

RCPsych

INSIGHT



Contents

4-5

Doing digital right

Why new investment in technology is needed

6-7

2020: A hard year

Faculty heads reflect on the last 12 months and what's to come

8-9

Meeting in Bethlehem

RCPsych-supported Palestinian trainees on the obstacles they face

10-11

Lifesaving learning

Improving training on eating disorders for all doctors

12

Physical matters

Increasing physical health checks for people with severe mental illness

13

Women in mind

Celebrating 25 years of the Women and Mental Health Special Interest Group

14-15

Centred on jobs

Why rising unemployment is an issue for psychiatrists

16

Altering perceptions

Is it time for drug policy reform?

17

An important test

We hear why migrating exams online mattered

18-19

Help at the end

Exploring the needs of people coping with terminal illness

20

Tapping into talent

Introducing the Association of Black Psychiatrists-UK

COLLEGE NEWS IN BRIEF



Professor Nandini Chakraborty

Professor Subodh Dave

Dr Chris O'Loughlin

Dr John Russell

Cast your votes

Two important elections for RCPsych officers are taking place over the holiday season. Voting is now open for members, fellows and specialist associates to choose who will be the next College Dean and Treasurer.

Four candidates are standing to become Dean (*above, from left to right*): Professor Nandini Chakraborty; Professor Subodh Dave; Dr Chris O'Loughlin; and Dr John Russell. A further three

people have put their names forward to become College Treasurer (*below, from left to right*): Dr Lenny Cornwall; Professor John Crichton; and Dr Anand Ramakrishnan.

Written statements from all the nominees outlining their qualifications and ambitions for the posts are available on rcpsych.ac.uk. Voting closes at noon on 13 January and a link to the ballot has been sent to your email registered with the College.



Dr Lenny Cornwall



Professor John Crichton



Dr Anand Ramakrishnan

Writing history

RCPsych is seeking submissions to its 'Future Archives' competition, which is part of the College's 180th anniversary celebrations next year. Whether it's a piece of prose (up to 1,000 words), poem, comic, or even a piece of music or film, the College is seeking your views about what mental health practices, politics, services and research were like in 2020 and 2021.

The aim is to create an archive that ensures people in the future will have access to all sorts of perspectives on what psychiatry is like today. The competition is open to all – psychiatrists, students, GPs, nurses, campaigners, patients and carers and anyone else interested in mental health. Search 'Future Archives' at rcpsych.ac.uk for details. The closing date is 30 April 2021.

Spending plans

Calls by the College for more funds for mental health have been heard inside government, at least in part. In his November Spending Review, Chancellor Rishi Sunak committed to investing £500m to tackle waiting times in mental health services. This will make a real difference to those already waiting too long for treatment and lead to fewer people ending up in crisis.

While more needs to be done to update the mental health estate, the £415m in the Review for replacing outdated dormitories with single en-suite rooms is also a welcome step towards parity. There is also money to support patients at home after they leave hospital; for pilots helping people with multiple complex needs; for green social prescribing projects; and for initiatives helping to reduce loneliness and support the homeless.

The College is disappointed, however, that the government did not commit to increasing the Public Health Grant budget, at least in line with the funding uplift for NHS England's budget. As a result, public mental health and addiction services, already facing unprecedented demand, are likely to be put under even greater strain, with devastating consequences in communities. Likewise, the promised £1bn in social care is not enough to cover the huge surge in demand for care services that we're seeing as a result of the pandemic.

While new spending is welcome, it is not a long-term solution. The mental health crisis, made worse by COVID-19, can only be tackled by serious, sustainable investment in services for years to come



President's update

A warm welcome to this issue of *Insight* in what has been a very challenging year for all of us. I want to say a big thank you to our members who have done incredible work supporting our patients, as well as one another.

As we cope with this second wave, the College is here to provide support. We have lots of resources on our website to help you and your patients navigate this difficult period. In all our interactions with policymakers, we have made sure that people with mental illness and those who work with them are prioritised in terms of funding, vaccination and test and trace. We have also continued to support our trainees through the digital exam.

This is also a time to celebrate achievements. This issue highlights the incredible work of women in mental health and the new Association of Black Psychiatrists.

I wish everybody the best for the festive season, and I hope that all of you will get the chance to rest. I am optimistic that 2021 will be an opportunity for renewal in how the College operates and how we go about our lives in a more equal and sustainable way.

Dr Adrian James



Hundreds of psychiatric trainees sat the College's first ever online CASC in September. See more on p17.

