Health Sciences and Practice Subject Centre

Burning Issues in Learning and Teaching about Mental Health

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Edited by Jill Anderson and William Penson

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Health Sciences & Practice Subject Centre in conjunction with the Mental Health in Higher Education project

Contents

I am very pleased to be able to support the publication of this set of Burning Issues focused on Learning and Teaching about Mental Health. As the editors say, these issues represent thinking in a point in time as well as different and sometimes conflicting views. All the authors offer material that is likely to be the focus of much dialogue within and across a wide range of disciplines and professions that are both directly and indirectly associated with mental health. I am confident that you will find something to think about and I would encourage you to respond, to engage in the debate, move it on and perhaps contribute your own burning issue? I am sure my students of Mental Health Promotion will find an even more provocative teacher with them.

Thank you to all members of our Mental Health Special Interest Group, to Bill Penson who has facilitated the group and invited submissions for this paper, to Jill Anderson who has provided support from mhhe (Mental Health in Higher Education) and who together have edited this publication. Thanks also to Bob Sapey for his support throughout the publication process.

Margaret Sills
Director, Health Sciences and Practice Subject Centre
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INTRODUCTION

This collection of *Burning Issues* has been compiled by the Mental Health in Higher Education project (*mhhe*) and the Higher Education Academy (subject centres[1]) Special Interest Group for Mental Health (MHSIG). Together we aim to increase networking and the sharing of approaches to learning and teaching about mental health, across the disciplines in higher education.

150 educators came together at Lancaster University in 2010 for the 'Living and Learning, Learning and Teaching: mental health in higher education' conference. That event drew on our joint work in building networks and connections. It bore witness to the benefits of sharing ideas, across the disciplines, about learning and teaching in the area of mental health.

mhhe and the MHSIG are both projects of the Higher Education Academy, with the Health Sciences and Practice subject centre taking a lead role in relation to the MHSIG. The Academy is currently restructuring its organisation and work.   Building on the conference, and discussions at the MH SIG over recent years, we were keen to take a snapshot of current issues in learning and teaching about mental health and consider how networking might be supported in the future.

A call for 'Burning Issues in Learning and Teaching about Mental Health' was issued in the autumn of 2010. Submissions were posted online as they were received. Educators and interested others were invited to comment and suggest how each issue might – through collective action or in other ways - be responded to.

www.mhhe.heacademy.ac.uk/burningissues

An opportunity to debate the issues, and their implications for supporting learning and teaching about mental health, was provided at a meeting of the MHSIG at Glasgow Caledonian University in February 2011. We are very grateful to all who submitted *Burning Issues* and/or commented on those of others – either online or at the Glasgow meeting.

Here we draw together the *Burning Issues*, as received from authors with minimal editorial amendments. The document is aimed at academics, service user and carer educators, practice mentors, students and all others with an interest in learning and teaching about mental health. We anticipate that it will be read by individuals, but also used to spark debate within teaching teams.

Some *Burning Issues* relate to the content of teaching and some to the process; some make reference to a specific discipline, whilst others have a broader focus; all pose challenging questions for educators. There is, as you will see, some interplay between the contributions. We invited people to take a strong stance or position in these pieces. They represent a snapshot taken at a particular point in time. We hope that the thinking represented here will deepen and diversify through dialogue with yourself and others, and will reach beyond these pages.

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[1] Social policy and Social work (SWAP), Health Sciences and Practice (HSAP), Medicine Dentistry and Veterinary Medicine (MEDEV), Psychology, ESCalate (Education)

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EMOTIONALLY ILLITERATE NURSES

I want to suggest that we are training a generation of nurses who are emotionally illiterate. Most student nurses would feel able to discuss the merits of z-tracking as a way of giving an I.M. injection; they could talk about the positive and negative symptoms of schizophrenia and be informed about the side effects of psychotropic medication (all skills that their mentors in practice seem to prize highly). Ask these same students to talk about a meeting with a patient, and they will reply in descriptive terms: "the patient complained that their 'voices' were bothering them today", or "patient X became disturbed and was given Acuphase and then secluded", or "Ms.Y was tearful on the ward." All of which is perfectly acceptable for a brief entry in the nursing notes. What is more difficult for our students to manage is when they are asked "and how did you feel about this?" 'This' being a conversation they had with a patient, or being involved in a restraint, and subsequent seclusion, or almost any one of an innumerable number of events that may take place on a ward. Many students have no language with which to think about their emotional responses. I have lost track of the number of times that a student looks embarrassed when I ask them "how did you feel about this patient?", "or this event?" The response that I hear with worrying frequency is "but I was told we weren't supposed to feel anything for our patients. It's unprofessional."

In Orwell's novel *Nineteen Eighty-Four* language itself is restricted as a means to restrict and control feelings and experience. One may be having a "double plus ungood" sort of day, or a "plus good day". One cannot be "happy" or "joyous" or "suicidal" or, even plain "sad". All shades of meaning are taken away and one is left with a tick box range of set responses (and, of course, when we limit language we limit thought, and fall victim to a linguistic fascism where someone else determines what we can or cannot think or say). My experience of teaching student nurses – whilst not as bleak as *Nineteen Eighty-Four* - does seem akin to it at times. And the time when this poverty of thought becomes most apparent is when discussing feelings. Or, more accurately, students' inability to access their feelings and to use them to inform understanding of themselves and their patient.

Hurley and Rankin (2008), in their paper, use the term "Emotional Intelligence" and outline four characteristics of this quality:

> The four branches consist of the ability to :(i) perceive emotion, involving the capacity to recognize emotions through non-verbal behaviour: (ii) use emotion to facilitate thought (my emphasis); (iii) understand emotions by analysis and prediction; and (iv) manage emotions in the context of other personality characteristics. (Hurley and Rankin, 2008, p.200)

In the language of psychoanalysis, what Hurley and Rankin are describing are the phenomena known as Transference and Counter Transference. These are described by Rycroft (1968:168) as:

> Transference. 1. The process by which the patient displaces on to his analyst feelings, ideas, etc., which derive from previous figures in his life; by which he relates to his analyst as though he were some former object in his life…

And of Counter Transference '… the analyst's emotional attitude to his patient…' (p.25).

The common thread that links Hurley and Rankin (2008) with Rycroft (1968) and, by extension all of counselling and psychotherapy, is the idea that feelings are important. And not only having feelings, but being able to be 'in touch' with them; recall them and use them to reflect about one's clinical practice.

In a thread currently running in the mhhe discussion group [www.jiscmail.ac.uk/mhhe], there is much discussion about emotional awareness and the need for nurses to be "wounded healers", able to use their own experiences to draw along side their patients (and we might usefully contrast the wounded healer with the "defended expert"; I know who I want to have looking after me!). I find it heartening that this is a discussion being held among those of us who teach Mental Health. It is also encouraging to find a good deal of agreement about the need for emotional literacy - albeit with some different shades of emphasis here and there.

