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7 November 2002. The meeting was a call to football professionals to endorse the use of sports psychologists.

Psychologists have received a cautious reception from sports professionals (Martin *et al*, 1997). Countries like Australia and the USA have been using psychologists in sports for decades. In the UK, developments have been slower, with important changes, such as the accreditation of the British Association of Sports and Exercise Sciences, happening in the late 80s.

The involvement of psychiatrists in sports has been more anonymous, as psychiatry not only carries a stigma but is also the antithesis of *Mens sana in corpore sano* (Carranza, 1999). Society perpetuates the problem by seeing sportsmen as highly-skilled entities, rather than primarily as human beings with strengths and weaknesses. Because of this, sports professionals in need of psychiatric help usually approach services as a last resort, during the final stages of their problem.

The FA strategy should be made extensive to other sports and, ideally, implemented at all levels. It would also be desirable to consider the inclusion in the strategy of professionals such as psychiatrists, who could play not only a therapeutic (Begel, 1992) but, equally important, a preventative role. Psychiatry can also complement psychology providing clinical input, or working together in a wider strategy towards changing behaviour in the public, and attitudes related to sport in society in general.

BEGEL, D. (1992) An overview of sport psychiatry. *American Journal of Psychiatry*, **149**, 606–614.

CARRANZA, F. (1999) Attitudes of Sportsmen to Psychiatry. Hamburg: Congress of Psychiatry.

MARTIN, S. B., WRISBERG, C. A., BEITEL, P. A. *et al* (1997) NCAA Division I athletes' attitudes toward seeking sport psychology consultation: the development of an objective instrument. *The Sport Psychologist*, **11**, 201–218.

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Combination therapy

Bains and Nielssen (2003) discourage the combined prescription of a (conventional) depot antipsychotic preparation with oral atypical medications, on the grounds that there is 'no published research to support such a combination on theoretical or practical grounds'. The authors considered that 'use of atypical antipsychotics may be seen as a way of minimising distressing side-effects and also reducing the risk of developing tardive dyskinesia (by allowing the use of lower net doses of depot antipsychotic)'. Ultimately, however, they appear not to accept this approach, stating that 'none of the treating psychiatrists [in their study] offered this rationale for treatment'.

Combination therapy with an atypical antipsychotic agent can, in some poorly-compliant patients, represent the most viable way of ensuring the delivery of an effective dose of antipsychotic medication, while at the same time limiting (especially extrapyramidal) side-effects.

Moreover, some patients, while rejecting varying doses of depot antipsychotic medication, are more accepting of a fixed dose of the injected preparation, with temporary addiction of an oral agent, the dose of which can be easily adjusted according to mental state and requirements.

The scientific literature and professional guidelines recommend antipsychotic monotherapy. However, while it is accepted that this should be a standard principle in antipsychotic prescribing, there seems to be a – perhaps substantial – minority of patients for whom the combination of oral atypical and depot conventional antipsychotic appears to be more appropriate. The authors' apparent espousal of a blanket rejection of combination therapy is therefore unfortunate.

BAINS, J. S. & NIELSSEN, O. B. (2003) Combining depot antipsychotics in forensic patients: a practice in search of a principle. *Psychiatric Bulletin*, **27**, 14–16.

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the college

Prevention in Psychiatry CR104, February 2002, 94 pp, £7.50 Summary

It is a truism that prevention is better than cure, yet preventive activities generally have low priority among interventions undertaken by psychiatrists. This report aims to provide psychiatrists and others involved in the promotion of mental health and the care of people with mental illnesses with an evidence-based approach to preventive interventions.

It begins with a background section, introducing concepts related to mental health promotion and the prevention of psychiatric disorders. Prevention is then considered in relation to the different stages of the life cycle, beginning in the womb and ending with the approach of death. Life cycle chapters are provided for the prenatal period and infancy; childhood, puberty and early adolescence; late adolescence and young adulthood; adulthood; older people; and the stage of approaching death. Account is taken of the fact that the influences acting at one stage of the life cycle will impact on the rates of disorder in later stages. Further, traumatic events such as physical or sexual abuse will impact not only on the individual concerned throughout the life cycle, but on subsequent generations.

Preventive activities are then considered in relation to the different settings in which they can take place. Settings considered include the neighbourhood and the community; early years provision, school and higher education; the workplace; residential care settings; the criminal justice system and prisons; primary care settings; the general hospital; and specialist psychiatric settings. In all of these, preventive activities relevant to psychiatric disorders need to be placed and maintained on the agenda, and the report provides practical, evidence-based information on how this may be achieved.

The Working Party has tried to keep the report brief and clear. To make the material more accessible, some information has been summarised and presented in the form of bullet points. A small number of key references to each section are provided for those readers wishing to pursue the subject further.

Domestic Violence

Council Report CR102 April 2002, £7.50. 44 pp.

