves assessing risks and focusing on rehabilitation where possible. This means that communication skills are essential. Whilst on the subject of communication skills, many of my patients are profoundly deaf and therefore communicate with sign language interpreters. Learning disability psychiatry is very much patient centred; all decisions where possible are made in collaboration with the patient, and we even have the patients chairing their own ward rounds and Care Programme Approach meetings (where all multi-disciplinary team member involved in the patient's care attends to discuss progress and challenges).

Every day is varied; every day is rewarding. I read with interest a paper in the journal Medical Education by Lefevre *et al* (2010) where nearly 2000 medical students responded what they wanted from an ideal career was one with a lot of patient contact, a healthy work-life balance, the ability to choose to practice privately, and one that is intellectually stimulating with interesting diseases. In both learning disability and forensic psychiatry fields, all of the above can be easily found in abundance.

References

1. Lefevre, J. H., Roupret, M., Kerneis, S. and Karila, L. (2010), Career choices of medical students: a national survey of 1780 students. Medical Education, 44: 603–612
2. For more information, refer to the Royal College of Psychiatrists publication on a career in psychiatry. Available at http://www.rcpsych.ac.uk/PDF/Make%20a%20difference.%20Improve%20lives.%20A%20career%20in%20psychiatry.pdf

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Interview with Dr Dinesh Bhugra

Dr Hankir A MBChB

Institution

National Institute for Health Research Academic Clinical Fellow in Psychiatry, Manchester University, Manchester, England

WJMER, Vol 8: Issue 1, 2014

Abstract
In this article, WJMER editor Dr Ahmed Hankir interviews Professor Dinesh Bhugra, the President-Elect of the World Psychiatric Association. The interview traces Professor Bhugra's ascent from his humble beginnings in a small industrial town in India to becoming the President of the Royal College of Psychiatrists and beyond. Professor Bhugra provides a candid and personal narrative about his experiences as a migrant in the United Kingdom and adjusting to the destination culture and he also discusses and describes his research interests which include cultural psychiatry, the public understanding of psychiatry and recruitment into psychiatry.

Key Words
Interview, Cultural psychiatry, Recruitment into psychiatry, Public understanding of psychiatry

Corresponding Author:
Dr Hankir A: ahmedzakaria@doctors.org.uk

I'm currently poised rather precariously on the edge of a seat in the executive suite in the Derby Hotel situated in Alfreton, England. The venue is sprawling with psychiatrists (including the President of the Royal College of Psychiatrists himself none other than Professor Sir Simon Wessely) who have travelled from far and wide to attend and present in the British Indian Psychiatry Association national conference.

I am about to be joined by the President-Elect of the World Psychiatry Association Professor Dinesh Bhugra. Before Professor Bhugra graces me with his presence I can't help but feel a surge of anxiety and excitement course through my being. Professor Bhugra's resounding reputation as a juggernaut in the realm of cultural psychiatry does precede him after all and it is a true pleasure and privilege to be able to interview him. What truly humbles and inspires me about Professor Bhugra is the person behind the professional. Professor Bhugra does not adopt a supercilious taciturnity or isolate himself in the confines of a lofty ivory tower as some academics might do. Rather, Professor Bhugra always, without fail, is approachable (on your terms) and reciprocates overtures with warmth and earnestness. In many ways he is my role model, the paragon I seek to emulate and I can only hope that I am as approachable to my juniors as he is to me as I progress in my career. My conjecturing must come to an end for Professor Bhugra has arrived…

Ahmed Hankir [AH]: Professor Bhugra, thank you so much for taking the time out of your extremely hectic schedule to be interviewed for the special issue on mental health of the World Journal of Medical Education and Research. My first question is this: who is the person behind the professor, who is Dinesh Bhugra?

Dinesh Bhugra [DB]: Oh dear! I think it is the same person who is also the professor because it is about multiple identities. I maintain that within us we all carry multiple identities and fragments of our identities are constantly shifting. We wouldn't be having this conversation if I wasn't President-Elect of the World Psychiatry Association and because I am that is why you are here interviewing me. Granted, underlying all that is the person who is a migrant, a person who migrated in his late 20s, a psychiatrist coming from a rather humble background from a small industrial town in North India. I would describe myself as a rather introverted soul, steadfast, hardworking and diligent and, above all else, a voracious reader.

[AH]: Can you give us some examples of the kinds of books you have a penchant for?

[DB]: At any given time I have 3 books on the go. Because I travel on public transport I always have an easy to read crime novel which invariably involves a plot that revolves around espionage and some sort of debauchery. I generally have a biography which varies from political biographies to historical figures to Bollywood stars. A third book would be on politics. At the moment I'm reading a spy novel, I'm reading a crime novel and I'm reading a biography from a film director from Bollywood.

[AH]: Can I ask you, you made reference to your humble beginnings. Do you think that this has had an influence on your vision?

[DB]: It is difficult to know. Both my parents were born in what is now Pakistan. They got married after Pakistan declared sovereignty from India in 1948. My father was a very bright student but his parents couldn't afford to send him to university after he finished school. He started working in a bank and worked his way up and became a bank manager but this was a struggle. On paper it might sound that a bank manager's job is quite glamorous and highly remunerated the reality was that it was pretty far from it. I think this had an effect on me. My response was to hide away in books. From as far as I can recollect, I can always remember being immersed in a book or two. That was my escape. Although I am aware that we need a rich fantasy world where creativity and hope can flourish I am not good at fantasizing and this is my problem. I think in psychiatry, creativity and fantasy are important and this is what makes psychiatry so exciting and rewarding and unlike any other medical specialty.

[AH]: Do you feel as if you are understood?

[DB]: I think there are people who do understand me, my modus operandi. There are people who know me well, people who have known me for forty years who know what makes me function the way I do and they will know what I mean and what I don't mean. I think it goes back to the question of multiple identities and multiple personas that we behave in different ways with different people, and that can depend on how comfortable we may feel with them or not.

[AH]: Why did you choose a career in psychiatry?

[DB]: It was a really bizarre moment that I'll never forget. In one of my previous interviews I used the term epiphany. I know epiphany has religious connotations but I remember in my second year in medical school back when I was in India cycling away from the dissection hall on my way to the hostel where I was lodging, there was this moment of clarity when it occurred to me that we all have similar anatomies, we all have similar physiologies but what makes us so different from one another? So I started thinking about it and reading about it and I came across a biography of Freud at the time. There was something about Egyptian medicine and mysticism also that I read that was really thought-provoking so I ended up wanting to do psychiatry. Everybody I would reveal this to thought I was crazy. Nonetheless, I decided to stick with it. I did dabble with other specialties such as Accident and Emergency and Medicine but the day I started psychiatry I felt I was at home and I have never looked back since. To my mind psychiatry is the most exciting, most intellectually stimulating specialty of medicine. There isn't any other speciality that produces that kind of challenge because it coalesces biological, psychological and social factors together to try to understand a patient's subjective experience and it is also about the way that they have been reared and the way that they have responded to their upbringing and personality and social networks. Illness is only one aspect of who they are. This is what makes psychiatry really exciting because you can actually understand the patient and look into the inner landscapes of their minds. No other speciality gives you that.

[AH]: Fascinating. You conducted some research into the recruitment crisis in psychiatry. Can you discuss some of the important findings of that research with us?

[DB]: The major issues about recruitment into psychiatry are there are three kinds of people: there are those who go into medical school to do psychiatry and they are very clear about this right from the outset. There are those who go into psychiatry passively; for whatever reason they end up in psychiatry. And there are those who end up in psychiatry actively because they see patients. What we found in 20 countries were that students who had good experiences of psychiatry, who have been given responsibility during their clinical attachments, things like performing risk assessments, interviewing patients who require psychotherapy, these students report enjoying those experiences and that this encouraged them to consider psychiatry as an attractive career option.

[AH]: Could you discuss some of the key findings of the research that you conducted into the portrayal of mental illness in Bollywood movies that was commissioned by the Wellcome Trust?

[DB]: The basic hypothesis that I set out to study was that whatever is going on in society affects the

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

portrayal of mental illness in film. Conversely, the portrayal of mental illness in Bollywood affects the attitudes that people have in society towards mental illness. The traffic is bidirectional. Certainly in a post -colonial India in the 1950s and 60s there were many films featuring people with mental illness who were subject to ridicule but there were also some films that had sympathetic portrayals of sufferers of mental illness. In the 70s and 80s when the country was going through major economic, social and political crises the portrayal of mental illness in film was very much of psychopaths who couldn't rely on the system to provide for the vulnerable so they were vigilantes taking the law into their own hands. This image of mental illness sufferers transformed in the 90s when there were many motion pictures that portrayed morbid jealousy, typically films in which men were trying to control women and women became a kind of object or property in the same way that economic liberalization allowed them to own objects so women were seen as property.

AH: Do you think we can use film to de-stigmatize mental illness?

DB: What you need to bear in mind is that films are not made for education. Films are made for entertainment and for generating revenue. So we can use films for educational purposes but you have to realize the limitations. The best option for de-stigmatizing psychiatrists, psychiatry and mental illness is interaction with the patient so in other words social contact.

AH: You mentioned once something about white doctors' attitudes towards Black and Ethnic Minority service users. You also spoke about the importance of Black and Ethnic Minority doctors having positive attitudes towards white service users. Could you elaborate more on this please?

DB: The question is about cultural competence. The crux of cultural competence is an awareness of who you are and being aware of what your prejudices are and what your discriminatory thoughts and feelings are and how you might deal with them. To argue that British culture is homogenous and a completely uniform culture is apocryphal because culture in Derbyshire is very different from culture in Devon. London, for example, in my opinion at least is a collection of villages in which there are unwritten and unspoken taboos and so on and so forth. What we need to bear in mind is cultural competency is about good clinical practice no matter where we work, Devon, Derbyshire or London, we need to know the strengths, the problems and the weaknesses of the population we are serving regardless of what your ethnicity may be. Ethnicity amounts to a visible marker and that's

about it in my reckoning.

AH: Could you describe some of Professor Sir Michael Marmot's research into life expectancy and the social determinants of health?

DB: Professor Marmot conducted a seminal study in which he revealed that if you take the Circle Line on the London Underground, for every Eastbound station stop life longevity decreases by 1 year. This clearly illustrates the social determinants of health which regrettably we do not take into account. One of the major roles I personally think is for doctors to advocate to our patients how the social determinants of health have relevance in psychiatry and mental well-being. One of the tragedies of modern medicine has been the split between physical health and mental health. I blame Descartes for his mind-body dualism theory. We know that if you have diabetes and you get depressed it is much more difficult to control your diabetes. If you have hypertension it is the same thing. If you have depression and you develop diabetes, your depression becomes difficult to control. So I think we need to change the way we look at illness and the way we treat our patients and the way we train our students. We need to adopt a holistic approach that incorporates the mind and the body.

AH: A recent study revealed that a high percentage of students in a Brazilian medical school experienced depressive illness. Could you expand on this study please?
DB: Yes, year 1 and year 6 medical students displayed high rates of depressive symptoms. The interpretation for year 1 students was teenagers were leaving home for the first time perhaps and they were finding their feet. It was noted in this particular study that a lot of them had been forced into medical school and that may have been a contributory factor to developing psychopathology. The interpretation for the 6th year medical students was that this group were worried about securing a job upon qualifying providing they passed their exams of course which was also extremely stressful for them. I think the big message from this study was that these medical students had low levels of help seeking for their own psychiatric problems because of fear of exposure to stigmatization. Many felt that it wasn't an illness at all but rather that they were experiencing these symptoms due to a lack of moral fibre which was causing the problems rather than anything else.