So what stops us from teaching emotional literacy in our universities? Let me quote myself from the discussion board (Burridge, 2010):

> But think of the training implications…! We'd have to have lecturers who could model this attitude. (How many lecturers do you know who've had any kind of personal therapy or counselling, for example? I'd see this as a prerequisite to knowing about oneself. Which must be an "entry level" skill if one is going to teach.

> Then how would we measure any outcomes? Is there a rating scale for Development of Insight? Would we mark students against Level 1 insight on interview and progress through to level 5 insight by the end of their training? How many "insight re-sits" would we give them?

> So much easier to stick with our current models of measurable knowledge-diagnosis; drugs; side effects; C&R etc.

> And how sad is this parody. But I can already hear the NMC and co already raising objections to wounded healing as an idea. Sad.

If I were a student nurse on the brink of qualifying, or a newly qualified staff nurse, I think I might demand a refund of my fees from my training organisation. Because they have failed to equip me for the task in hand, that of being a psychiatric nurse.

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MENTAL HEALTH RECOVERY: ESSENTIAL IMPLICATIONS FOR LEARNING AND TEACHING

Personally speaking

In the early days of my mental health journey a consultant psychiatrist explained that my depression was so deep-seated that nothing could be done to change it. Inwardly I protested and later requested a referral for group therapy. He agreed, adding "… but it won't do you any good."

I have great respect for the integrity and commitment of such highly trained practitioners. What is not appreciated, however, is the devastating effect such observations can have on one's inner self. At that instant something dies – it's called hope. There follows anger and resolution. I am not prepared to be a passive recipient of treatments or diagnoses. I need to know what is going on, and why, and what my options are for dealing with it.

Clearly, occasional ten minute sessions with the consultant psychiatrist weren't going to cure my depression. So, for the cost of a counselling session I bought and devoured a handful of carefully selected self-help books on depression and related issues. The most significant insight to emerge at that time came from the psychologist Dorothy Rowe:

Depression is not a genetic fault or a mysterious illness which descends on us. It is something we create for ourselves, and just as we create it, so we can dismantle it … and if you want to get out of the prison of your depression you need to let your own natural resources buoy you up. (1983, pp. 13 & 177)

This was the first ray of hope in a long dark tunnel.

Psychiatry

It soon became abundantly clear that psychiatry is not the exact science I had imagined it to be, and I grew increasingly suspicious of what was on offer. Edward Shorter noted:

The risk of wandering in the wilderness heightened as psychiatry took on the challenge of diagnosis and found it as much driven by politics as science … compared with psychiatry, diagnosis in other medical specialities is relatively straightforward because the causes of most conditions are known … not so in psychiatry where, genetics apart, the causes of few conditions are known. (1997, p. 295)

Recovery

There is no mystery in the process of recovery. That organic and social systems tend to self-repair is a dynamic universally observed life-force working in and around us - as intrinsic as the capacity to reproduce. Micro-organisms mutate in response to the 'threat' of antibiotics, ecosystems re-establish themselves in the wake of environmental disasters, and economies recover from recession. As psychiatrist Anthony Storr noted:

Jung has long held the view that the psyche is self-regulating, and that neurotic symptoms are not just unpleasant disturbances to be got rid of, but are also attempts on the part of the psyche to restore equilibrium. (1960, p71)

In the context of medicine and general nursing, recovery is the aimed for outcome and in most cases the prognosis is good. The recently updated *NMC Standards for Pre-registration*

Nursing Education (2010, p. 152) which covers all branches, including mental health, defines recovery as:

A person's ability to live what they believe is a meaningful and satisfying life, with or without symptoms. Recovery means having control over and input into your own life.

Psychiatry and Recovery

As a mental health service user it has been my privilege to work with associates in higher education and the NHS who are wholly committed to the principles of awareness, enablement and recovery. Mental health recovery initiatives have their roots in twelve step recovery programmes. Unity of vision and purpose is essential for the health of recovery programmes, whatever their aims and origins. Psychiatry too is in recovery. A visit to the Royal College of Psychiatrists' website will dispel any doubts in this regard. This is a sample of quotes from their *Fair deal for mental health* manifesto (2008):

Recovery and rehabilitation should be integral to mental healthcare and treatment. A coherent rehabilitation policy based on recovery-orientated practice is needed for people experiencing long-term mental health problems.

Although improvement in individual symptoms and clinical outcomes is important and may play a key role in a person's recovery, the overall quality of life, as judged by the individual, is central. There is a necessary shift of emphasis from being clinically and professionally centred to being user or person-centred.

Confusion about the meaning of recovery, concerns about a perceived lack of evidence about recovery-based services and fears about risk have impeded the development of recovery-orientated services. These need to be addressed.

People can and do recover from mental health problems. They can take control of building a meaningful life for themselves even while continuing to experience mental health problems or following a period of poor mental health (parallels the NMC Standards referred to earlier). (p27)

Summary and Conclusion

The tortuous history of madness has skewed and obscured the inescapable truth that, given opportunity, organic systems aim to self-heal and self-balance. That mental health recovery is also possible is only counter-intuitive in the context of psychiatry's previous history of unenlightened and obstructive practices. As a long-time user of mental health services it is my carefully considered view that students in all disciplines need help and support in recognising the following:

1. The knowledge that the very system entrusted with our mental wellbeing has in certain significant respects 'got it wrong' could well be troubling both personally and intellectually
2. Recovery is not just another transient buzzword – it's enshrined in nursing standards and practice and is here to stay
3. Recovery is a universal naturally occurring phenomenon that needs to be acknowledged and worked with, not impeded
4. The instilling, and maintaining, of hope and belief is crucial for the successful outworking of recovery principles in a mental health context

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THE SOCIAL DETERMINANTS OF MENTAL HEALTH

This issue highlights the importance of the social determinants of health and well-being and argues that issues of inequality and social justice should be central to the mental health curriculum. This is all the more important at a time of cuts in welfare spending that are likely to impact on housing, benefits, employment and access to public services such as libraries and sports facilities as well as specific services for people experiencing mental health difficulties. Ensuring that students are familiar with the social determinants of health and able to acknowledge these in their practice requires a shift in emphasis from an individual focus on pathology and a biomedical discourse to one that incorporates a social perspective, recognising the wider impact of inequalities and drawing attention to wider population issues (Krieger, 2001; Thompson, 2003)

Health inequalities involve both the higher risks of mental ill health associated with disadvantage and inequalities as well as differential access to health care. This is well evidenced in relation to certain groups such as Black and Minority Ethnic communities, lesbians, gay men and bisexual people as well as women, recognising the impact of underlying issues of discrimination with some ethnic groups over-represented in terms of certain diagnostic categories. With regard to access to mental health care, certain groups are also over-represented in terms of their presence in the more controlling aspects of services whilst under-represented in their access to community provision (NIMHE, 2003; CQC, 2010; King and McKeown, 2003; Williams, 2005).