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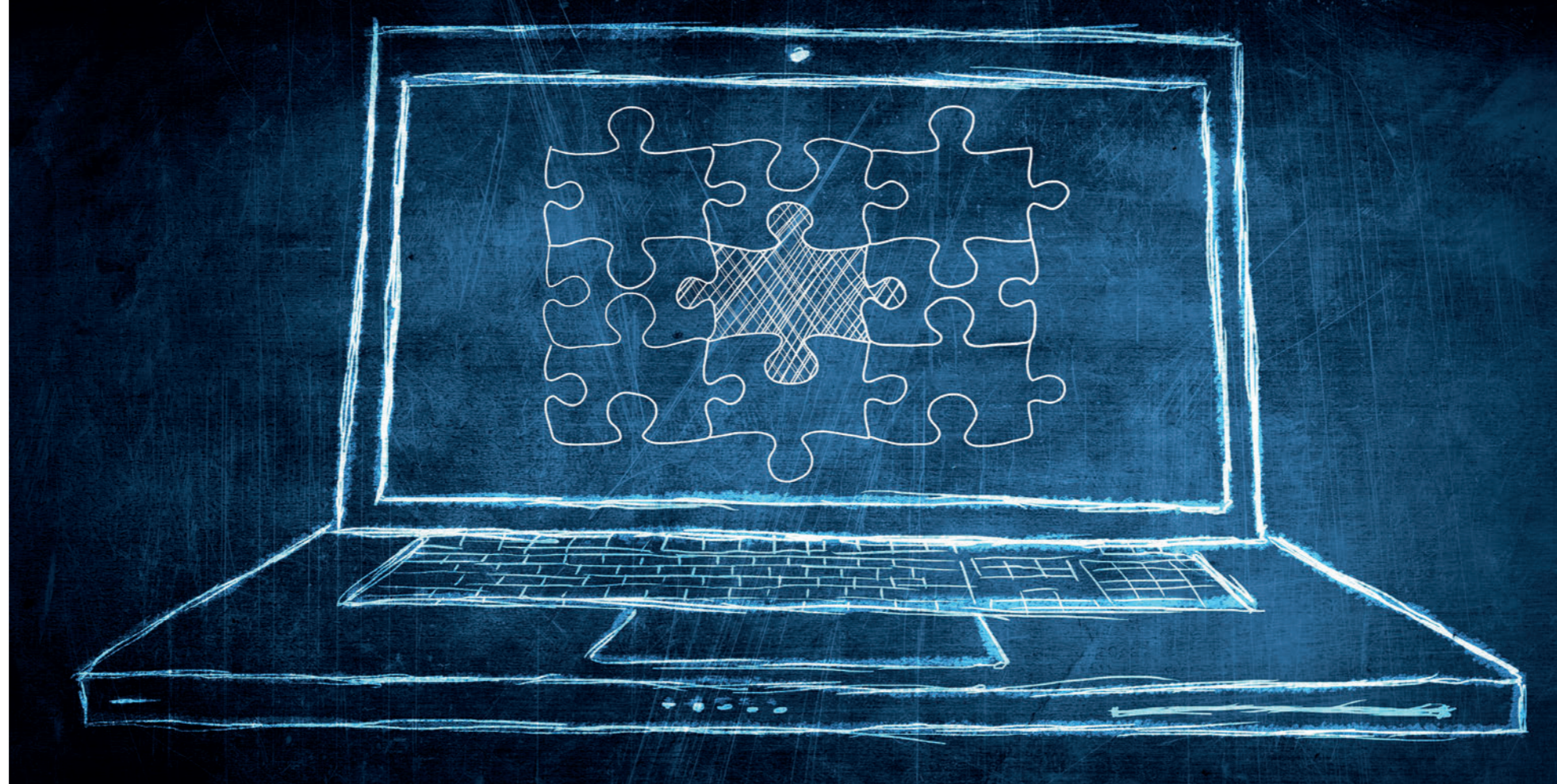


RCPsych Insight is a magazine for you, our members. As such, its aims are: to give you a window into just some of the activity that the College undertakes on your behalf; present a range of views, including from academics and people with lived experience, on the many issues that affect your practice and the profession; and reflect the diverse experiences of psychiatrists, from trainees to international volunteers.

Do you have ideas for topics we should cover, or psychiatrists or projects that we should profile? Would you like more articles on policy, practice or pioneering psychiatrists? Similarly, are there aspects of the profession that we have neglected to cover, or voices that are missing?

Insight is your magazine. So, we would love to hear your views and ideas, and ensure that it reflects your professional experience. Please get in touch with the magazine team either by email (magazine@rcpsych.ac.uk) or via Twitter (using #RCPsychInsight).

Dr Santosh Mudholkar,
Associate Registrar for Membership Engagement



Doing digital right

Since the beginning of lockdown, mental healthcare IT systems have come under strain as remote consultations have become the new normal. That's why RCPsych is calling for new investment in digital technology.