AH: There is a paper in the British Journal of Psychiatry that describes the efficacy of Coming Out Proud with mental illness as a means to reduce self-stigma. What are views on Coming Out Proud with mental illness?

DB: I personally think it is an individual decision. I don't think we should force people to divulge this information. It is similar to homosexuality in a way. People should be free to choose when and to whom to come out to and if they don't want to come out that is their decision. Stigma to my mind is a much more complex issue than it is made out to be. It is what a French philosopher calls the creation of the other. We all create the other because it validates our identity. And that is what stigma is about. We have someone else or something else that validates who we are. Having someone who is mentally ill validates that we are mentally healthy. So any anti-stigma programme needs to take that on board. It does help when celebrities come out and say I have had alcohol problems or post-natal depression or I have had depression. It humanizes them and also makes it okay for others to say that they have had those kinds of experiences. Ultimately it is a personal decision.

AH: What does it mean to be British?

DB: Haha! I think there are stereotypes take for instance the old stereotypes of stiff upper lip, British reserve, Dunkirk spirit and all of that. That all changes when Paul Gascoigne cried openly in a football match, that gave the British identity a human side but also changed the whole ethos of being British. One of the things you have to bear in mind is that all of these identities and cultural formulations change and shift as time changes and social, political and economic situations change. When I first arrived in the 1980s, in the three decades I've been here Britain has changed dramatically. When I first started in the Maudsley, we didn't have any female professors or consultants. As time went by, this gradually changed and we started having more and more female consultants and consultants from Black and Ethnic Minority backgrounds. So the culture has changed dramatically over the last three decades.

AH: If you could have a meal with any three people from the history of humankind, who would they be?
DB: Hmmm. I would certainly like to have a meal with Plato in order to try and understand what his ideas and vision were. The other person I would think about would be Chanakya who was a Prime Minister for one of the ancient Kings of India. He wrote an economic treatise on how to manage and govern a state. The person I would most like to meet is an Indian Bollywood singer- Lata Mangeshkar.

AH: What is meant by professionalism?

DB: Professionalism is something that everyone recognizes but it can be very difficult to define. It is about taking pride in what we do. It is about having certain standards. It is about training and mentoring. It's about self-regulation and having certain ethical and moral imperatives in what we say and do.

AH: Last question: do you have any advice to students who have an interest in a career in psychiatry?

DB: Choose it! Do psychiatry. One of the major attractions for psychiatry is that you can learn so much from your patients, no two patients are ever alike. Even if they are both having hallucinations, the individual content of those hallucinations is personal and very different. You can learn so much about a patient's inner world from their narratives and from poetry, literature, art, film and so on. And this is what makes psychiatry such a wonderful specialty. Take for instance initiatives like the International Medical Film Festival Medfest, no other specialty can boast to have a similar initiative.

AH: Thank you very much Professor Bhugra for you time and for answering all of our questions for the World Journal of Medical Education and Research.

DB: My pleasure Ahmed.

Clinical Research
DAUIN 20140070

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

Using the DISCERN Instrument and Flesch-Kincaid Readability Scale to Assess the Reliability and Readability of Online Mental Health Treatment Information

Dr Mehul Patel, MB ChB, BSc; Dr Neel Halder, MB ChB, MCRPsych, MSc; Dr Louise Theodosiou, BSc Hons, MBChB, MSc, PGCE

Institution

**Glasgow Royal Infirmary, Glasgow, UK*

***Consultant Psychiatrist, Alpha Hospital, Bury; Senior Honorary Lecturer, University of Manchester, UK*

****Consultant Child and Adolescent Psychiatrist, Central Manchester University Hospitals NHS Foundation Trust*

WJMER, Vol 8: Issue 1, 2014

Abstract

Background: As people use the internet more to retrieve information about health, it is very important that the information they read is reliable, particularly as online information is not regulated in any way. The object of this research was to determine the reliability and readability of mental health treatment information currently available to patients online.

Methods: Eight conditions (Depression, Bipolar, Post Natal Depression, Schizophrenia, Anorexia, Bulimia, Insomnia and Anxiety) were entered into the Google UK search engine. Using the DISCERN instrument for reliability and the Flesch-Kincaid Readability algorithm for readability, the relevant websites found on the first page of results for each term were assessed.

Results: 77 websites were assessed, with 9 being excluded for being unrelated to the search term, unworkable with the DISCERN tool, or for being duplicates of previous results found with in the same search category.

Key Words

Internet, Mental health, DISCERN, Readability, Reliability, Flesch-Kincaid Readability scale

Corresponding Author:

Dr Halder N: neel.halder@alphahospitals.co.uk

Introduction

The Internet has grown from a research project commissioned by the government of the United States of America to build a system of connected networks between computers into a vast global series of computer networks serving approximately 2.27bn of the world's population[1], used for a huge variety of functions by vastly different demographics, and a major part of many people's lives. In the UK alone, there are approximately 52.7m internet users; a penetration of 84.1%[2].

One of the most revolutionary changes in the way we search for news and information today has been the development and vast expansion of search engines on the internet. The largest of these companies is Google Inc., an American multinational corporation founded by Larry Page and Sergey Brin when they were students at Stanford University[3]. They devised an algorithm known as PageRank[4] which ranked websites not on the number of search terms but on the relative importance of the page within other pages that also came up under that search term. This system became known as Google Search, and is currently the most used search engine on the internet today with over 80% market share worldwide and currently ranked as the number 1 most visited website on the internet over the last six months[5] by Alexa.com. Currently Google handles over 4.7bn searches per day.[6]

Health information on the internet

A survey found that approximately 80% of people worldwide who have access to the internet use it for looking up information related to health, a figure which is only increasing.[7]

Because of the unregulated nature of the internet, the huge amount of information appearing every day available to anyone who finds it has been criticized by health professionals for its unreliability.[8] While there are a large number of reputable websites created by health professionals and based on guidelines, there are equally a large number of websites with no regulation of the health information published, leading to the possibility that patients could be misinformed over their condition or treatments available to them. Furthermore, the

technical and communication skills necessary to create an accessible website, are not necessarily part of a clinician's training, while excellent technological skills may not sit alongside detailed medical knowledge. Without a medical background, it may be difficult for people to ascertain which websites they choose for information related to health are in fact reliable regulated sources, and which are not.

DISCERN Instrument

To attempt to assess the reliability of these sources, various models and instruments have been designed. These models are often aimed at patients so that they themselves can rate the usefulness of the health information they find[9] but can also be used by health professionals. One of these tools is the DISCERN questionnaire, a sixteen question instrument, described on its website, among other things, as being[10] a "checklist for authors and producers of written consumer health information." The DISCERN questionnaire involves rating the websites using 16 questions split into three sections. Section 1 looks at how reliable and trustworthy a website is; section 2 looks specifically at the treatment choices; and section 3 evaluates the overall quality of the website in the reviewer's opinion.

This tool cannot however be used to assess the scientific quality and accuracy of a website. One study in which the DISCERN tool has been used previously is the 2009 paper by Batchelor et al entitled "Use of the DISCERN Instrument by Patients and Health Professionals to Assess Information Resources on Treatments for Asthma and Atopic Dermatitis.[11]" One of the findings from this study was that there was a high correlation between the DISCERN Scores rated by the different raters, suggesting that the instrument allows users to be consistent in their ratings. However, due to the fact that people in general may be harsher or more generous in their ratings, there was a large range of kappa values when comparing the different raters' scores. This suggests that the tool is not appropriate for evaluating the absolute reliability of treatment information and depends very much on the marker's subjective choices. This means that the DISCERN scores for the asthma and atopic dermatitis papers cannot be compared to any other DISCERN scores for any other conditions unless those scores were found by the same raters.

Flesch-Kincaid Readability Algorithm

Another option for comparing health information websites is looking at how readable they are, and therefore how easily patients would find it to take information from them. There have been tools designed that assess how readable a section of text is, one such tool being the Flesch-Kincaid readability algorithm. This assesses a website's readability based on the average word length and sentence length, which can then be converted using a formula into either the Flesch Reading Ease scale or the Flesch-Kincaid Grade level[12]. The Flesch Reading Ease scale gives a score between 1-100, with a score of 0-30 indicating a body of text is more difficult to read and more suited to university graduates, while scores of 90-100 indicate that text is easily understood by an average 11 year old. The tool can also be used to give the aforementioned Flesch-Kincaid Grade level, a score inverse to the readability score with higher scores indicating more difficult to read passages. These grade levels roughly correlate to the US Grade Level system and again give a general idea of how difficult a block of text is to read.

Method

Google Analytics lists the eight most searched for conditions on Google related to mental health, namely Depression, Bipolar, Post Natal Depression, Schizophrenia, Anorexia, Bulimia, Insomnia and Anxiety. On the 2nd of June 2012, these terms were then each entered into Google.co.uk, with location settings set to United Kingdom and with search results including any pages from "the Web" as opposed to from the UK. All websites found on the first page of search results which were able to be used with the DISCERN tool were then evaluated for relevance to the search term, while websites unrelated to Mental Health were discarded (See Appendices). The first page was chosen due to an Optify study which found that 89.5% of users only select links from the first page, with 58.4% only clicking on one of the top three links appearing in the search results.[13] Additionally, websites which reappeared on each search category list more than once were discarded to ensure there was no duplication of data. The list of websites for each search term was randomised to ensure that familiarity with the questionnaire did not alter the ratings given for each site. All websites were viewed on Internet Explorer 9 with ad blocking tools turned off.

Each website appearing on the first page of the Google search was read through and then reviewed with the DISCERN instrument, with the results noted down on a spreadsheet. These were then averaged for each search category, as well as for the overall health information.

Secondly, the readability of each webpage was analysed using the Flesch-Kincaid Readability algorithm. This tool is a way of analysing how readable a passage is based on the average length of sentences and how many syllables each word has.

Using this data, it is then possible to calculate the reading level of passages. Using the Flesch-Kincaid algorithm in Microsoft Word 2010 the first two paragraphs of each website on the list were chosen and copied and pasted into Microsoft Word 2010. The Spelling and Grammar was then taken without making any corrections as this provides a Flesch-Kincaid Readability score as well as a Flesch-Kincaid grade level. The grade levels were then averaged for each category and these results were compiled in spreadsheets then charts as shown below.

After compiling the list of all websites, data was collected for all the websites with four or more appearances in all categories. These websites had their appearances reviewed and their DISCERN scores and Flesch-Kincaid grade levels averaged. Finally, their Alexa.com traffic ranking for the UK was also added to the table. This number is a rank, calculated using a combination of the average daily visitors to the websites along with page views for that website from users from that country over the past month. The sites with higher combinations of these two factors are ranked with higher ranks, meaning for example that Google.co.uk is ranked #1 in the UK while Patient.co.uk is ranked #949 meaning that Google UK is the most visited website in the UK while Patient.co.uk is the 949th most visited.

Results

The first page of each generated set of search results was noted down. Any results that were not usable or were duplicated were discarded (see appendices).

Of the websites remaining, 77 were assessed for whether they were appropriate for use with the DISCERN tool. Of these, 6 websites were excluded for not being related to the search term or for being found to be unworkable with the DISCERN tool, with 3 more being excluded for being duplicates of previous results found with in the same search category, leaving 68 websites which were assessed below (figure 1).