The Strategic Review of Health Inequalities in England (Marmot, 2010) points out that mental health is very closely related to many forms of inequality and that the social gradient is particularly pronounced for severe mental illness. For psychotic disorders the prevalence among the lowest quintile of household income is nine times higher than in the highest. The effect of social drift is not likely to fully account for this. The social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles. The comparison both within and between countries is highlighted by Wilkinson and Pickett (2009) who draw attention to the higher levels of mental illness in more unequal countries. They also highlight the fact that societies with low levels of trust and weaker community life are also those with worse mental health.

Research across the life-course has produced substantial evidence that the body accumulates socially-created benefits and insults from the moment of conception to death. Experiences in the early weeks and months of a child's life are likely to significantly affect the development of neural pathways in the brain which may have long-lasting influence on their health and well-being in childhood and beyond into adult life. The experiences of stress, trauma and / or abuse at any stage in life affect complex bio-psycho-social processes that will also have lasting consequences for health. In short 'the political and economic context of life is embodied in people's lives' (Rose, 2009:41) and these are further affected by issues of power, oppression and disadvantage.

In order to address this I propose that the social determinants of mental health occupy a central place in the curriculum, raising broader questions regarding health inequalities and positioning mental health as a crucial aspect of education and practice in social work. In respect of other 'Burning Issues' this re-iterates the need expressed by Mike Maas-Lowit to mainstream mental health in social work education and to promote the social attributes of mental health more widely in the education of all the relevant professions. This in turn will raise other challenges, not least how to develop practice underpinned by principles of social justice and human rights in response to the circumstances of individuals, families and communities. Creating spaces for further debate and dialogue involving service users, students, practitioners and educators will be essential to the development of creative and effective approaches to tackle these important issues.

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IS EDUCATION FIT FOR PRACTICE?

What and Why?

With university places for all branches of nursing in high demand, an expected reduction in jobs for qualified nurses and recently updated guidance from the NMC on 'fitness to practice', the focus is very much on student's performance. They are asked to provide evidence of their continued academic calibre to secure a place on a degree course, during which they are expected to perform at a high level both clinically and academically, integrating their learning into practice. There is also an expectation that they enhance their CVs to enable them to compete in a challenging jobs market.

The emphasis at this time is on students to prove that they are a 'commodity' worth investment in by Universities and NHS Trust employers, all of whom are attempting to adapt to a market based model with varied results. However as students become increasingly aware of their consumer power there will be a change in the power dynamics of this transaction, as they will realise that whilst they have to pay for their education they also can choose what to purchase.

University based education must prove able to adapt to two sets of customers - the NHS or future nurse employers an students themselves. In the very near future all education providers will need to be flexible and resourceful, addressing the question 'are we fit for practice?'

How?

To provide an education fit for practice we need to formulate some answers to the following questions:

- What is the future of nursing?
- How can we best support the provision of education that is responsive to the changing environment?
- What skills will newly qualified nurses need?

What is the future of nursing? – It seems likely that the trend towards managing clinical areas with fewer qualified staff and more generic workers will continue. As the NHS changes take shape in the light of a decrease in public funding, the independent and corporate sector is expected to grow – our students will need the skills to be resilient in an evolving workplace and manage change. In mental health we are also seeing a continued shift from ward-based care to community and hub and spoke models, this is already changing the experience of student nurses in placement and will provide them with a different range of work options than their lecturers experienced.

How can we best support the provision of education that is responsive to the changing environment? Contemporary mental health education seeks to actively include service users, carers and representatives from practice within the syllabus, Although to be welcomed, in reality this has often been tokenistic. The challenge within our new mental

health curriculum 2010 was to provide innovative learning linked to a rationale which explains how the designed learning package meets expected outcomes.

There is a need for all those engaged in teaching to be credible, both academically and in practice, to enable them to connect the syllabus to reality. Academics have taught students a vision of 'best practice' which makes little sense when compared to the reality they experience on placement. It is not acceptable when supporting students to become independent practitioners to dismiss the division between the 'optimum practice' referred to within the classroom and the reality many students experience within practice. This disconnection is not simply a matter of the theory practice gap but in some ways is the practice verses optimum practice gap. Educators need to return to practice areas and help to provide creative solutions to these issues and role model reflective practice in action.

Reflective practice has been shown to increase self awareness and has led to a more questioning approach to the delivery of care within nursing. However, studies show a number of factors hinder reflection during clinical practice relating to academic preparation and the clinical learning environment. As a part of our new curriculum, we will run 'creative thinking days' throughout the practice modules. These will deliver a more interactive approach, through case studies and service users' experiences, thus allowing the student to consider a range of issues facilitated by the lecturer.

What skills will qualified nurses need? Future nurses will need to be increasingly skilled in team working, as partnerships outside of statutory systems will increase. There's an expectation that nurses will continue to be managers of caseloads and teams, potentially resulting in 'one qualified staff on a shift'. To provide quality care as a sole agent instead as part of a team means that encouraging autonomous skills such as creative thinking and clinical decision making will become more important. The development of these skills depends in part upon the students ability to reflect upon their 'creative thinking days' and critically apply these into practice. A decision was made to incorporate action learning sets within the practice modules in order to provide a real opportunity for mental health students to bridge the gap between practice, theory and 'optimum practice'. Reflection in action learning sets allows students to develop a much greater level of awareness of the complexity of the internal and external world and their interrelationships. Action Learning is a continuous process of learning and reflection, individuals learn from each other by working on real problems and reflecting on their own experiences. We aim to involve clinicians from practice areas within this process thereby promoting a seamless transition from the classroom to the clinical area.

Future Directions?

Within the current climate of change and uncertainty affecting the NHS and University Education, mental health nurses need to be increasingly resilient. Potentially this may be a time of pessimism for many in health and education. Strategies such as creative thinking days and action learning sets and their application from classroom into practice, will develop a sense of creativity and flexibility in students. Future mental health nurses will need to have these skills in order to work autonomously, making clinical decisions alongside service users in a variety of settings. The creative learning proposed provides a realistic grounding for

students to apply learning to practice, creating a sense of resilience and ability to function at an optimum level in the changing arena of mental health nursing.

