quote the following extract from their website (http//:www.mhac.trent.nhs.uk/hospreport2000.pdf).

> "In 1998/99 there were 4245 managers' reviews where detention was contested, resulting in 338 (8%) discharges. In 1997/98 there were 3598 contested reviews and 324 (8.2%) patients discharged following a managers' review."

Second, contrary to the impression created by your editorial, sadly, patients are not currently allowed to apply for legal aid to enable them to be represented at managers' hearings. This support is only provided for mental health review tribunal hearings.

Patricia Gregory Kingston & District Community NHS Trust Chairman, Woodroffe House, Tolworth Hospital, Red Lion Road, Surbiton, Surrey KT6 7QU

Changes in the practice of electroconvulsive therapy

Sir: Having abandoned the use of electrolyte solution in favour of gel, our local monitoring and recording systems showed a marked increase in impedance. Despite adequate skin preparation and electrode placement and the use of greater mechanical pressure in the application of the electrodes, impedance levels remained higher by a factor of approximately times four compared to previous levels.

As impedance provides a measure of the resistance to current flow from the electrode to the patient, the change in method (and hence impedance) is likely to necessitate a significant increase in the current required for effective treatment (Royal College of Psychiatrists, 1995).

In addition, increased side-effects may be a result. The two patients treated during the cross-over period complained of significantly more side-effects of headache, memory impairment and general feelings of 'unwellness' when the impedance levels rose.

For the time being, in the absence of better evidence, we have chosen to return to the use of pads and electrolyte solution for the comfort of our patients.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *ECT Handbook: The Second Report of the Royal College of Psychiatrists Special Committee on ECT.* Council Report CR39. London Royal College of Psychiatrists.

Sara Smith Specialist Registrar in General Psychiatry, Redditch, **Agnes Nalpas** Consultant Psychiatrist responsible for ECT, Kidderminster Hospital

the college

Nominees elected to the Fellowship and Membership under Bye Law III 2 (ii)

At the meeting of the Court of Electors held on 20 February 2001, the following nominees were approved.

The Fellowship

Dr Syed Wasi Akhlaq Ahmad; Dr Mohammed Hussain Ali; Dr Saravanamutta Ananthakopan; Dr Karl Michael Asen; Dr Rosemary Anne Baker; Dr Donald Francisco Bermingham; Dr Anne Stuart Bird; Dr Andrew Kilgour Black; Dr Dawn Black; Dr Patrick Farrar Bolton; Dr Nisreen Hanna Booya; Dr Andrew Frederick Clark; Dr Peter Richard Cohen; Professor Sally Ann Cooper; Dr Michael Gregory Curran; Dr Ahmed Kasem Darwish; Dr Ian Alexander Davidson; Dr Thomas Richard Dening; Dr Salah El Din Rashwan Aboul Fadl; Dr David John Findlay; Dr Fiona Craig Margaret Forbes; Dr Pauline Marie Forster; Dr Graham Reginald Gallimore; Dr Catherine Anne Gillespie; Dr Merajuddin Hasan; Dr David Vaughan James; Dr Josanne Holloway; Dr George Ikkos; Dr Ziad Subhi Issa Jabarin; Dr Shantha Leicester Wijayasingha Jayewardene; Dr George John; Dr Philip Lewis Alan Joseph; Dr Rajkumar Hiralal Kathane; Dr Kalyani Katz; Dr Peter Hammond Kay; Professor Anthony Robert Kendrick; Dr Henry Gerard Kennedy; Dr Sean Patrick Lennon; Dr Gillian Avril Livingston; Dr Mervyn London; Dr Clare Joan Mary Lucey; Dr Donald Lyons; Dr Andrew James McBride; Dr Graeme Harding McDonald; Dr David Robison Craig McVitie; Dr Chinta Mani; Dr Diana Patricia Morrison; Dr Matthijs Frederik Muijen; Dr Martin William Orrell; Dr Alastair Noel Palin; Dr Mary-Jane Pearce; Dr Sanjay Rastogi; Dr Brian Robinson; Dr Michael Alexander John Rosenberg; Dr Packeerrowther Thulkarunai Saleem; Dr Kishore Santa Kumarsingh Seewoonarain; Dr Aman Ullah Shaikh; Dr Keshar Lal Shrestha; Dr William Gerard Smith; Dr Nicholas Geoffrey Dare Sorby; Dr David George Sumners; Dr Kolappa Sundararajan; Dr Timothy Charles Ayrton Tannock; Dr Muthusamy Subramaniam Thambirajah; Dr Christopher James Thomas; Dr Mohan George Thomas; Dr Guinevere Tufnell; Dr Timothy Ewart Webb; and Dr Francis Edgar Winton.