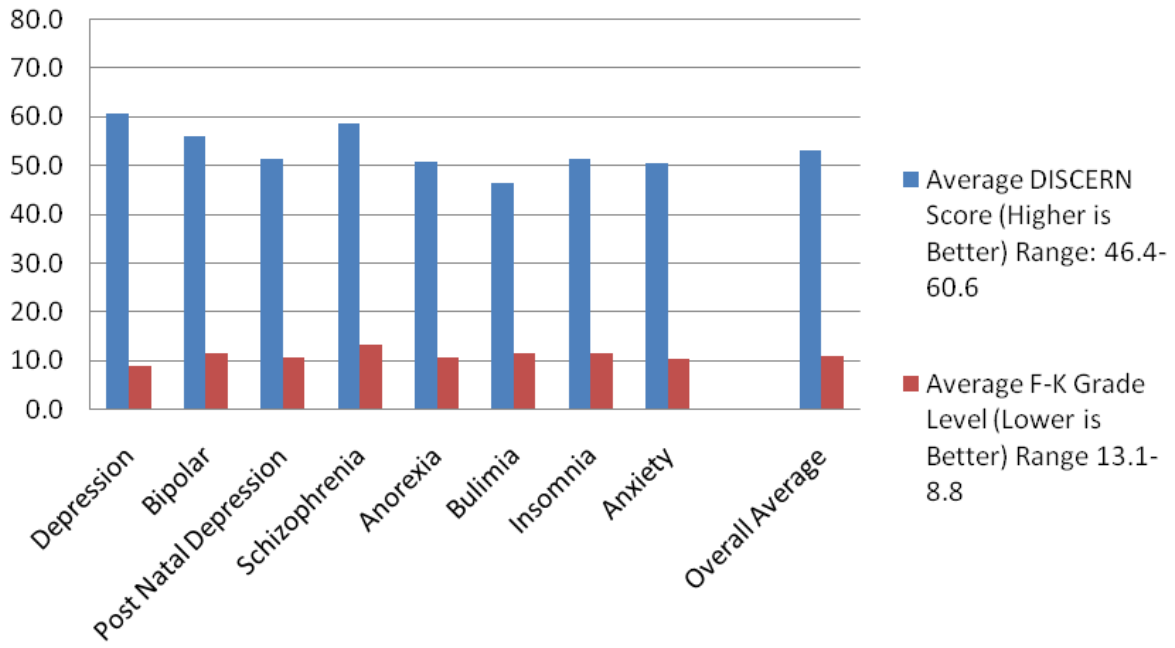


Figure 1: Overall Results

Depression (+7.5) and Schizophrenia (+5.5) websites on average have a higher DISCERN Score in comparison to the average, while Bulimia websites have a lower DISCERN Score (-6.8) in comparison to the average. Depression websites were also to have the best readability grade level, at 8.8. This lower level indicates that these generally include shorter sentences and paragraphs with fewer sentences and that they are therefore more readable. In comparison, the Schizophrenia websites have on average a higher average grade level of 13.1, indicating they are on average more difficult to read.

The results from each of the categories are given below (Figures 2-9)