MIKE MAAS-LOWIT

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ADDRESSING QUESTIONS OF DEFINITION

The problem of how mental health is addressed in higher education is many faceted: two critical issues stand out as significant:

- There is a tendency amongst those not attuned to the subject to marginalise it, failing to take into account at least some aspects of mental health which are more or less universal to us all, let alone to those vulnerable people in need of services and

- there is a seeming difficulty to reconcile, a tension between perspectives which seem to stand in opposition; between what are often called the social and the medical models; between liberal rights-based approaches which take strong account of personal experience and those approaches which seem to objectify the subject and cast him or her in the passive patient role.

I would suggest that both of these issues may be tackled by addressing questions of definition.

The subject area has been dogged by lack of definition or, at best, lack of agreement of definition. The very term mental health brings with it a set of loaded problems- what is health? Is it the same thing as illness? What is mental about mental health? Are mind and brain the same thing? Is mental health just a polite euphemism for mental illness and a sop to those who disagree that they are ill?

I expect others to argue for the very necessary focus upon discrimination and stigma, the orientation to recovery, the need to bring in service-user perspectives and to address law and policy proportionately. In the following, I do not disagree with any of these and other necessary orientations. I simply want to emphasise that, if we cannot find an agreement upon what we are actually discussing, multi-disciplinary work will not be possible and a tension will marginalise service user-orientated perspectives from core medically orientated frameworks of support in health services. An artificial divide will be perpetuated between the social and the health aspects, when in fact no such divide exists between any person's health and their social welfare.

As Millan suggested, we are somewhat stuck with the ambiguous term "mental health", which conflates two aspects which may be separated out:

Health is a spectrum upon which we are all positioned variably according to our circumstances and attributes at any given time. We all experience periods of good and poor mental health at different moments and to varying degrees. Hence, the reference above to universality of "mental health issues". Another feature of health is our ability to engage with it to protect ourselves from poor health, whether this is collectively, through law, policy and services or individually, through action and education. This last point hints at Recovery as a concept central to mental health in its true meaning. It also suggests that mental health is a very different concept from mental illness.

Illness is a more problematic in that some people dispute the existence of mental illness. At the very least, without acknowledging some kind of neurological and bio-chemical dysfunction, it is difficult to adequately explain away the more serious manifestations of depression and other affective disorders, those clusters of experience referred to as

schizophrenia and so on. Therefore, while exercising some caution, it is as important to convey the human potential for the mind (as a function of the brain) to become ill or disordered, as it is to argue for a continuum of mental health.

These two ideas are clearly inter-related: On the one hand there is the detriment to mental health caused by discrimination and other social forces experienced by people when mentally ill. On the other hand there is the risk of poor mental health exacerbating mental illness. However, rendering the ideas down to a simplistic notion of models does not serve to sort out and then view as dynamic these two aspects.

Medical and social models are often viewed as oppositional. Within social work for example, there is a tendency to confuse the evidence-based medical model (in so far as it is a model) with the critical historical view of psychiatry as paternalistic. In other words, the model risks being viewed negatively on the basis that it may be misapplied on occasion and on the basis of irrelevant things like its seemingly non-holistic approach. This statement should not be taken to be rejecting of the need to view psychiatry, or any other strand of activity in a critical light.

Human beings are far too complicated animals to be reduced to a conflict between our biological functioning (organic/bio-chemical) and our social functioning. By dismissing the notion of models we can view the medical and social as overlapping perspectives and we can introduce many more perspectives which critically relate to our mental health and which may contribute to the generation of mental illness in us: the psycho-dynamic, the economic, the political and so on. In this way we may begin to explain how and why it is more likely that there will be poor mental health in circumstances of poverty and that poverty is more likely to generate the sequelae that we call mental illness. We can break the artificial divide that exists between mental health (so called) and risk of harm because of a range of social and cultural, race, gender and age related attributes and so on.

What it would take to achieve this is a little more explicit analysis of the terms "mental health" and "mental illness" in our teaching and a proportionate focus on bio-chemical aspects of brain functioning as it relates to mental processes. This latter point is often lacking in teaching in social work and subjects with a social science orientation. It need not be complicated or in great depth but it needs to be sufficient to give explanation of the otherwise difficult-to-understand manifestations of mental illness (so called). From this, a greater practice understanding may be achieved about how and why we need to work across professional disciplines, how to help people to manage their experiences of mental illness and how to both improve the mental health of people whose lives are affected by mental illness and how to tackle endemic problems of poor mental health in the rest of the population.

There are numerous text based resources already in existence which would support this approach. It is an approach which could work side by side with other remedies, such as making teaching more inclusive of people with experience both of poor mental health and of mental illness and increasing the regard we pay to recovery. The approach would help to reconcile the tensions inherent in application of mental health law and the approaches adopted by voluntary and statutory agencies. Most significantly, it would help to mainstream mental health in social work education and to increase the regard in health professions' education for social attributes of mental health.

PEARSE MCCUSKER

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MENTAL HEALTH IN SOCIAL WORK: A BURNING ISSUE FOR HIGHER EDUCATION

30 years on from the disability movement's challenge to the 'medical model' of disability (Oliver, 1983), within mental health, the call for recognition of the multifarious role social factors have, both in constructing notions of and causing 'illness', continues (Beresford *et al.*, 2010). Ironically, this is set against an extensive and increasing evidence-base for the negative impact poverty, poor housing and social exclusion have on mental health. The 'Glasgow effect' (Scottish Government, 2010; Melzer *et al.*, 2004) describes the increased prevalence of mental and physical health problems, including anxiety and depression, within the Glasgow population, as compared to the rest of Scotland. Whilst it identifies difficulties in establishing exact causal relationships, the study finds socio-economic variables play a key role in determining the prevalence of mental illness, with economic status having 'the largest impact on predicting health outcomes' (Scottish Government, 2010:41). Drawing from extensive empirical evidence from international studies, Wilkinson and Pickett (2009) unearth a consistent relationship between societies with high levels of inequality and increased health and social problems, including mental illness.

Reflecting these developments, significant efforts have been made to redefine and explain mental illness within a wider social and cultural context, spearheaded by service user groups and the voluntary sector, and encapsulated in the 'recovery' strand of mental health policy. 'Recovery' represents an attempt to more accurately depict the complexity of mental illness and enable service users and professionals to develop more comprehensive and empowering ways of dealing with it (Brown and Kandirikirira, 2007). Recovery's impact, in terms of changing professional attitudes and wider discourses of mental illness is, however, unclear. Beresford *et al*'s recent exploration of the views of mental health service users suggest that the perspective of 'madness' as a medical condition, located at the level of the individual, still pervades and provides eloquent testimonies to the lived experience of stigma:

> What I think that [medical] model does is blame the individual…there's something wrong with you, that's the message that you get... (Beresford *et al.*, 2010:2).