This policy statement on domestic violence was produced by a working group under the chairmanship of Dr Gill Mezey. The following are the key points:

- Psychiatrists need to have a working knowledge of the aetiology, effects and range of interventions available for victims of domestic violence.
- Domestic violence, that is the physical, sexual or emotional abuse of an adult victim by an adult perpetrator in the context of an intimate relationship, occurs in around 23% of women and 15% of men over their lifetime.
- Women are more likely to sustain physical injuries than male victims, they are more likely to experience repeated assaults and they are more likely to report emotional distress or fear as a result of the violence.
- Domestic violence is associated with psychiatric illness, including depressive

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disorder, suicidality, anxiety, alcohol or drug misuse and post-traumatic stress disorder.
- Because of the association between domestic violence and poor mental health, enquiry about domestic violence in the past and present should be included as part of the clinical assessment of all patients (men and women) and families.
- Victims are unlikely to disclose domestic violence spontaneously to health professions and should be specifically asked.
- Routine questioning of patients about domestic violence experiences has been found to be acceptable to, and indeed welcomed by, patients.
- Attempting to leave increases the danger for the woman and is likely to precipitate an escalation in the violence against her.
- Psychiatrists need to be aware of the severe and enduring effects of domestic violence on children and its association with child abuse.
- All reported cases of domestic violence require a risk assessment.
- Key interventions include: establishing the victim's safety, treating mental illness, providing information about local resources and assessing current and future risk.
- Psychiatrists should also be familiar with treatment and approaches, resources and risk assessment for perpetrators.
- Specific training on domestic violence at pre- and post-membership should be introduced into the curriculum and continued through professional development.

obituaries

Brian Ward

Formerly Medical Superintendent, Winwick Hospital

Born in Dewsbury, Yorkshire, Brian qualified MB ChB (Manchester) with three distinctions in his finals. He worked for several Manchester hospitals in his early years and was then appointed area psychiatrist for the Northern Command of the armed forces. His career developed further when he became the senior registrar at the Department of Psychiatry in Leeds and then again with his appointment as the medical officer for the Leeds Regional Hospital Board (1960–1964), with responsibility for provision of psychiatric and elderly care for the Yorkshire area. He was also involved in the planning of Airedale General Hospital. At 35, he was the youngest ever NHS appointee to the position of medical superintendent of Winwick Hospital in Cheshire. He was elected FRCPsych in 1972.

For 25 years, between 1963 and 1987, Dr Brian Ward was the Medical Superintendent of Winwick Hospital, then the Chairman of Psychiatry in Warrington, leading the largest mental institution in Europe in the 1960s, 70s and 80s. Brian masterminded, with a great and rare combination of compassion, wisdom, vision and leadership, the process of 'running down' Winwick asylum, which accommodated over 2000 psychiatric in-patients. By the time of his retirement, the size of Winwick asylum in Warrington was reduced by over 50%. This was done with the least possible distress to patients and carers, to whom he was so devoted. The closure of Winwick Hospital was finalised, but not without difficulties 10 years after he retired.

Brian was very active in both the Royal Medico-Psychological Association (RMPA) and the early days of the Royal College of Psychiatrists. He was secretary of the North West Division of the RMPA and later the same division of the College until 1975. He was secretary of the College Public Policy Committee from 1983 to 1986. His medical administrative expertise was shown at a College meeting in 1974, when he presented, together with Julian Leff, a report on 'Confidentiality and Medical Records'. His views continued to be sound, relevant and true.

At home, Brian was a great 'do-it-yourself' man and one of his favourite pastimes was maintaining and overhauling the 'vintage' fleet of Triumph Standard cars that he loved. He was immensely practical and inventive, but his main joy was music. He was an accomplished musician and began playing saxophone and clarinet at the age of 13. He led and played with a band at prestigious events country wide. His favourite music was jazz: his band had a huge repertoire, ranging from the Glenn Miller variety through to present day hits. Even when his illness prevented him from attending recent bookings, he continued to write and put together the musical programme for each event.

Brian died peacefully on 12 October 2002 aged 75, after a long illness that he endured with courage and dignity. He leaves his wife, Joan, daughter Barbara and son Richard.

Emad Salib and **Janet Connah**

Dr Gabrielle Maria Kearney

Formerly Consultant Psychiatrist, The Hesketh Centre, Southport, Merseyside

Gabrielle Kearney, Consultant Adult General Psychiatrist, died at a local Hospice aged 42. She was a compassionate woman who will be greatly missed by family, friends and colleagues.

Born in Liverpool in 1960, Gabby, as she was always known, attended Notre Dame High School in Woolton. She studied Medical Microbiology at the University of Dundee, gaining a BSc (Hons) in 1984. She remained in Dundee to study medicine, qualifying in 1987. After completing her pre-registration year, she was appointed to the North Staffordshire/South Cheshire Psychiatric Training Scheme based at the Department of Postgraduate Medicine, University of Keele. She was elected MRCPsych in 1991 and joined the North Wales Higher Psychiatric Training Scheme in August 1992.

Gabby took up post as a full-time Consultant Psychiatrist in Southport in January 1996, and continued working at the Hesketh Centre until shortly before her death. She was involved in providing

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