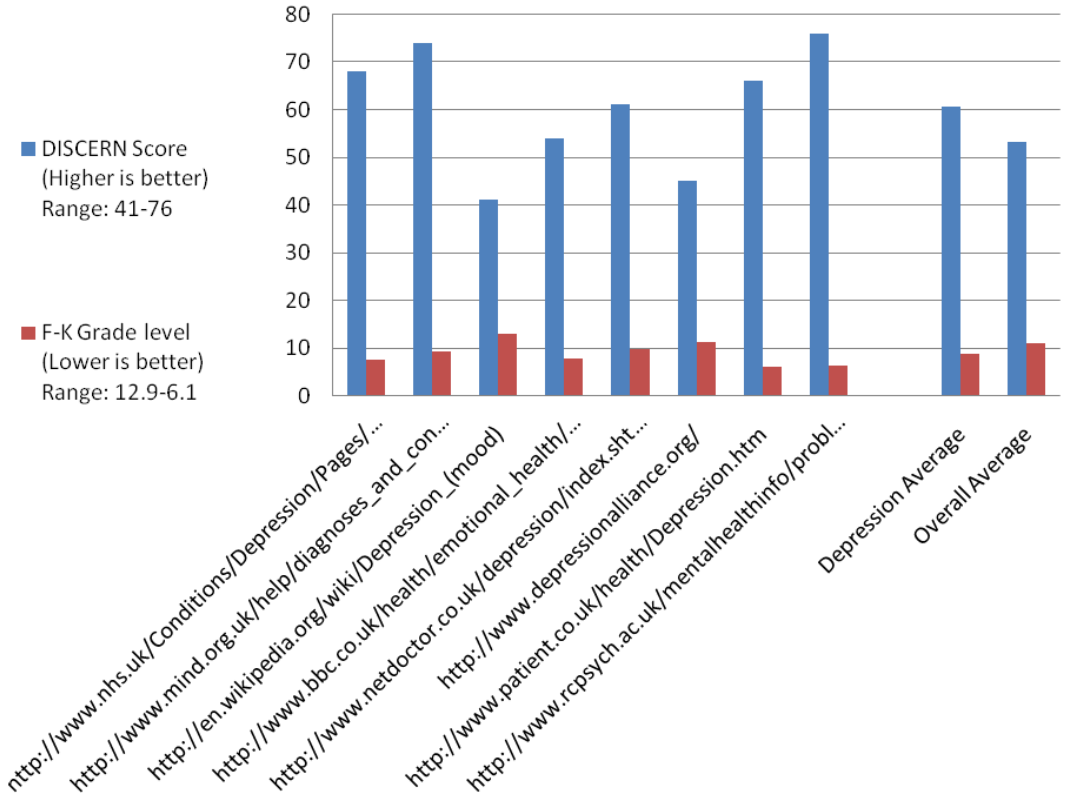


Figure 2: Depression

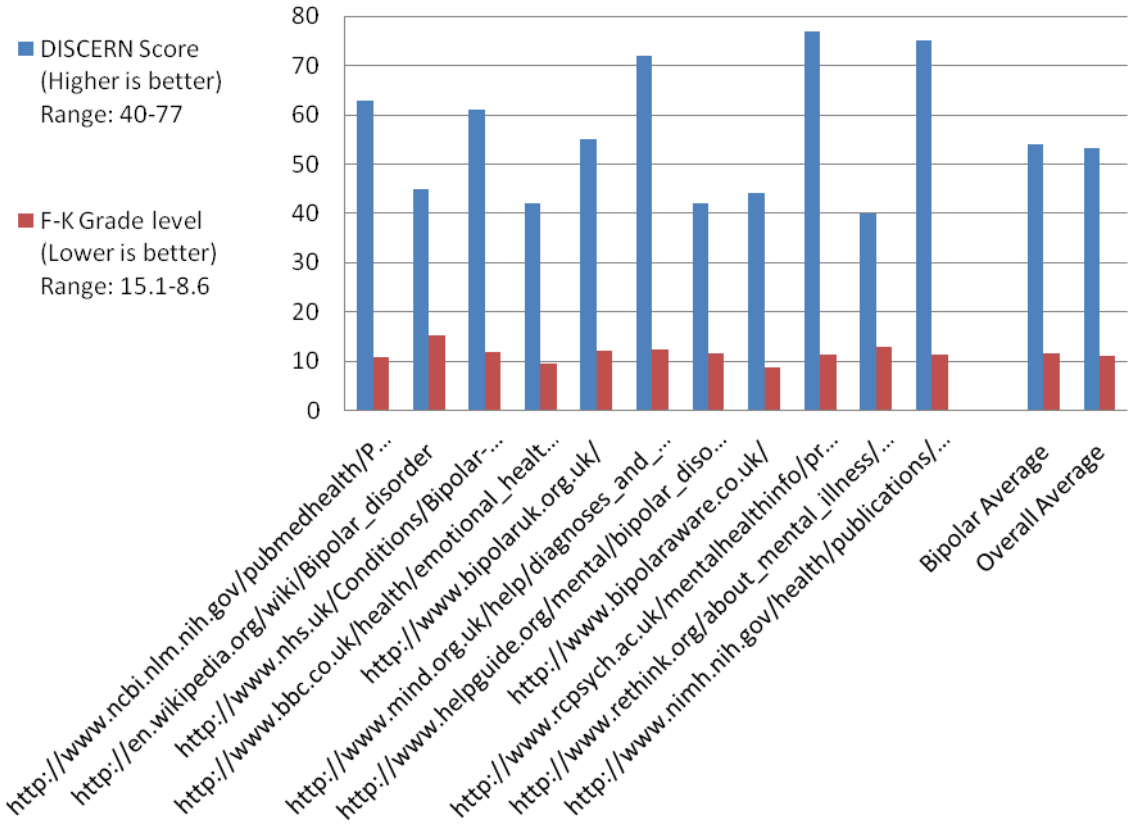


Figure 3: Bipolar

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

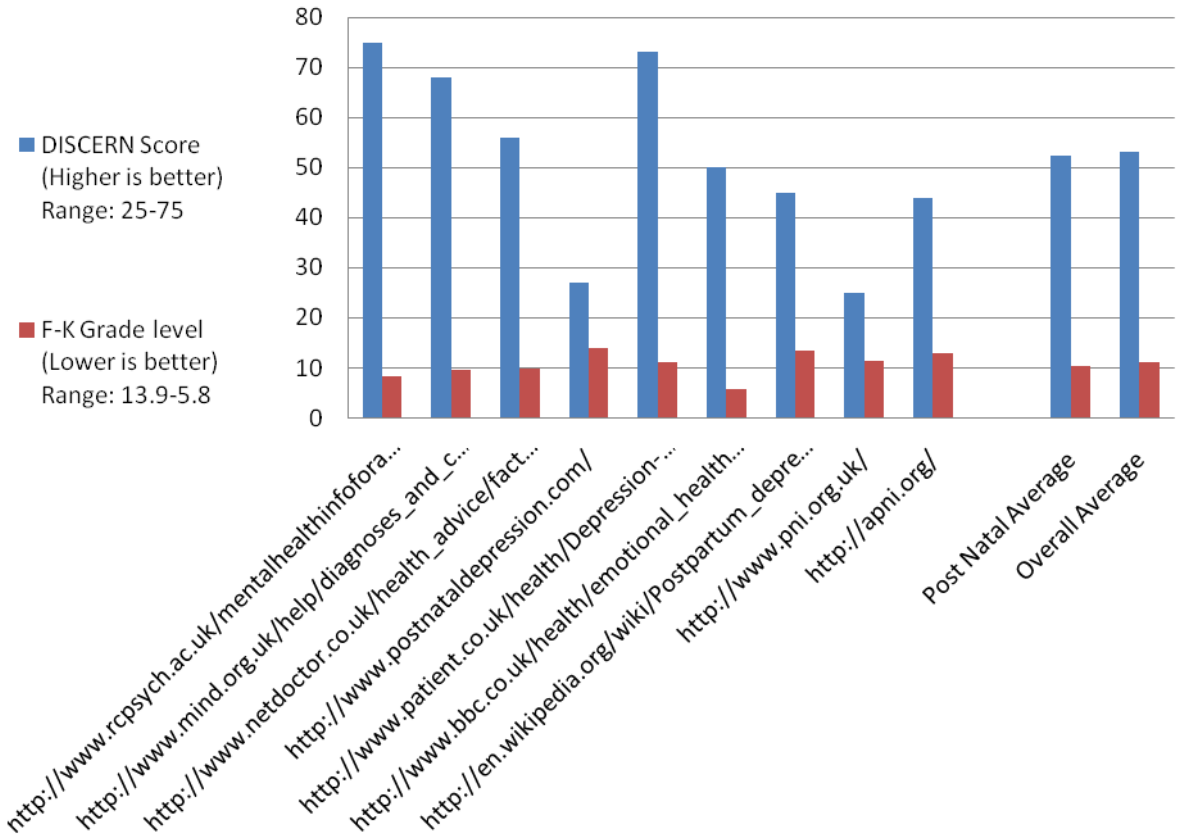


Figure 4: Post Natal Depression

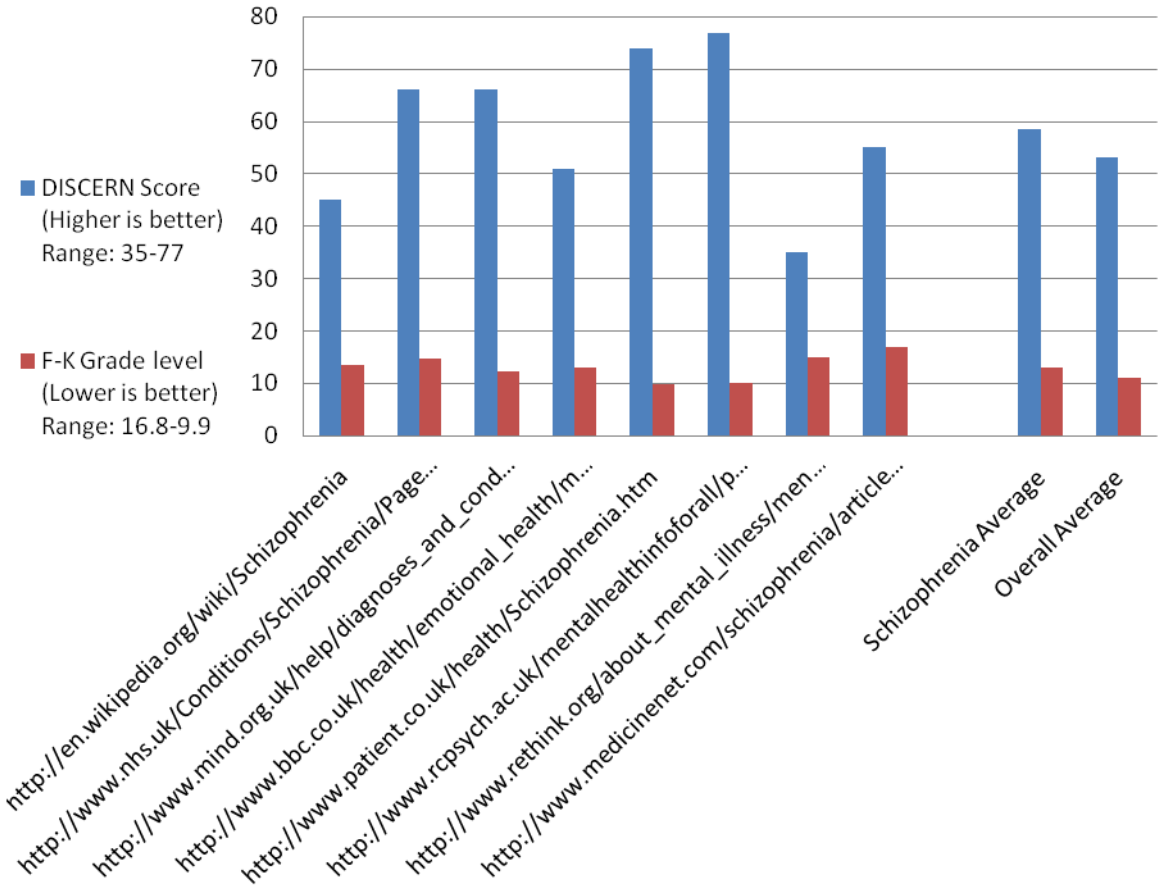


Figure 5: Schizophrenia

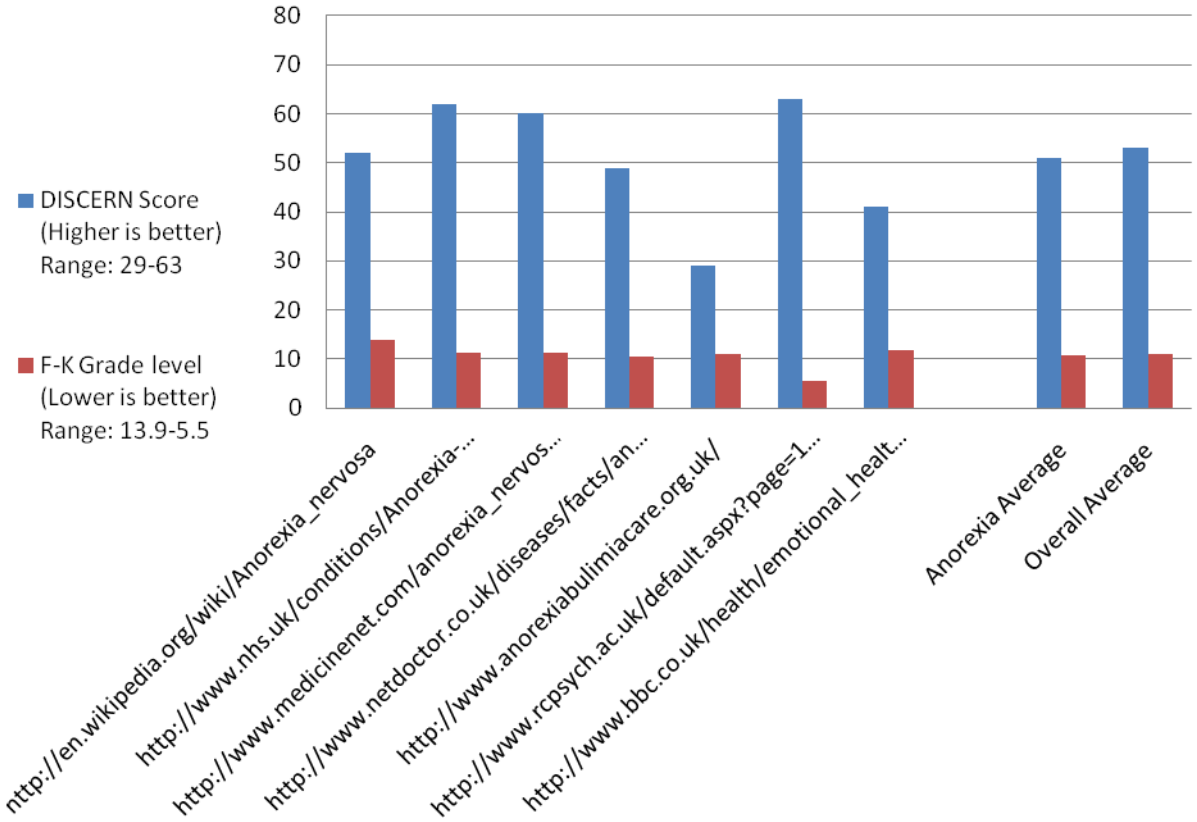


Figure 7: Anorexia

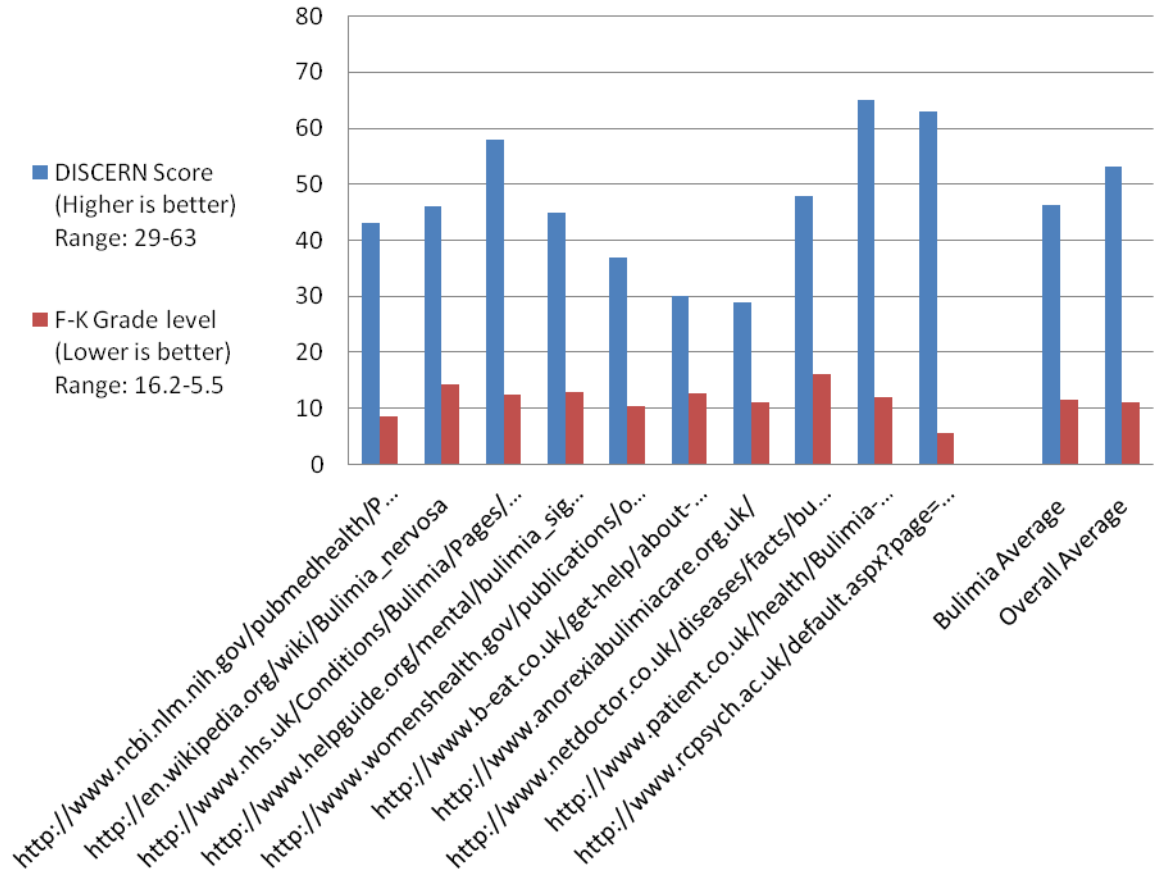


Figure 7: Bulimia

World Journal of Medical Education and Research:
An Official Publication of the Education and Research Division of Doctors Academy