Whilst Beresford *et al.* also critique the usefulness of the social model of disability as an alternative conceptual framework, because it supports ideas of 'impairment', they find broad agreement for developing ways of thinking about mental illness that capture its multi-dimensional nature, including the relationships between "psychological state, shared social circumstances, experiences and barriers" (2010:3) and at the same time recognising the individuality of service users' needs.

Social work, whose central theoretical premise is founded on the importance of the inter-relationship between people and their social contexts, is a natural conduit for the development and transmission of such broader perspectives on mental illness. Social workers are uniquely positioned to utilise knowledge of the social determinants of mental illness to enable service users to tackle the problems that really matter and communicate the power of doing so to other disciplines (see Karban's contribution – page 8 in this document). As a profession, however, social work's main organisational model, of service provision by care group, arguably militates against qualifying social workers expanding the comprehensive knowledge bases their degrees are required to prepare them for (Scottish Executive, 2006). Thus social workers are funnelled into the specific knowledge silo required

to deal with the demands and complexities of the relevant care group. As a social work team leader in a community mental health team, I was often struck by the lack of focus children and families' social workers gave to addressing the needs of parents with mental health problems, combined with characteristically medicalised and risk-focused perspectives on mental illness. Further, individual social workers' level of knowledge and understanding of mental illness are likely to depend largely on the attention paid to the subject in their degree courses. Inevitably, this will vary, however, practice observations suggest the extent to which social work training prepares qualifying workers for recognising and addressing the mental health needs of service users, regardless of 'care group', is limited.

Even 'specialist' social workers may struggle to articulate informed, holistic definitions of mental illness. Within mental health, social work is, arguably, perceived as a 'junior partner' to psychiatry and allied health professions, where treatment for 'illness' is still dominated by use of medicine and 'clinical' know-how sits atop the knowledge hierarchy. In these environments social workers often find it difficult to clearly delineate their role, not least because of its expansive nature, encompassing the gamut of physical, mental, economic and social problems users and carers face. Within the community mental health team environment, I was aware that social workers, me included, often struggled to assert with confidence, counter arguments in the face of 'expert' medical knowledge. Notwithstanding the need for pharmacologically and neurologically informed care and treatment, I also witnessed the transformative effects many social workers' interventions had in the lives of service users they worked together with. In addition to stopping vulnerable people having benefits cut, advocating on behalf of asylum seekers with intransigent officialdom and tackling other fundamental needs, these interventions recognised the centrality of development of self and positive identity to achieving something approaching a fulfilling life.

The burning issue here is the position of mental health within social work education. Adding to the arguments of Kate Karban and Mike Maas-Lowitt, this paper asks for universities to respond to the call from service users and to an increasing body of research, which underline the position of social factors as key players in forming, maintaining and exacerbating mental illness, and to embed informed and progressive mental health teaching within qualifying and post qualifying social work education. It reflects a wish to move beyond simplistic, polarised or reductive conceptions of illness to equip qualifying social workers with knowledge that enables them to counteract the compartmentalisation of the profession, support service users to achieve quality of life and contribute towards the development of more subtle, sophisticated and human ways of understanding mental illness.

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ETHICAL TEACHING AND THE LIMITS OF KNOWLEDGE

This piece may read like a rehash of well-worn argument on the nature of knowledge, but this is an argument worth revisiting for two reasons - it is an argument that remains unresolved by its very nature, and so it is an argument that should reflect a given time and place, which is now, here. Our very human need for certainty and a loathing for ambiguity, continues to feel its presence in the most reasoned of spaces. Filling in the gaps, seeing patterns, creating stories, psychologically defends us against randomness, ambivalence and what we come to think of as capriciousness. In the modern age we have written the rules and processes of rationality and reason; truth and fact is revealed through their application. Conversely, we do ignore these very same rules and processes, and we camouflage our inconsistency of rigour through a varying application of 'truth rules', behind half hearted efforts, obscurantism and privileged status.

In looking for a field of scholarly activity that exemplifies this tense and paradoxical relationship between knowing, truth and rigour, we need look no further than the disciplines, or field, of mental health, and indeed later in this piece a very specific example that in turn illuminates a number of contingent practices; the stress-vulnerability model. The terms of our field (because we have encircled it) such as schizophrenia, stress-vulnerability, predisposition, treatment, inclusion, and recovery, have an authoritative presence, but on reflection remain provisional. Mental health and the human sciences are guilty of casuistry, relying on little more than systems of classification and speculation to uphold and evidence key psychiatric concepts; the naming of a given phenomena is an insufficient approach to science. However this has been shown to be enough to constitute a presence and an effect, around which a fiction may be written - SCHIZOPHRENIA. The authoritative terms above are problematic in that they represent and constitute efforts to make generalizations, and furthermore, they marginalize other views, perspectives and rules for knowing. However, there are partial truths in such phrasings; we know people report hearing sounds that can distress them, we know we cannot see nor measure a thought, we know that we are all a mix of our inherited and acquired biology interacting with our experience, and we know that if you are poor or badly treated, this raises the possibility of experiencing problems and reduces your prospects.

To practice ethically as an educator, I cannot, on the one hand, know that the knowledge of our subject discipline is of the most provisional and partial status, and then, on the other hand, offer views to learners that communicate a greater sense of certainty and authority than they warrant. I am ethically compelled to be transparent about the limits of knowledge claims, and the methods employed to construct them. Learners in health and social care are not signed up to a philosophy course, and they are in the 'real world' of practice and they need to get on with employers and colleagues. That is tough to do if you become paralysed with the thought of the uncertainty of everything. However, I believe paralysis or surrender need not be the only outcomes for a learner or teacher, although any engaged learner will experience those freezing moments when a known 'given' has overturned. I believe that

understanding the limits of knowledge, and exposing the relationship between power and knowledge in a given place, equip the practitioner. Learners and practitioners are in a field populated with the assertiveness of policy documents, clinical guidance and knowledge/skills frameworks, which in turn shape and acculturate the practitioner. It becomes harder to disavow authoritative positions, resist induction into the norms of the 'clinical contact', and to accept a multiplicity of views and the polyphony of experience. And so an early casualty can be humility. The temptation then becomes one of making a demand, then a show of criticality only insofar as it accepts certain givens without further qualification- illness models, psychopathology.