Fellowships – overseas

Dr Muhammad A-Hamid Salih Al-Samarrai; Dr Moshe Avnon; Professor Siegfried Kasper; Dr Frank Gitau Njenga; Dr Farouk Ahmed Randeree; and Dr Jeffrey David Thompson.

The Membership

It was agreed that the following should be awarded Membership under Bye Law III 2 (ii):
Dr David James Burke; Dr Tom Fryers; Professor Mohamed Hamed Ghanem; and Professor Jude Uzoma.

Learning objectives for child and adolescent psychiatry and learning disability placements at senior house officer level

Introduction

A 6-month placement in child and adolescent psychiatry and/or the psychiatry of learning disability is now a mandatory part of basic specialist training in psychiatry. Although candidates may sit the MRCPsych examination before such a placement or while completing it, the MRCPsych cannot be awarded (and the candidate cannot proceed to higher specialist level training) until the placement has been satisfactorily completed.

The rationale for such a mandatory placement is that all qualified psychiatrists need to have a proper understanding of the developmental basis of psychiatric practice. To achieve this they not only need the relevant theoretical knowledge but also to have had the clinical experience of working with both children, adolescents and their families and with people with a learning disability and their families.

The main purpose of clinical placements in child and adolescent psychiatry and/or the psychiatry of learning disability is to complement trainees' theoretical learning on local MRCPsych courses. It is critical that trainers of senior house officers (SHOs) in these specialities concern themselves primarily with the learning objectives of a general psychiatrist-in-training, rather than view this as the beginning of higher training. Some trainees will take advantage of the placement to study a preferred subject in depth, but this enthusiasm should not detract from the main aims of the placement, which are to equip psychiatrists pursuing a general psychiatry career or entering another speciality with the skills necessary to recognise the need for a more specialist input, and also to consider their patients' presentation in both developmental and systemic terms.

The faculties of child and adolescent psychiatry and of learning disability have worked together to produce educational objectives for these mandatory place-

https://doi.org/10.1192/pb.25.6.238-a Published online by Cambridge University Press

ments (which can be in either single speciality or in a combination of the two), as well as guidelines as to how these educational objectives can best be achieved. These are summarised below.

Overall aims

(a) To become familiar with the principles and practice of assessment, diagnosis and treatment, including therapeutic modalities, psychoactive medication and environmental manipulations of patients of all ages and their families presenting to child psychiatric or learning disability services.
(b) To learn to consider their patients' presentations in developmental and systemic terms.
(c) To acquire the skills necessary to differentiate between distress, disturbance and disorder, and to recognise developmental disabilities and delay.

Educational objectives

(a) To become familiar with developmental and child psychiatric disorders.
(b) To be able to communicate with their patients at an age or developmentally appropriate level.
(c) To understand the influence of developmental factors on the presentation and treatment of psychiatric disorders.
(d) To recognise the importance of interviewing other members of the family or network and to be able to carry out interviews with those involved both together with the patient and separately.
(e) To consider the context of the presentation in terms of family life-cycle and wider systemic influences including race, ethnicity and culture.
(f) To understand the concepts of vulnerability and resilience that lead to each individual's unique presentation, and to varying degrees of distress, disturbance and disorder.
(g) To recognise and evaluate the interaction between genetic and environmental factors, including parental illness and developmental disability.
(h) To understand the relationship between physical, cognitive, emotional, social and developmental factors that contribute to emotional behavioural difficulties or more serious mental illness.
(i) To be aware of the ethical and legal issues that are applicable to children, adolescents and people with learning disabilities, including those who cannot give informed consent.
(j) To understand the roles of other disciplines and agencies in assessment and treatment.
(k) To become familiar with the presentations of abuse, its sequel and its management.
(l) To be aware of the impact of labelling, and the ways in which it is utilised.
(m) To be able to consider the significance of personal values, beliefs and assumptions in relation to one's professional role, particularly in the context of service provision for children, adolescents and people with learning disability.