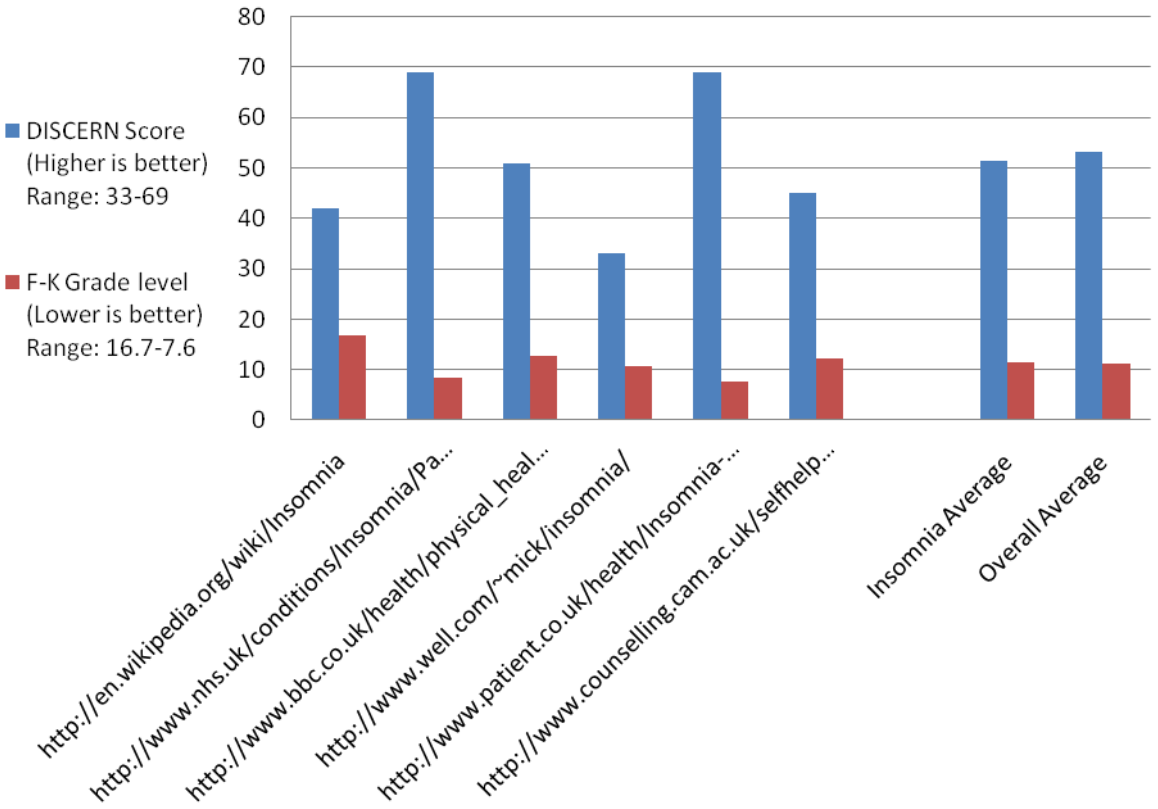


Figure 8: Insomnia

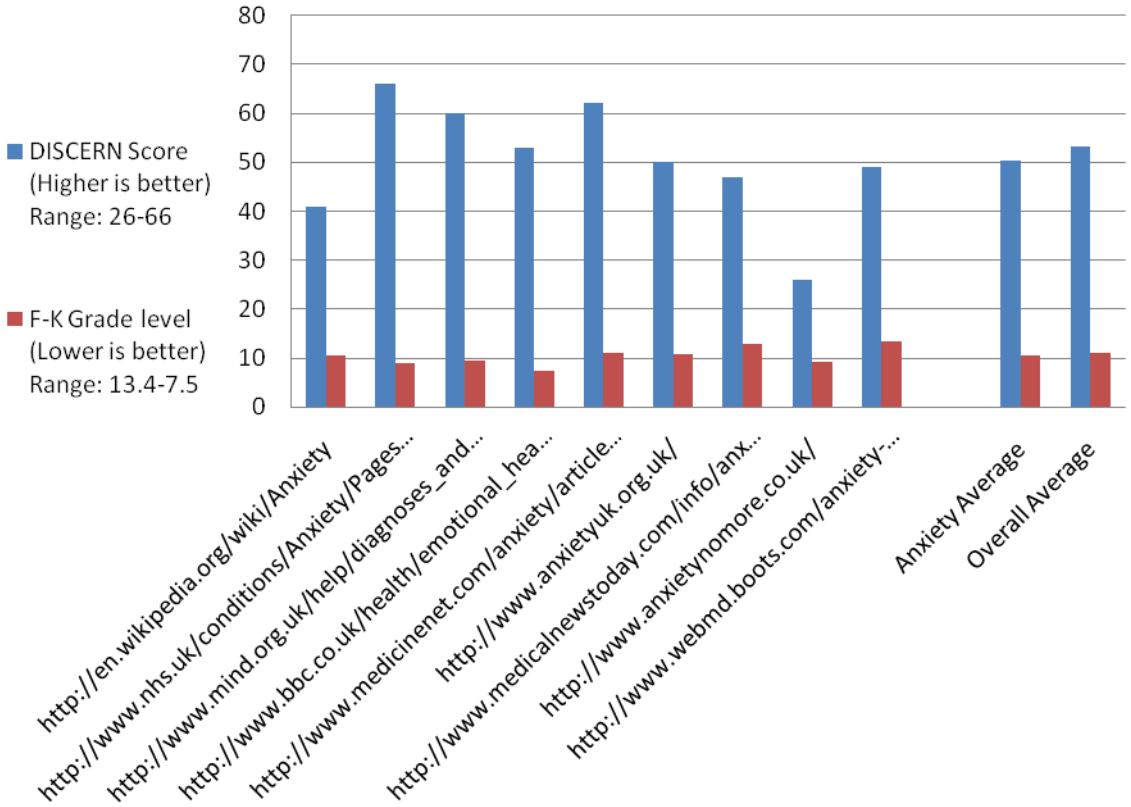


Figure 9: Anxiety

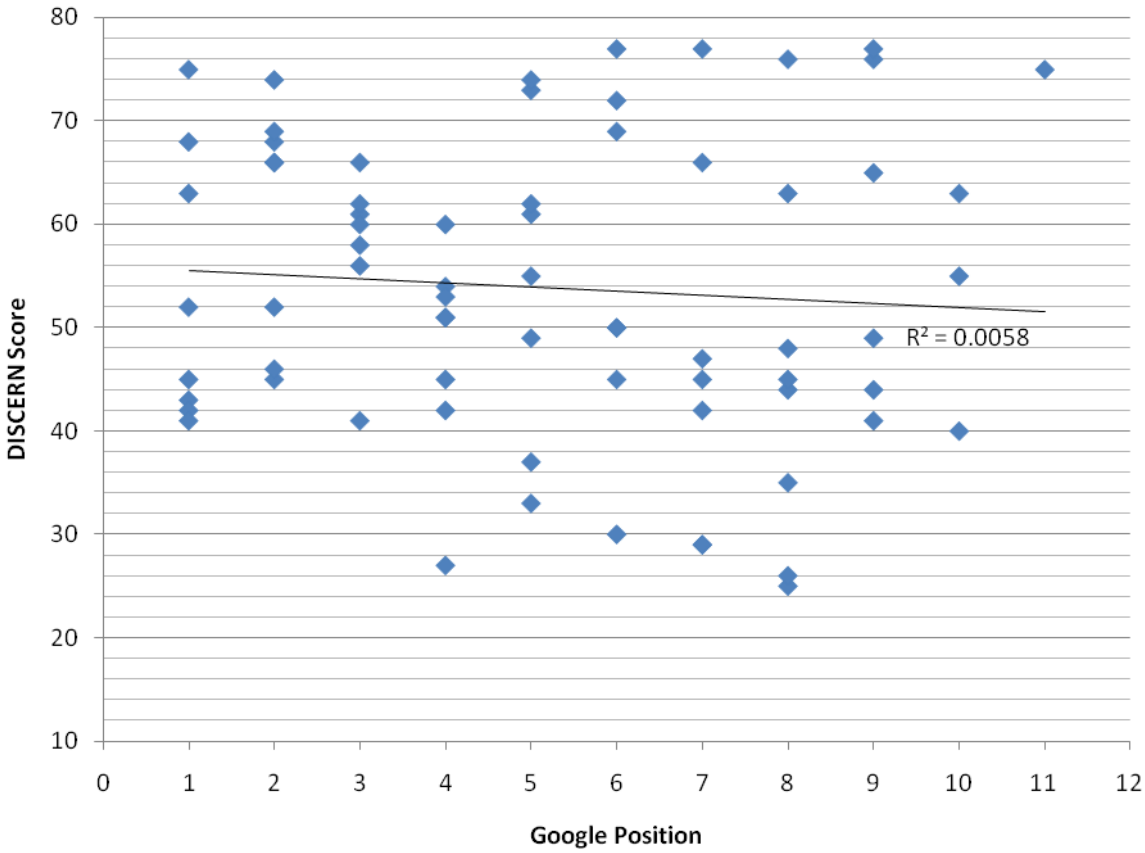


Figure 10: DISCERN Score against Google Position

There is no correlation between the DISCERN score and the Google position, with a p-value of 0.14 and an R^2 found to be 0.0058.

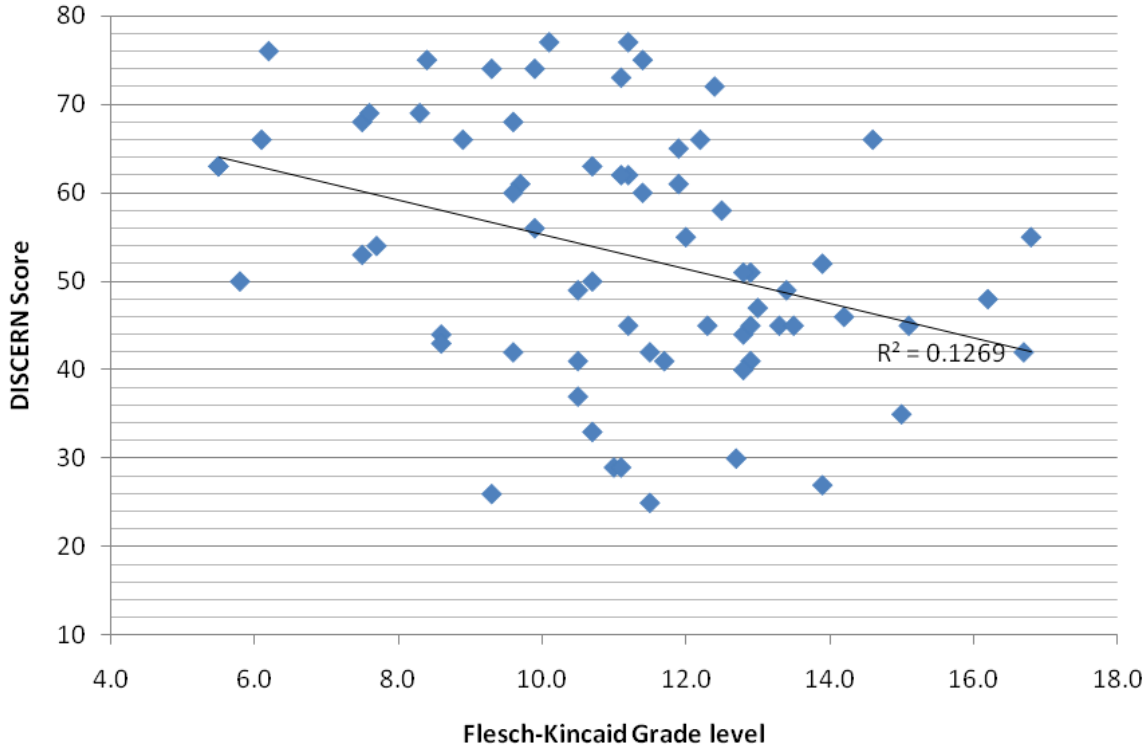


Figure 11: DISCERN Score against F-K grade level

When comparing Flesch-Kincaid Grade level to DISCERN scores to see whether there is any correlation between quality of website and readability, a correlation was found with a P-value determined to be 0.0014.