Stress-vulnerability models are frequent guests in mental health teaching and they make their path into education for service users, families, carers, lay practitioners and allied professions. Such 'models' have managed to diffuse without dilution and offer themselves as a heuristic before they become a truth. The notion that we are a stew of inherited and acquired biology, which interacts with our environment, has been around for a while, and this is the extent to which the model is often articulated. Except for some it constitutes the mechanisms of their pathology. However, there is no specificity offered as to why stress-vulnerability explains poor mental health, including particular phenomena such as voice hearing; is it not just describing the state of being human (or indeed any animal which can learn)? Vulnerability, that is, a fundamental pathology (why not stress-resilience model?), lacks rigour as a construct, and only applies if the outcome of a predisposition is negative; unfortunately, I do not have an inherited vulnerability to physical athleticism. The interaction between vulnerabilities (genetic, structural, and psychological), remains unarticulated, and the relationship and mechanisms by which they interact with stress, how this is mediated, remains, at best, obscure. Stress-vulnerability models offer nothing in terms of predictive power. Unfortunately, despite the occasional passing nod to the provisional status of this stress-vulnerability hypothesis (it does not now meet the expectations that constitute the status of a model), repetition in texts, classrooms and practice have elevated it to a position of fact.

While often at the margins, in the human sciences, critical psychiatrists, radical psychologists, post-colonial, queer, disability and feminist theorists appear to be the true human scientists, because they are most prepared to accept the limits of knowledge claims, the problems with generalization and normativity, and the benefit of a range of methods for revealing and interpreting data. They are likely to question from different paradigmatic positions, interrogate the role of authority and power in knowing and knowledge, and integrate the influences of culture and humanness into how we know.

My burning issue is that an ethical educator has to teach from the position of the partiality of knowledge where they are engaged in the human sciences. I am convinced that this ethos is not a major driver in mental health education, but it is the one that will lead to the most reflective and ethical practitioners. We can trust that learners can and do tolerate ambiguity, manage uncertainty and navigate their learning through this choppy sea.

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MINDFUL OF A GAP

Mindfulness is purposefully paying attention to the present moment with an attitude of openness, non judgement, and acceptance. Whilst it is most associated with Buddhism, paying attention to the present moment is a practice which features in most spiritual traditions. Exercises and practices which use mindfulness are , however, straightforward and not tied to any particular religious tradition.

Mindfulness is increasingly being given attention by the helping professions as a demonstrably powerful tool in assisting mental health and well being. Melded with CBT to produce mindful-based, cognitive therapy (MBCT) this practice has been shown to be a most effective intervention for recurrent depression, for example. So much so that it is now recommended by NICE as the treatment of choice for those who have had at least three episodes of clinical depression, and has been shown to cut relapse rates significantly (NICE, 2009)

Whilst it often appears that Mindfulness is about meditation, and the enhancement of relaxation and well being, one of the more important results of practicing mindfulness is a greater awareness of and engagement with the world and personal relationships.

Social work is a notoriously stressful thing to do. As I write, Community Care (30th November 2010) have just highlighted again stress in the social work profession. The Personal Social Services Research Unit at Kent recently published a piece of research which estimated that the average expected working life of a social worker in the UK is 8 years, compared with 15 for a nurse, 25 for a doctor and 28 for a pharmacist.(Curtis *et al.*, 2010). My current students and previous students who have qualified and gone into practice have repeatedly suggested that whilst their training was academically sound it did not prepare them sufficiently for the emotional work of the job and did not teach skills and strategies for self care and for dealing with the intense personal stress of the job.

Recognising such actual and potential strains and stresses for social work students Birnbaum developed a programme for teaching mindfulness to social work students. (Birnbaum, 2008) She noted the pressures that students feel from both the field and the academy and posited "an unmet need for an 'accompanying place' where thoughts, feelings and dilemmas can be observed in a non-evaluative way". She provided a group based mindfulness training programme for students over an eight week period. Birnbaum suggested that a key finding was "students' strong desire to learn about mindfulness meditation and experience it for themselves." Mindfulness provides a space and a mechanism for deepening personal observation and reflection in a way which is non evaluative and which seems to facilitate self development. The processes of detached observation involved in mindfulness practices share many similarities with the reflection in action as delineated by Schon, and which is heavily promoted in the training of most modern health and care professionals.

Teaching Mindfulness to social work students may offer several related,important and proven benefits. It may provide an additional therapeutic skill to add to the social work toolkit and one which is increasingly being shown to be one of the most promising interventions in the field of mental health. Secondly it may provide a simple and powerful practice for maintaining personal well being for the student as they progress on their journey through training and into practice. Since stress and burnout are repeatedly suggested as a key factor in prompting individuals to leave the profession, it may be that the regular practice of Mindfulness could also improve the mental well being of the workforce and lead to an extended typical working life for social worker.

Steven Hick's book *Mindfulness and Social Work* has recently been published. Hick makes interesting links and points to a bigger picture in which mindfulness has a role not only in personal well being but in increasing awareness of issues in our communities and in cultivating more compassionate and engaged daily living which is informed by social justice. Buddhist teachers emphasise the ways in which mindfulness leads to greater compassion, both for self and others. Perhaps the bigger pay off from teaching mindfulness to students may then be an enhanced capacity for individuals to practice and live in ways which are congruent with the espoused values and ethics of the profession into which they are being socialised.

Reviewing Hick's book in Community Care recently, Peter Gilbert suggested that almost anywhere you go in mental health these days, somebody will mention mindfulness. This may be the case but mindfulness does not feature in the three specific text books on social work and mental health which have been published in the last couple of years (these three are Coppock and Dunn, 2010; Gould, 2009 and Golightley, 2008) and it is not something which yet features on the syllabus of most social work training programmes.

While I have highlighted issues pertaining to social work, most of the above applies equally well to the other helping professions.

For all of these reasons my burning issue is to increase awareness of the benefits of including teaching about Mindfulness within the higher education curriculum, whether as part of a mental health module or as part of personal and professional development, readiness for practice or other related parts of the programme.

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USER/ CARER INVOLVEMENT IN EDUCATION: WHY YOU SHOULD USE WEB 2.0 TECHNOLOGIES

The involvement of service users and carers is central to effective learning and teaching in mental health education. A major lesson we have learned and are promoting as a Centre of Excellence in Interdisciplinary Mental Health (CEIMH) at the University of Birmingham is that service user and carer involvement in education does not have to be confined to the classroom. Educators must look beyond the confines of the campus and start thinking about how the communication and collaboration opportunities offered by freely available Web 2.0 tools might be used to engage service users and carers in the processes of designing and delivering effective mental health teaching.