The child and adolescent and learning disabilities faculties have also produced guidelines to help basic specialist training rotations to achieve these aims and objectives within existing placements and those developed specifically to meet the new mandatory requirements. These guidelines (see below) are also intended to provide a framework within which basic specialist training accreditation visitors can monitor progress and problems and advise scheme organisers accordingly.

Adult learning disability psychiatry placements

Most of the learning objectives of the curriculum can be met by having the opportunity to interview, assess and treat people with learning disabilities with a range of psychological and psychiatric disorders and by also interviewing their families. It is important that this includes patients with different degrees of learning disability and with other developmental disorders such as autism, Asperger's syndrome and hyperkinetic disorder.

In addition, there should be sufficient opportunity to relate directly to children and adolescents and their families. This can be achieved by spending approximately one session per week or equivalent, over the whole placement, in a local child development centre and/or a child and adolescent psychiatric service.

Experience of working alongside a range of other professionals is required and also the opportunity to attend case conferences or multi-disciplinary reviews during the placement. At least one case conference/review that deals with issues of child protection and abuse (looking at victim and perpetrator perspectives) should be attended.

In addition to the weekly meetings with the educational supervisor for the placement, it is suggested that regular supervision should be provided to discuss the child mental health aspects of the placement with the supervising consultant, or with other senior professional staff. This may enable the integration of the learning opportunities provided by the placement, including addressing ethical issues and self-reflection.

Supplementary experience can be gained through selected visits to special schools, training centres, nurseries, etc., to gain an understanding of the range of local resources.

Life span learning disability placements

The trainee should spend at least one session per week of the placement (or equivalent), over the whole placement, in services for children or adolescents with a learning disability and at least the equivalent of one session per week, over the whole placement, with adults with learning disabilities. There should be opportunities to undertake full assessments that include developmental and psychiatric histories taken both from and with the patient and the family.

There should be the opportunity to work as a member of a multi-disciplinary team and to attend the weekly case review meetings. Whenever issues related to the protection of children or vulnerable adults arise, these should be discussed with the trainee, who will be encouraged to attend any relevant reviews or case conferences. At least one case conference/review that deals with issues of child protection and abuse should be attended.

Depending on the nature of the experience being provided in the placement, regular supervision should be provided, with the supervising consultant or with other senior professional staff, to discuss and integrate the child mental health aspects of the placement, in addition to the weekly meetings with the educational supervisor.

Supplementary experience can be gained through selected visits to special schools, training centres, nurseries, etc., to gain an understanding of the range of local resources.

Child and adolescent psychiatry placements

Most of the learning objectives of the curriculum can be met within a child and adolescent psychiatry placement, either in a community-based or hospital-based service. Trainees will need to have the opportunity to assess and to participate in the treatment of the specific disorders highlighted in the MRCPsych curriculum for child and adolescent psychiatry. In child and adolescent psychiatry placements, trainees will usually have the opportunity to participate in inter-agency work and case conferences about specific children or young people, and in the assessment and treatment of young

https://doi.org/10.1192/pb.25.6.238-a Published online by Cambridge University Press

people individually, their parents and families.

Possible ways in which these placements can be organised to meet the agreed training objectives with regard to learning disability are suggested as follows:

(a) Experience with children and adolescents with learning difficulties and learning disabilities can be gained by attendance with a child development team, by linking with youth offending teams for the assessment of learning disabled young offenders, or by linking with local learning disability services in relation to children and to adolescents in transition to adult services. Most child psychiatry services also see children with mild/moderate learning disability.

(b) Experience with adults with learning disability can be gained by working with local community learning disability teams. These teams are multidiciplinary and provide the opportunity to work with adults with a range of disabilities and difficulties both in family and residential settings.

Approximately one session per week or equivalent, over the course of the 6-month placement, should be spent in working with patients with learning disabilities and their families. Selected visits to special schools (day or residential), adult training centres and voluntary sector services will provide an understanding of the range of local resources.