Websites	Appearances	Average DISCERN Score	Average Flesch-Kincaid Grade Level	Alexa UK ranking
www.RCPsych.ac.uk	6	71.8	7.82	11180
www.Patient.co.uk	5	69.4	9.32	949
www.Mind.org.uk	5	68	10.62	7347
www.NHS.uk	7	64.3	10.70	197
www.MedicineNet.com	5	55	12.06	968
www.NetDoctor.co.uk	4	53.5	11.58	1025
All websites	68	53.2	11.1	n/a
www.BBC.co.uk	7	48.9	9.71	5
www.en.Wikipedia.org	8	44.6	13.76	8

Figure 12: Websites with most appearances

The above table looks at the 8 websites which appeared in four or more categories, along with their average DISCERN score of each appearance, their average Grade level from each appearance, and their Alexa ranking of page traffic from the UK. The websites were then sorted based on their average DISCERN scores to assess how reliable the more frequently appearing websites were.

Wikipedia, while appearing in each of the 8 categories and accounting for 12% of all the websites reviewed, has an extremely low reliability as examined with the DISCERN instrument, along with pages which according to the Flesch-Kincaid Grade levels are less readable than the other health websites reviewed in this study on average. However, it also has a very high Alexa UK traffic ranking, coming in as the 8th most visited website from the UK.

Discussion

The number of websites reviewed for each category (figure 1) was fairly low and there was a large variation in the number of websites for each search term, ranging from 6-11 websites.

Looking into each search category in more detail, it is clear that in each there are vast variations in the reliability and quality of websites, as well as with the readability. One thing to note about the Depression results (figure 2) is that only 8 websites were available from the front page in comparison to the Bulimia results which had 10 and the bipolar results which had 11 websites available. Due to the fact that the Mind.org.uk, the RCPsych.ac.uk and the NHS.uk websites appeared on the first page, this could have increased the average of the Depression category in comparison to some of the others.

As mentioned previously, the top three websites receive 58.4% of clicks from users, so it is significant to see that a Wikipedia article on Depression as a mood was the third link on the search results for that day. This received a very low DISCERN score of 41 as well as a moderately high score of 12.9 for its Flesch-Kincaid Grade level. This is also significant as according to Alexa.com, Wikipedia is the 8th most visited website in the UK, meaning a large number of people looking for information on Depression are likely to end up going there. The DepressionAlliance.org website barely performed better with a DISCERN score of 45 and a Flesch-Kincaid score of 11.2. Another site lowering the average of the Depression category is the BBC.co.uk website which only received a Discern score of 54. With the BBC being a well-respected organisation, and the website being amongst the top 50 most visited in the world and 5th most visited in Great Britain, this is a very low score. On the other hand, the Mind.org.uk and RCPsych.ac.uk websites performed extremely well with the scoring systems, receiving a DISCERN score of 74 and 76 respectively, and a Flesch-Kincaid Grade Level of 9.3 and 6.2 respectively. This placed the RCPsych.ac.uk website for Depression at one of the highest DISCERN scores as well as one of the lowest Flesch -Kincaid readability Grade Levels from the entire study. However, it was relevant that it only appeared eight in the list of search results. Due to the fact that over half of people who use Google do not proceed past the third link, this suggests that very few people will in fact go down to the 8th link on the results page and the high quality of information available in the RCPsych website will be ignored.

In the Bipolar category (Figure 3), there were 11 usable websites, the most that appeared for any of

the other categories. This was partly due to the fact that unlike the other categories, the Bipolar category did not have any YouTube Videos or Google Images appearing on the first page results, which was instead made up solely of websites. Along with this, the Bipolar results page did not include any duplicate websites or websites that were not useable with the DISCERN instrument.

In terms of the websites which appeared in the results, it is worth noting that the Patient.co.uk website, which generally performed well wherever else it appeared, did not appear here. It was found that it did not appear till the third page, at position 24 on the results list, which suggests that using the PageRank algorithm it was quite far from reaching the first page and would be unlikely to do so any time soon.

Five websites in the Bipolar results category performed well below average on the DISCERN score, these being HelpGuide.org, BipolarAware.co.uk, ReThink.org, and again the BBC Health website and Wikipedia. These websites obtained scores of 42, 44, 40, 42 and 45 respectively. With Wikipedia and the BBC website being so popular and yet again receiving such low scores this suggests a real cause for concern should patients continue to use them.

In comparison, again Mind.org.uk and RCPsych.ac.uk performed very well, receiving scores of 72 and 77 respectively, while nimh.nih.gov also performed very well, getting a score of 75. These extremely high scores indicate a very reliable website for patients to use. On the other hand, they also all received Flesch-Kincaid Grade level scores of over the average of 11.1 (12.4, 11.2 and 11.4 respectively.) This indicates that while these websites include very well presented information which appears reliable according to the DISCERN instrument, they are less readable than others.

In particular, the BBC and BipolarAware.co.uk websites, while performing very poorly on the DISCERN score, were found to be very readable, with low Flesch-Kincaid Grade levels of 9.6 and 8.6 respectively.

Again, it is notable that the two highest DISCERN scores from the first page of results were found in positions 9 and 11, suggesting that they were less likely to be looked at than those featuring higher up on the list of results.

In the Post Natal Depression search category (Figure 4), it was found again that the RCPsych.ac.uk, the Mind.org.uk and the Patient.co.uk pages again achieved the highest DISCERN scores, obtaining 75, 68 and 73 respectively.

This was also the first category reviewed where the top three websites all achieved a higher DISCERN score than both the search term average and the overall average, and in a probably related note, this was also the only category in which Wikipedia was not found in the top three results.

As mentioned previously, over 50% of people clicked solely on one of the top three links, meaning that for Post Natal Depression most people looking for health information would be clicking on websites with better than average reliability in terms of information on treatment. The top three websites also had better than average Flesch-Kincaid Grade levels, scoring 8.4, 9.6 and 9.9 respectively. The fact that the RCPsych.ac.uk website was the first link on the page of results meant that Post Natal Depression was also the only category in which the website with the highest DISCERN score was the first website on the results page.

On the other hand, the Post Natal Depression search category also included two of the three websites with the lowest DISCERN scores recorded from all categories, PostNatalDepression.com and PNI.org.uk. These websites scored 27 and 25 respectively, far below both the overall average DISCERN score as well as the Post Natal average DISCERN score. They also both had poor readability, scoring worse than average scores of 13.9 and 11.5 respectively.

This category was notable for being the only one which did not include any websites from www.nhs.uk, also known as NHS Choices. Of the websites with over 4 appearances, this website was the third highest ranked in terms of page traffic, and also the fourth highest ranked in terms of average DISCERN score over the other seven search categories.

The Schizophrenia category (Figure 5) again has 8 websites which were able to be used with the DISCERN instrument. Its average DISCERN score was found to be higher than the overall average, suggesting that the Schizophrenia pages found during this study are more reliable for treatment information than most of the other websites related to mental health conditions. This is perhaps due to the fact that of the eight, it includes all of the top four websites in terms of average DISCERN score, namely NHS.uk, Mind.org.uk, Patient.co.uk and RCPsych.ac.uk, which received DISCERN scores of 66, 66, 74 and 77 respectively.

In terms of readability however, it was found that

on average the Schizophrenia websites had a lowest Flesch-Kincaid Grade levels of all categories of websites, with only two of the eight websites with a Grade level below the overall average. These sites were Patient.co.uk and RCPsych.ac.uk, which obtained scores of 9.9 and 10.1 respectively. However, these two sites which also had the two highest DISCERN scores of the category were in the bottom half of the results page, and therefore would receive less clicks than those higher up.

In comparison to the Post Natal Depression category, it was found that only two of the top three websites had above average DISCERN scores. These were NHS.uk and Mind.org.uk, which both scored 66 and received Flesch-Kincaid Grade levels of 14.6 and 12.2 respectively. However, the first link on the results page and therefore the most likely to be clicked on, Wikipedia, only obtained a score of 45 along with a Flesch-Kincaid grade level of 13.5. This score is approximately 13.6 points below the DISCERN average, a notable and worrying gap.

In the Anorexia category (Figure 6) only seven websites were available on the first page for use with the DISCERN instrument, with Patient.co.uk and Mind.org.uk again not available. Again Wikipedia was the first link on the first results page, but this time it achieved a higher score than the category's average (52 compared to 50.9.) However, it still did not achieve a higher score than the overall average of 53.2 and also received the highest Flesch-Kincaid grade level of 13.9, the worst in the category and far worse than the averages of 10.7 for Anorexia and 11.1 for the overall average.

The second and third websites, NHS.uk and MedicineNet.com also received the second and third highest DISCERN scores of the category after RCPsych.ac.uk, receiving 62, 60 and 63 respectively. The RCPsych.ac.uk page also received the best readability statistics of the entire study, receiving a Flesch-Kincaid grade level of 5.5. However, while it yet again received the highest marks of its category, its Anorexia and Bulimia page received overall the lowest DISCERN score of all the RCPsych.ac.uk webpages.

The Bulimia category (Figure 7) had the second highest number of websites available which were rateable with the DISCERN instrument, with ten websites. However as a category it also obtained the lowest average DISCERN scores of all eight categories (46.4), as well as the joint second worst average Flesch-Kincaid grade levels (11.6), indicating that the Bulimia websites reviewed were amongst the least reliable as well as the least readable.

Another place where the Bulimia websites fell down was that of the top three websites on the results page, only one received more than the Overall average DISCERN score. This website was NHS.uk, which received a score of 58 in comparison to the overall average of 53.2. However, it did not receive a better Grade level compared to the Overall averages, achieving a score of 12.5 in comparison to the average of 11.1 Indeed, only two websites in the Bulimia category received better grade levels than the overall average, which were the RCPsych.ac.uk page and the ncbi.nlm.nih.gov page, which received Grade levels of 5.5 and 8.6 respectively.

This category was also the only category in which the RCPsych.ac.uk website appeared where it did not gain the highest DISCERN score. It only received a score of 63, which was second only to Patient.co.uk which received a score of 65. These websites however were less likely to be clicked upon compared to others rated in this study, as they appeared 9th and 10th on the first results page.

The websites in this category which received the lowest DISCERN scores were B-Eat.co.uk and AnorexiaBulimiaCare.org.uk, which only received scores of 30 and 29 respectively. AnorexiaBulimiaCare.org.uk did perform slightly better in terms of readability, with a score of 11.1, almost exactly the overall average and slightly better than the average for Bulimia. On the other hand, the b-eat.co.uk website performed poorly again in readability, only receiving a score of 12.7.

The Insomnia search category (Figure 8) only had six pages on the first page of results relevant to the mental health term, with others relating to films and songs with the name Insomnia. This meant that the category had the lowest number of websites which could be rated with the DISCERN instrument. It was also relevant that none of the six websites were from RCPsych.ac.uk, which performed the best in scores on average over the entire study.

On average, the Insomnia category as a whole had a slightly lower than average DISCERN score, with 51.5 compared to 53.2, while its Flesch-Kincaid Grade level was also slightly worse than average, with 11.4 compared to 11.1. However, what is perhaps more relevant is that of the 6 websites, only 2 of them received DISCERN scores which were higher than the overall average, namely NHS.uk and Patient.co.uk, which both obtained scores of 69.

Of the top three websites, only one site was better than average in either their DISCERN score or Flesch-Kincaid Grade level. This website was NHS.uk, which as mentioned before received a DISCERN score of 69 and a Grade level of 8.3. The

other two websites in the top three, Wikipedia and BBC.co.uk both received below average DISCERN scores and grade levels. Wikipedia received 42 for its DISCERN score and a very high 16.7 for its grade level, while BBC.co.uk received 51 for its DISCERN score and a moderately high 12.8 for its grade level.