Mental health service users and carers tend to bring a vast pool of authentic experiences and knowledge to the task of teaching at the pre and post-qualifying levels. By virtue of their past involvement with services they can provide insights that can enable students from a range of disciplines to understand the holistic nature of mental distress and its impact on the service user, their carer and those around them. Using these experiences in the education and training of mental health professionals can help produce practitioners capable of working in partnership to provide improved and appropriate provision for service users and their carers (Tew *et al.*, 2004). Whilst the arguments for involving service users and carers are clearly articulated, putting them into practice in higher education can prove quite challenging. Tyler (2006) highlights how practical barriers can prevent service user and carer involvement. These barriers can include issues of time, place and access where involvement can be prevented because service users and carers need to organise substitute care, may not be well enough to travel, have problems accessing funding for travel, paying child care costs as well as a myriad of benefit related and practical problems a busy life can present. For service users and carers who have access to the Internet, Web 2.0 technologies can provide some opportunities to overcome a number of these barriers.

The term Web 2.0 was first coined by Tim O'Reilly (2005) and has no agreed definition. The work of CEIMH in this area suggests that Web 2.0 should be thought of more as a concept than as a technology. Terms such as the "read/write web" and the "social web" have been used to describe some of its main properties. Web 2.0 enables people to connect flexibly to overcome some of the barriers of time, place and access. For example, Web2.0 can allow a wide range of people to engage in the collaborative processes of learning by freely accessing and sharing with others to consume, remix, repurpose and collectively generate new knowledge and ideas. Where service users and carers have Internet access at home or via their local library etc all they require to access Web 2.0 tools is a web browser. Our own critical appraisal of Web 2.0 tools and processes suggests there are four related properties that should encourage academics to use these services to design and deliver effective interdisciplinary teaching and learning.

The first property is the ability of Web 2.0 tools and services to support a high degree of communication and collaboration. Using these freely available facilities, service users, carers, students, practitioners and academics can plan teaching, share information, coordinate research/problem-based activities, engage in debate and build learning communities within a flexible environment that can be free from the traditional constraints of time and place. We found for example that using GoogleDocs online word processor as the main medium for planning and designing teaching events reduced the need for face-to-face meetings. This enabled service users and carers to participate fully in these processes by working remotely at a time, place and pace convenient for them.

The second property Web 2.0 offers is the ability to easily create content such as text, video or audio files and then freely publish these to a select group, or potentially worldwide audience. We found that the "write, publish and discuss" simplicity of Blogs (such as Google's Blogger.com) provided an excellent medium for mental health service users and carers to develop a supportive community of practice by creating an online space to share, discuss and archive their experiences of engaging in and seeking to improve interdisciplinary teaching and learning processes. (For more on Blogs see http://tinyurl.com/2kobxs.)

The third property enables the development of skills such as enquiry. This can be achieved by combining problem-based case studies with the simple collaborative functions of a Wiki (such as PBWorks.com). As part of the Collaborative Learning Initiative (see http://tinyurl.com/pfgu4a) we utilised a Wiki link function that enabled us to guide students to additional learning content on the Internet. Working alongside mental health service users, carers and practitioners, students learned to develop the skills required to retrieve, interrogate and assess the validity of sources they intended to use. Working as a team they used the write, edit and save functions of a Wiki to collaborate and collectively produce potential solutions to complex life like mental health situations. (To find out more about Wikis see http://tinyurl.com/23y3wp)

Exposure to these learning opportunities covers the fourth property, that of developing literacy (through experience) in using these tools and reflecting on how they could be used to aid effective interdisciplinary practice in the mental health field of the future.

With all the benefits outlined above, why would you not explore the potential on offer?

(To find out more about some of the tools mentioned, please see Mason and Rennie, 2008 and Richardson, 2009).

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SHOULD SERVICE USER INVOLVEMENT BE CONSIGNED TO HISTORY

Mental health education has responded more than any other area to the challenge of "service user involvement". I've deliberately put this in inverted commas because my burning issue is regarding how the concept has been constructed and subsequently construed in health discourse. Whilst it is clear that the concept has been widely accepted in mental health education, I wonder if the nature of this acceptance has resulted into a form of rhetorical assimilation rather than a radical transformation that many of us had once hoped for. I'll illustrate my point with a few examples.

When I started in Higher Education, over 10 years ago, a group of us were highly motivated to embrace the new agenda of involvement that implied emancipation and social justice. OK, I for one was naïve, visionary and idealistic. But why should I not be? At the heart of nursing and social work in particular are the values informed by ethics, rights, justice and liberty. I, like many others, had become frustrated and angry with a system that continued to oppress as much as it "cared". I saw good honest workers who had entered their respective professions with integrity leave with shame and bitterness. I witnessed the workings of a system that was stretched beyond anything that might be considered reasonable. I also saw evidence of really good practice conducted by people with compassion, skill and integrity.

The opportunity for the involvement of service users in mental health education was a breath of fresh air. It made so much sense that the best people to impart understanding of mental health problems were those who themselves had experienced mental distress. This model may help workers of the future to grasp the emotional "knowledge" needed for empathic, compassionate care desperately needed in mental health care.

Having worked with a team of people over 10 years attempting to develop robust models of "involvement" I have learnt a lot. Much of what I've learnt is to do with the complexities rather than the achievements. Whilst the achievements are worth celebrating (see Stickley *et al.*, 2009; Stickley *et al.*, 2010) it is all too easy to gloss over the difficulties. For example, whilst the idea of students being assessed by service users sounds highly (see the second article referenced above) appropriate and desirable, in reality the research showed how fraught with complexity the idea is in practice. Furthermore, apart from discovering difficulties from research, there are many barriers to effective change in any organisation and the NHS is the largest employer in the UK. Genuine transformation based upon ideas of emancipation is beginning to feel illusory for me.

Make no mistake, the notion of user involvement is well established in NHS discourse. But this is largely rhetoric. In reality, systemic barriers exist that are apparently insurmountable. The most obvious one is money. For every project we have designed, it has been wholly reliant upon short-term funding. My School at the University of Nottingham have been incredibly supportive and have paid for development work and teaching fees for service users, but there is no "pot" of money from the NHS commissioners, anywhere as far as I can make out that will pay for what is called for in policy. Even last week, I was told not to include

payments to service users in a Research Council application because it would be rejected. Even if we were allocated adequate funds to pay for "service user involvement" (I'll address the inverted commas issue soon) there is still the issue of the rigidity of the benefits system that appears to punish people for working part-time or on a sessional basis. Huge amounts of money are spent by institutions developing staff, but there is often little money for developing service users and providing training and support for their role in teaching.

It is not good enough, to "wheel in" a service user to "tell their story" and wheel them out again (to my shame that's what I started off doing). To tell a story of pain, suffering, loss and so on, will take its toll. I would go as far as to say it is unethical to ask this of people. We need robust models of "service user involvement" that include training, development, support, supervision, evaluation and so on. But this needs investment and should not be done on the cheap. The NMC are preparing for a new curriculum for nursing and their guidelines are peppered with references to "user and carer involvement" (note the lumping together). I recently telephoned them to ask if they'll pay for research to provide evidence for this (you can guess their response...).