The educational supervisor should meet the trainee weekly and ensure that this discussion includes an integration of the learning opportunities that have been provided by the placement, in particular, with regard to their experience with patients with learning disabilities and their families and the issues that have arisen for the trainee with respect to this experience. Regular supervision with the supervisory consultant or with other senior professional staff should be provided for the learning disability component of the placement.

obituaries

Dr Thomas Farewell

Formerly Consultant Psychiatrist, Napsbury Hospital, St Albans, Herts

Tom Farewell was born in 1922 and was educated at Malvern College and the New Royal London hospital. For 10 years after qualifying he worked in accident and orthopaedic surgery at the New Royal London and other hospitals. His interest in human consciousness led him to a career in psychiatry and in 1959 he came to Napsbury Hospital as a senior house officer. Napsbury Hospital, with its connection to the Tavistock, was a hotbed of explorations into the dynamics of schizophrenia. Aaron Esterson explored the reality beneath schizophrenic obfuscations and Denis Scott was actively researching interpersonal perception in families with schizophrenia. Awareness of the effects of incarceration on the individual led them to explore the concept of closure – the point in the schizophrenia process when all human relations are cut and the experience is perceived as alien. Together with Scott, Ratna and Montanez, he developed the Napsbury Crisis Service. Though crisis services are part of the National Service Framework, in 1971 it was a highly controversial policy. It evoked a storm of opposition, and in an age dominated by finance it is incredible that such a 24-hour community service was developed and successfully run without funding, resources or support. It remains the oldest, largest and most comprehensive community crisis service in the world.

Tom was influential in developing the concept of furore – or pseudocrisis, which was the echo of a past crisis and not a point of change or growth. He was also innovative within the hospital, becoming actively involved in rehabilitation. He organised the Industrial Rehabilitation Unit and was later involved in creating the Industrial Therapy Organisation in the North-West Thames region. Tom foresaw the IT revolution and set up the Protechnic system, which was one of the first computer-based comprehensive patient information systems for psychiatry in the NHS.

Tom took a deep and abiding interest in policy development and administration. In the 1960s he was one of the joint founders of the Junior Hospital Doctors Association and later, as Chairman of the North-West Thames Regional Junior Doctors, he was a member of the Executive of the Junior Hospital Doctors' Group of the British Medical Association (BMA). As a consultant, he became Chairman of the North-West Thames Committee for Hospital Medical Services and was a member of the Central Committee for Hospital Medical Services of the BMA. He served on numerous other committees in the hospital, the region and the BMA, as well as on working parties and tribunals for the Department of Health.

Tom remained at Napsbury Hospital until his retirement from the NHS in 1987. However, he remained active in psychiatry and held a post as consultant to the Metropolitan Police until 1995.

In recent years he maintained some professional interest by lecturing on crisis work and other aspects of psychiatry, but enjoyed his leisure walking and gardening in a much-loved corner of Devon. He also took much pleasure in travelling extensively, particularly in Australia.

Tom will also be remembered for his brilliance as a raconteur and speaker. He spoke at many national and international conferences where he would hold the audience spellbound. He spoke without notes and never prepared his talks. As a clinician, he was a model communicator with an ability to sum up complex situations in a few vivid, pithy and insightful sentences.

Tom died on 21 June 2000. He leaves a wife, Joan, a son and a daughter.

Lawrence Ratna

Augustus Charles Robin Skynner

Formerly Consultant Psychiatrist, Group Analytic Practice, London

Robin Skynner, wartime Royal Air Force (RAF) bomber pilot, psychiatric pioneer and innovator, child psychiatrist, family therapist and writer, died in October 2000, aged 78.

This most unusual and highly talented man was born on 16 August 1922 of local stock at Charleston, Cornwall. He was the eldest of five boys and Robin freely admits that he bitterly resented the advent of each and every sibling. So deep was the resentment that he claims it was at the root of an unhappy and rebellious childhood, as well as the cause of an embarrassing stammer.

He was educated at St Austell County School and Blundells, after which, at the age of 18, he volunteered for the RAF and was selected as a prospective bomber pilot. He was adversely affected by the shared destruction and slaughter he was obliged to carry out, an experience that, for a variety of complex reasons, drew him to psychiatry as an eventual vocation.

https://doi.org/10.1192/pb.25.6.238-a Published online by Cambridge University Press