Finally, the Anxiety category (Figure 9) contained 9 websites, ranging from a high DISCERN score of 66 for NHS.uk and a low score of 26 for AnxietyNoMore.co.uk. The best Flesch-Kincaid grade level was found to be 7.5 for the BBC.co.uk website, while the worst was 13.4 for WebMD.Boots.com.

As a category, Anxiety had a below average DISCERN score (50.4) but a better than average Flesch-Kincaid grade level (10.4). It was one of the two categories along with Insomnia which did not include a website from RCPsych.ac.uk which could have contributed to its lower than mean average score.

Also, along with Insomnia, Anorexia and Schizophrenia, Anxiety was the fourth category in which Wikipedia.org was the first website appearing on the page of results, the most appearances at position one of any of the websites reviewed. It was also the seventh category in which it had appeared in the top three results, the equal most appearances in the top three positions along with NHS.uk. Of these seven categories, in each one Wikipedia received a lower DISCERN score than the Overall average, and in the only category it was not found in the top 3 results (Post Natal Depression) it still received a lower than average DISCERN score.

The correlation scores between DISCERN and the position on Google is interesting (Figure 10). It may have been expected that the higher a website is positioned, the better those websites would perform on the DISCERN instrument. The fact that there is no demonstrable correlation is relevant as it shows that while people are generally more inclined to choose to click on only the top three links on Google searches, there is no reason to suggest that for health information, these websites will be any more reliable than any of the others on the first page.

Figure 11's finding means that there is a correlation between readability and reliability of websites, meaning that websites which were found to be more reliable were also found to be more readable. However, the R^2 value of only 0.1269 indicates it is not a good predictor.

Regarding the results of Figure 12, the BBC Health website is perhaps a surprising case as while being a generally well respected website, and indeed the fifth most visited in the UK, its health section has a much lower than average DISCERN score. On the other hand, it was found to be the third most readable of all of the top eight websites, suggesting that with a few improvements it would be a good site to recommend to patients for health information.

Medicinenet.com and NetDoctor.co.uk both performed reasonably close to the average DISCERN score, but also both had pages which were deemed less readable than the average.

The top four websites based on their average discern scores were NHS.uk, Mind.org.uk, Patient.co.uk and RCPsych.ac.uk, which received average DISCERN scores of 64.3, 68, 69.4 and 71.8 respectively were a good distance from the average DISCERN score of all the websites of 53.2. They also all were found to be more easily readable than the average of the other websites, with scores of 10.7, 10.62, 9.32 and 7.82.

It is not possible to compare the Alexa UK Traffic ranks of Mind.org.uk and RCPsych.ac.uk with the other websites due to the fact that these two are the only ones specifically aimed at mental health issues while the others cover a much broader range of topics. However, it is relevant that Mind.org.uk is 3833 places higher than RCPsych.ac.uk in Alexa's ranking system. This means that it is more likely to be visited for health information than RCPsych.ac.uk, even though the study showed that RCPsych.ac.uk was more readable by 2.8 grade levels and of a higher reliability by 3.8 DISCERN points. Also, while they cannot be compared with the other 6 websites that are not based on mental health, the fact that they are so much lower in the Alexa traffic rank algorithm suggests that people could be less likely to search these websites if they were not using Google as they may not have heard of them.

The other websites have more interesting information that is available from their Alexa rankings. For example, while Patient.co.uk has a far superior average DISCERN score and Flesch-Kincaid Grade level than MedicineNet.com and NetDoctor.co.uk, it is barely higher on the Alexa UK traffic ranking. This suggest that although Patient.co.uk is both much more reliable as well as more readable than the other two websites, when it comes to patients they are similarly likely to use any of the three.

Limitations

With only one person doing the reviewing, there

was the possibility of bias occurring. Other studies using the DISCERN tool, such as the study on Chronic Pain websites by Kaicker et al (2010)[14] used more than one reviewer.

Another limitation to the report was that as the analysis of the websites continued, familiarity with the tool grew meaning that websites reviewed later may have received different scores to those reviewed earlier in the same questions.

Another limitation was that while the list of websites taken from Google were all taken on one day (02.06.12,) these websites were then reviewed over the next three weeks, meaning that their order on Google could have changed, as well as the content of those websites.

There was also a problem that while these were searched using the same Internet Browser each time with advert blocking software turned off, the huge variability now in how people can look at websites means that not all people would see the sites in the same way. For example, people have a vast choice of internet browsers these days, including Internet Explorer, Google Chrome, Mozilla Firefox and Apple Safari, along with versions of websites which are optimised for mobile phones, which can all display websites slightly differently.

Another limitation in this study is that the results obtained using the DISCERN instrument are not comparable to other studies of other websites with different reviewers as it was found in Batchelor et al (2009) that the DISCERN tool has low inter-rater agreement.

A final limitation was that while the DISCERN tool examines the information about treatment provided on websites, it does not look at how the information is presented or how easy it is to navigate and find the information required from the website. This means that while some websites could perform extremely well in the DISCERN instrument scoring system, they may still be difficult to navigate.

Conclusion

In conclusion, this study has shown that there is a wide variety of mental health treatment information available on Google, with a large range of reliability and readability. Across search terms there wasn't a vast difference, though Depression and Schizophrenia websites in particular were found to be better than average, and Bulimia websites were found to be worse than average. This may not be entirely significant due to the fact that the number of websites reviewed for each search category was very low.

Many of the websites reviewed were found to be excellent sources of information, in particular pages from the Royal College of Psychiatrists, Patient.co.uk and Mind. However, these websites were not guaranteed to appear on every page of search results, and not at all guaranteed to appear amongst the top few search results.

On the other hand Wikipedia, which in general performed very poorly with both the DISCERN and the Flesch-Kincaid tool, appeared at the top of the search results four out of eight times. This is a real cause for concern and suggests that patients may be reading unreliable information.

One of the important findings is therefore that patients should be directed towards certain websites to find mental health treatment information, namely the Royal College of Psychiatrists, Patient.co.uk and Mind, rather than searching for this information through Google. All three websites in general performed well with the DISCERN Instrument as well as being amongst the most readable websites reviewed in this study.

A previous study found only 12% of the study population regarded the internet as one of the top three sources providing the most accurate information for mental health matters.[15] If this percentage is to increase, the quality (both perceived and actual) of the information needs to improve, and this will have implications for both public and professionals alike.

Conflict of interest: None

Appendix

Websites taken from Google UK as described in Method

Depression

1. http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx
2. http://www.mind.org.uk/help/diagnoses_and_conditions/depression
3. http://en.wikipedia.org/wiki/Depression_(mood)
4. http://www.bbc.co.uk/health/emotional_health/mental_health/disorders_depression.shtml
5. http://www.netdoctor.co.uk/depression/index.shtml
6. http://www.depressionalliance.org/
7. http://www.patient.co.uk/health/Depression.htm
8. http://www.rcpsych.ac.uk/mentalhealthinfo/problems/depression/depression.aspx
9. http://www.rcpsych.ac.uk/mentalhealthinfo/problems/depression.aspx (DUPLICATE)

10. http://www.guardian.co.uk/society/depression (UNWORKABLE)

Bipolar
1. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001924/
2. http://en.wikipedia.org/wiki/Bipolar_disorder
3. http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Introduction.aspx
4. http://www.bbc.co.uk/health/emotional_health/mental_health/disorders_bipolar.shtml
5. http://www.bipolaruk.org.uk/
6. http://www.mind.org.uk/help/diagnoses_and_conditions/bipolar_disorder_manic_depression
7. http://www.helpguide.org/mental/bipolar_disorder_symptoms_treatment.htm
8. http://www.bipolaraware.co.uk/
9. http://www.rcpsych.ac.uk/mentalhealthinfo/problems/bipolardisorder/bipolardisorder.aspx
10. http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/bipolar_disorder
11. http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml

Post Natal Depression
1. http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx
2. http://www.mind.org.uk/help/diagnoses_and_conditions/post-natal_depression
3. http://www.netdoctor.co.uk/health_advice/facts/depressionpostnatal.htm
4. http://www.postnataldepression.com/
5. http://www.patient.co.uk/health/Depression-(Post-Natal).htm
6. http://www.bbc.co.uk/health/emotional_health/mental_health/disorders_pnd.shtml
7. http://en.wikipedia.org/wiki/Postpartum_depression
8. http://www.pni.org.uk/
9. http://apni.org/

Schizophrenia
1. http://en.wikipedia.org/wiki/Schizophrenia
2. http://www.nhs.uk/Conditions/Schizophrenia/Pages/Introduction.aspx
3. http://www.mind.org.uk/help/diagnoses_and_conditions/schizophrenia
4. http://www.bbc.co.uk/health/emotional_health/mental_health/disorders_schiz.shtml
5. http://www.patient.co.uk/health/Schizophrenia.htm
6. http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia.aspx
7. http://www.rcpsych.ac.uk/mentalhealthinfo/problems/schizophrenia/schizophrenia.aspx (DUPLICATE)
8. http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/schizophrenia/?shortcut=schizophrenia
9. http://www.medicinenet.com/schizophrenia/article.htm

Anorexia
1. http://en.wikipedia.org/wiki/Anorexia_nervosa
2. http://en.wikipedia.org/wiki/Anorexia (DUPLICATE)
3. http://www.nhs.uk/conditions/Anorexia-nervosa/Pages/Introduction.aspx
4. http://www.medicinenet.com/anorexia_nervosa/article.htm
5. http://www.netdoctor.co.uk/diseases/facts/anorexianervosa.htm
6. http://www.dailymail.co.uk/health/article-2074086/Kate-Chilver-dies-16-year-anorexia-battle-worst-case-doctors-seen.html (UNWORKABLE)
7. http://www.anorexiabulimiacare.org.uk/
8. http://www.rcpsych.ac.uk/default.aspx?page=1428
9. http://www.bbc.co.uk/health/emotional_health/mental_health/mind_eatingdisorders.shtml
10. http://blogs.independent.co.uk/2012/05/19/growing-out-of-anorexia/ (UNWORKABLE)

Bulimia
1. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001381/
2. http://en.wikipedia.org/wiki/Bulimia_nervosa
3. http://www.nhs.uk/Conditions/Bulimia/Pages/Introduction.aspx
4. http://www.helpguide.org/mental/bulimia_signs_symptoms_causes_treatment.htm
5. http://www.womenshealth.gov/publications/our-publications/fact-sheet/bulimia-nervosa.cfm
6. http://www.b-eat.co.uk/get-help/about-eating-disorders/types-of-eating-disorder1/bulimia/
7. http://www.anorexiabulimiacare.org.uk/
8. http://www.netdoctor.co.uk/diseases/facts/bulimianervosa.htm
9. http://www.patient.co.uk/health/Bulimia-Nervosa.htm

10. http://www.rcpsych.ac.uk/default.aspx?page=1428

Insomnia

1. http://en.wikipedia.org/wiki/Insomnia
2. http://www.nhs.uk/conditions/Insomnia/Pages/Introduction.aspx
3. http://www.imdb.com/title/tt0278504/ (UNRELATED)
4. http://www.bbc.co.uk/health/physical_health/conditions/insomnia1.shtml
5. http://www.well.com/~mick/insomnia/
6. http://www.patient.co.uk/health/Insomnia-Poor-Sleep.htm
7. http://iseries.multiplay.co.uk/ (UNRELATED)
8. http://www.counselling.cam.ac.uk/selfhelp/leaflets/insomnia
9. http://www.last.fm/music/Faithless/_/Insomnia (UNRELATED)