The instructions for this blog dictate that this entry should be under 1,000 words so I'd better address my issue with "service user involvement". My point is that I think the notion is flawed and to peddle it, we merely perpetuate the problems identified above and reinforce the hierarchies that dominate healthcare rather than achieve the liberty and emancipation that the promise of "involvement" seems to imply. For a full argument of the point please see Stickley, 2006. I know I'm likely to get branded cynical, jaded and gloomy but my call is for GENUINE COLLABORATION IN MENTAL HEALTH EDUCATION that acknowledges and addresses the barriers that I've presented in this blog. Without adequate funding and support and a genuine investment in the philosophy of collaborative working, I think we should tell the Rhetoricians to take a run and jump and come to terms with the fact that the "system" is far more interested in protecting the public than promoting social justice. I suggest that the effort we've been putting in to "do" user involvement would be better spent arguing with those who hold the purse strings to fund genuine collaboration in practice and educational development in the future.

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NOT WHAT BUT WHO AND WHY?

Teaching will define the Psychiatry of the future. Unless steps are taken to educate medical students and the medical students of the future more completely, Psychiatry will be forced into the peripheries of the NHS and generic mental health care will become domain of the non-medical practitioner. It is therefore not what, but who we need to be educating which is of importance, and how.

> "Why be a psychiatrist, I thought you wanted to be a doctor?"
> "Nobody gets better..."

The old lines are the best. In no other specialty would such misguided, ignorant, prejudiced garbage be allowed to be voiced without fear of a scalpel sharp riposte. You're right, I haven't discharged a single patient from my clinic in ten years and the ward is now at 10,000% capacity. I don't know why the Government hasn't shut us down by now. That money could be much better used on something like, hips or something.

So how come I don't think this, how come I don't regret every day I spend in this Cinderella speciality? Psychiatric training has taught me the power of empathy and how the taking of a complete history and mental state examination can lead to treatment that greatly improves the patient's quality of life and of the family around them and I have learned to appreciate the value of a therapeutic alliance in my practice. Undoubtedly some of these attributes were deep within me but some of these skills needed to be honed through practice under the auspices of my teachers. Those teachers taught me not only what passivity phenomena were and how to recognise them, but also the real-world merit of what I was doing. Those teachers inspired me.

Yet still the reality is that we face a wall of misconception. Medical students and junior doctors alike come to psychiatry with preconceived notions that can take an entire rotation to break down and even then, despite experiencing the exact opposite on the wards, they remain in the default states quoted above. A true disconnect between attitude and experience. On the very first days of teaching medical students I have experienced a general malaise from some, a reluctance to participate from others, and a disenfranchisement from a few towards a specialty they know nothing of, except what they have heard from their seniors and peers via word of mouth.

So how can we remedy this via teaching and learning? How do we convince medical students that Cinders should go to the ball? (And be allowed just as much complementary punch as the other guests!)

It has been evidenced that charismatic teaching can influence recruitment when the emphasis is placed on the effectiveness of Psychiatry, rather than concentrating on the difficult to manage or unsuccessfully managed patient (Brook, 1983). We need to be charismatic, and learn how to teach our speciality in an effective way, instead of dictating endless words on PowerPoint slides and giving copious handouts with lists of "recommended reading".

Charisma is one thing, but the core argument that charisma alone cannot eliminate the fact that comparatively, mental illness is poorly understood. It would follow therefore that a speciality considered conceptually weak and unscientific (Brockington and Mumford, 2002) coupled to the generalism of NHS Psychiatric Strategy will lead to an unappealing picture.

The lack of a scientific approach has been shown to negatively impact the patient and this is not something easily sold to the psychiatrists of the future(3). What we should be highlighting is the advancements we have made to reduce the fear medical students may have. I have recently attended lectures on f-MRI and deep brain stimulation and these were received very well by students, clearly more of this would be welcome. The BIO part of the biopsychosocial model is there all around us and we must promote it alongside the psycho and the social.

By keeping up to date with guidelines and taking this scientific approach into our clinical work we can improve the poor public image and increase the respect from other specialities. We must teach our medical students how we come to decisions, sharing the scientific basis for our choices to instil confidence in them as to the validity of what we do (Lambert et al 2006).

It has been shown that school and college students with an interest to study medicine have greater interest in psychiatry (Maidment et al, 2003). Why shouldn't Psychiatry be targeted to prospective medical students in colleges? Something happens to the average medical student during their clinical attachments which makes them less likely to apply for psychiatry– despite very positive student feedback during their time here.

If we wait until our second period of captivity (junior doctors rotating during the foundation programme) it may be too late. Some doctors there will be only doing Psychiatry because it came with other choices and in foundation year two, two of the three rotating trainees will have made up their mind and practically submitted their application before their rotation in psychiatry begins. On Monday the 20th December the CT1 application window closed. For the country as a whole there was a deficit of 118 candidates for jobs, and this could be higher when psychiatry as a second preference is considered. Recruitment issues in psychiatric training are not new (Storer, 2002) but they are no less relevant now and the increasing numbers of medical students attending medical school is not bridging the gap.

The attributes and competencies required of a good psychiatrist have been defined (Bhugra, 2008) and should serve as a challenge to those who wish to be a psychiatrist. Only a truly competent clinician could cope with the demands of the role and it is certainly not a "fall back position".

Teaching not only the clinical aspects of Psychiatry, but the value of Psychiatry is of paramount importance. To not do so condemns the specialty to a slow death. The numbers are showing this. We must act now.

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AFTERWORD

There is no common voice here. As in our professional and personal lives, so too in this document, a multiplicity of views can co-exist. What these *Burning Issues* do have in common is the plea that they make for an engagement with, and questioning of, the status quo.

They have been written at a particular point in time and will be read on specific occasions. As readers we bring our own self - our current preoccupations and emotions - to our reading. This applies to each re-reading too. This was brought home to us, as editors, when one of us asked the other if a revised version of one *Burning Issue* had been submitted; so altered appeared to be the message of this piece on a second reading. It was, in fact, unchanged!

People with mental health problems can be marginalised within society; so too learning and teaching about mental health within universities. Educators and interested others, learning and thinking together within a higher education context, are addressing that. Please get involved: go to www.mhhe.heacademy.ac.uk/burningissues. Links to a range of other resources are provided there too.

This document makes no claim to representativeness – many perspectives and disciplines are absent, key themes as yet unexplored. We hope, with your help, that sparks from these *Burning Issues* may travel. Perhaps they may kindle fires elsewhere.

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