Anxiety

1. http://en.wikipedia.org/wiki/Anxiety
2. http://www.nhs.uk/conditions/Anxiety/Pages/Introduction.aspx
3. http://www.mind.org.uk/help/diagnoses_and_conditions/anxiety
4. http://www.bbc.co.uk/health/emotional_health/mental_health/disorders_anxiety.shtml
5. http://www.medicinenet.com/anxiety/article.htm
6. http://www.anxietyuk.org.uk/
7. http://www.medicalnewstoday.com/info/anxiety/
8. http://www.anxietynomore.co.uk/
9. http://www.webmd.boots.com/anxiety-panic/default.htm

Reference

1. Miniwatts (2011) World Internet Usage and Population Statistics [online] Available at http://www.internetworldstats.com/stats.htm [accessed June 2012]
2. Miniwatts (2011) Internet and Facebook Usage in Europe [online] Available at http://www.internetworldstats.com/stats4.htm [accessed June 2012]
3. Google (2012) Our History in Depth [online] Available at http://www.google.com/intl/en/about/company/history/ [accessed June 2012]
4. Brin, S. and Page, L. (1998). The anatomy of a large-scale hypertextual web search engine. Proceedings of the Seventh International WWW Conference Brisbane, Australia
5. Alexa (2012) Statistics Summary for google.com Available at http://www.alexa.com/siteinfo/google.com [accessed June 2012]
6. Anon (2012) Google Annual Search Statistics [online] Available at http://www.statisticbrain.com/google-searches/ [accessed June 2012]
7. Fox S, Fallows D. (2003) Internet Health Resources: Pew Internet & American Life Project; TPRC 2003
8. Sonnenberg FA. Health Information on the Internet: Opportunities and Pitfalls. Arch Intern Med. 1997;157(2):151-152.
9. Gagliardi A, Jadad A. Examination of instruments used to rate quality of health information on the internet: chronicle of a voyage with an unclear destination. BMJ 2002; 324:569-73.
10. http://www.discern.org.uk.
11. Batchelor JM, Ohya Y: Use of the DISCERN instrument by patients and health professionals to assess information resources on treatments for asthma and atopic dermatitis. Allergol Int 2009, 1:141-145
12. Flesch R (1948). "A new readability yardstick". Journal of Applied Psychology 32: 221–233
13. Optify (2012) The Changing Face of SERPs:Organic Click Through Rate. Available at http://www.optify.net/inbound-marketing-resources/new-study-how-the-new-face-of-serps-has-altered-the-ctr-curve [accessed June 2012]
14. Kaicker et al.: Assessment of the quality and variability of health information on chronic pain websites using the DISCERN instrument. BMC Medicine 2010 8:59.
15. Powell, J. Clarke, A. (2006) Internet information-seeking in mental health: Population survey. The British Journal of Psychiatry. 189: 273-277.

Continued Medical Education

Test Your Knowledge

THEME: DIAGNOSING PSYCHIATRIC DISORDERS

OPTIONS:

A. Autism
B. Drug induced psychosis
C. Bipolar disorder
D. Depressive illness
E. Schizophrenia
F. Delirium
G. Dementia
H. Emotionally unstable personality disorder
I. Anxiety
J. Post-Traumatic Stress Disorder
K. Traumatic brain injury

From these OPTIONS choose the most likely diagnosis in each clinical scenario described below. Each answer may be used once, more than once, or not at all.

QUESTIONS:

1. A 29-year-old woman is brought into Casualty via ambulance services reporting that she has attempted suicide and that she has ongoing thoughts of wanting to self-harm. She reports that following a hostile quarrel with her boyfriend she consumed 20 tablets of Paracetamol (500mg) with alcohol and that this was an impulsive act. A mental state examination revealed that the patient was low in mood for 1 week and a clinical examination revealed scars on the volar aspect of both arms.

2. A 55-year-old woman was admitted into intensive care following intra-operative complications during a total hip replacement. Although she is conscious, family are concerned that she does not seem to be concentrating when people attempt to engage in conversation with her and that she can suddenly burst into tears. Nursing staff report that the patient has lost one stone in weight and that she is not eating her meals.

3. A 27 year old man is brought into the Emergency Department under a Section 136 accompanied by Police. He reports that he has special powers and that he was destined to conquer the world. Nursing staff notice that he is attending to inaudible stimuli. He suddenly bangs his head on the wall and reports that 'the voices in his head commanded him to behave in this way'. He denies any drug or alcohol consumption.

4. A 35-year-old man presents to his GP accompanied by his wife. He reports a six week history of not being able to get much sleep due to vivid nightmares which he describes as terrifying. The patient was a soldier in the British Army and is currently unemployed (his last job was a Security Guard in a hotel however he was fired due to poor occupational performance). His wife reports that his behaviour has not been the same since his return from a tour of duty in Afghanistan where a fellow serviceman lost his life following an ambush whilst on patrol.

5. A 75-year-old man is brought into Casualty via ambulance services and is accompanied by his son. He has a heart rate of 100 bpm, a respiratory rate of 40 bpm, a temperature of 40.1 degrees centigrade and he is desaturating at room air (saturation 80%). A chest X-ray reveals consolidation in the lower zone of his left lung. The Foundation Doctor responsible for his care is unable to elicit a history from the patient because of how confused he is. The patient's son reports that the patient is usually very lucid and cooperative.

Continued Medical Education

Test Your Knowledge

ANSWERS: 1 – H; 2- D; 3 – E; 4 – J; 5 – F

EXPLANATION:

QUESTION 1: This patient is a young female who has a history of suicidal behaviour. The character traits of impulsiveness and hostility would be in keeping with patients who have emotionally unstable personality disorder. Although self-harm is common in both depressive illness and in patients with EUPD this patient did not report low mood or anhedonia.

QUESTION 2: This patient was admitted into the Intensive Care Unit following an intra-intraoperative complication. Rates of depressive illness in the ICU department are high and healthcare professionals should be mindful that patients in this setting are more vulnerable to developing this condition. The symptoms of low mood, episodes of tearfulness, inability to concentrate, loss of interest and reduced appetite all satisfy the ICD and DSM criteria for diagnosing depressive illness.

QUESTION 3: This patient has delusions of grandeur and command auditory hallucinations. These are the classical First-Rank symptoms of schizophrenia. The fact that the patient denies alcohol or substance abuse means that a diagnosis of drug induced psychosis can be ruled out as a possible cause of his symptoms.

QUESTION 4: Combat troops and veterans are vulnerable to developing Post-Traumatic Stress Disorder due to the nature of their occupation (i.e. exposure to psychological and physical trauma). The patient reported a history of vivid nightmares which was greater than four weeks in duration which would be consistent with PTSD. PTSD also causes impairment in occupational functioning which might explain why he was made redundant.

QUESTION 5: This patient has community acquired pneumonia and has also developed Systemic Inflammatory Response syndrome. Patients who contract an infection, particularly older patients, are vulnerable to developing an acute confusional state/delirium. We can rule out a diagnosis of dementia since the patient is usually lucid and coherent according to a collateral history obtained from the patient's son ('brain failure' like other organ failures can be broadly categorized into 'acute' or 'chronic'. Delirium can be considered a form of acute brain failure and dementia a form of chronic brain failure. As in other organ failures patients can develop 'acute on chronic' brain failure i.e. delirium superimposed on dementia.)

Continued Medical Education

Test Your Knowledge

Multiple Choice Questions

Question 1:

A 70 year old man presents to his GP accompanied by his wife. He reports feeling low in mood for 6 weeks and that he no longer enjoys following the football which, according to his wife, was a life-long passion of his. A mental state examination did not reveal any evidence of psychosis although the patient did report an inability to concentrate. Which from the following options would be the best way to treat this older man?

Options:

A: Amitriptyline
B: Donepezil
C: Citalopram
D: Diazepam
E: Ketamine

Question 2:

Police officers receive a phone call from a member of the general public reporting that they are in conversation with a lady who is standing next to a bridge overlooking a highway and that she has expressed her intention to jump off it. At the scene, the policemen feel that she poses a risk to her own safety and place the lady under which of the following acts from the Mental Health Act?

Options:

A: Section 135
B: Section 2
C: Section 3
D: Section 136
E: Section 5(2)

Question 3:

Which option below is NOT a component of the mental state examination?

Options:

A: Perception
B: Mood
C: Appearance
D: Imagination
E: Delusion of grandeur

Question 4:

Question 4: Which one of the following drugs is NOT associated with QT prolongation?

Options:

A: Citalopram
B: Metronidazole
C: Lithium
D: Amiodarone
E: Amoxcillin

Continued Medical Education

Test Your Knowledge

Multiple Choice Questions

Answers:

1: C
This older patient has presented with the 'cardinal' symptoms of depressive illness namely low mood and anhedonia. A mental state examination ruled out a possible diagnosis of schizophrenia in later life. Although people with dementia have cognitive impairment which can result in poor concentration, people who have depression can also have poor concentration (also referred to as 'pseudodementia'.) Both Tricyclic Anti-depressants (i.e., Amitriptyline) and SSRIs (i.e. Citalopram) are effective in treating depressive illness in older people however SSRIs are the first-line therapy in this group since people later on in life are at higher risk of developing suicidal behaviour and SSRIs are safer in higher dosages than TCAs are should an overdose occur.

2: D
Section 135 of the MHA accords Police Officers with 'Police powers' in a community setting to take you to a safe place for 72 hours from a private place. Section 2 of the MHA is used to detain a patient (usually involuntarily) in hospital for assessment of their mental health and is valid for up 28 days. Section 3 of the MHA is used to detain a patient (usually involuntarily) in hospital for treatment purposes and is valid for up to 6 months. Section 136 of the MHA accords Police Officers with 'Police Powers' to take a patient to a safe place for up to 72 hours from a public place. Section 5(2) of the MHA is a doctor's holding power. It can only be used to detain a person in hospital who has consented to admission on an informal basis (although not detained under the Act) but then changes their mind and wishes to leave the hospital.

3: D
The Mental State Examination is the 'bedrock' of psychiatric practice and its components are as follows:
Appearance
Behaviour
Speech
Mood
Thought (content and form)
Perception
Concentration
Although imagination is a product of thought, it is not, strictly speaking, a component of the MSE.

4: E
SSRIs (i.e. Citalopram) and the mood stabilizing drug Lithium are known to be associated with QT prolongation. The antibiotic Metronidazole and the anti-arrhythmic Amiodarone are also associated with QT prolongation. Amoxicillin is not known to be associated with QT prolongation.

The World Journal of Medical Education & Research (WJMER) is the online publication of the Doctors Academy Group of Educational Establishments. It aims to promote academia and research amongst all members of the multi-disciplinary healthcare team including doctors, dentists, scientists, and students of these specialties from all parts of the world. The journal intends to encourage the healthy transfer of knowledge, opinions and expertise between those who have the benefit of cutting-edge technology and those who need to innovate within their resource constraints. It is our hope that this interaction will help develop medical knowledge & enhance the possibility of providing optimal clinical care in different settings all over the world.

DOCTORS ACADEMY

BETTER EDUCATION. BETTER HEALTH.

ISSN 2052-1715

WJMER

World Journal of Medical Education and Research

An Official Publication of the Education and Research Division of Doctors Academy

978-93-80573-45-8