The sudden switch to digital technology in the wake of COVID-19 is proving to be a challenge. A survey conducted by RCPsych earlier this year found that while almost two thirds (64.2%) of College members in England reported being 'fully' or 'well' equipped to carry out their duties remotely, 15% said they were unequipped to conduct some or all of their work. One respondent said: "IT infrastructure has been very poor and impacted on clinical care." Another reported that their hospital mobile phone reception and internet connections

"The emotional side of things can be more difficult to interpret"

"belong to the 20th century". Inadequate hardware is not the only problem. Dr Hashim Reza, RCPsych's Specialist Advisor for Health Informatics, points out that different software is in



Dr Hashim Reza

use in different parts of the healthcare system around the country, meaning that record-keeping and information-sharing is often a cumbersome process. Community clinicians are spending over a third of their time on paperwork, more than they are on direct patient care.

In September, RCPsych published a report, Next Steps for Funding Mental Healthcare in England, which sets out a series of recommendations for investment in digital technology. Among other things, it calls on the government and the NHS to invest £135m in IT infrastructure in mental health trusts by 2024/25. And it supports Dr Reza in calling on the NHS to take the lead in working towards "making IT systems interoperable between all health providers, primary and secondary care, and between themselves and providers of social care".

Meanwhile, psychiatrists and their patients are finding that the new way of working has both benefits and drawbacks. One disadvantage with video consultations, says Dr Reza, "is not getting the non-verbal cues clearly enough. Even if I bought a high-definition camera and everything, I wouldn't really be able to pick up the nuances that I can detect when the person is in the room".

Dr Ken Courtenay, chair of RCPsych's Faculty of the Psychiatry of Intellectual Disability, agrees. "Assessing people can be

a bit more of a challenge. When they're with you in the room, you get a better feel for their mental health and how they're presenting. Whereas if you're doing it across a screen, the emotional side of things can be more difficult to interpret. Some people with an intellectual disability rely on non-verbal communication and that may not come across fully to the clinician in a remote consultation. So the person could be sitting there looking quite happy. But in fact, you might not see them wringing their hands."

On the other hand, says Dr Courtenay, one of the benefits of remote working "is that you can actually have regular contact with people, even at short notice. And it may be helpful not having to travel, which can be an issue – if the person doesn't want to go, for example, and staff really have problems getting them to attend. But the person might be quite happy to just see you on the screen, knowing that they have more control and can switch you off. In contrast, attending in-clinic consultations can make it more difficult for them to get out the door."

Dr Reza agrees: "A lot of reviews can be done much more frequently, promptly and over a shorter duration of time, through focused conversations using electronic platforms."

There remains the problem of exclusion, though: not everyone has access to digital technology or has the requisite skills or confidence to use devices such as computers or tablets. People with dementia, cognitive impairment or intellectual disability are all at risk of being disadvantaged. Support from care staff can make all the difference, but they, too, may not always be adequately trained. RCPsych's Next Steps report calls on clinicians and managers to develop strategies for mitigating any inequalities arising from the use of digital technology.

But it is also important not to make assumptions: psychiatrists in old age mental health services report that a significant number of older adults are able to access video consultations – with support from friends and family. Dr Reza refers to work done pre-COVID with young people, who, when surveyed by clinicians, "were found to prefer to have the first consultation face to face because they want to suss you out. I think we risk being disrespectful and probably patronising to our service users," he says, "insisting it has to be digital first, I think we need to give them choice."

The same applies to clinicians. In another survey, 81% of RCPsych members in England said they wanted to return to face-to-face consultations being the default, with digital tools available where appropriate. However, with parts of the country still experiencing high rates of the virus, that day could be some way off.

2020: A hard year

Psychiatrists have had to respond to enormous changes in how they work, services have been put under strain or paused, and the pandemic has impacted on the mental health of patients and the wider population. Here, some of RCPsych's faculty heads look both back on the last 12 months and forward to what comes next.

Old age

Older people have suffered with lockdown and shielding restrictions, with loneliness, isolation and grief from the loss of loved ones leading to significant mental health problems. Reductions in formal community support have been a cause of significant worry, and memory clinics were also initially affected as face-to-face contact was limited and staff redeployed.

The Old Age Faculty webinar held in May addressed some of these issues, including around remote consultations, and future online events are planned on topics such as the impact of COVID-19 on the management of functional mental illnesses in older people.

Looking forward, we urge RCPsych members to engage with their employer organisations and get involved in the new transformation plans shaping community mental health care.

These should include better access to psychological therapies and a 24-hour crisis service for older adults. And with the WHO's new 10-year action plan on ageing and health providing a positive backdrop, we are convinced that our learning from the pandemic will influence changes that will improve the mental health of older people.

**Dr Mani Santhanakrishnan and
Dr Josie Jenkinson**

Liaison

It's been a hard year for all of us and the specialty has striven to continue delivering care to our patients while rapidly changing the way we work, whether that's communicating through masks, managing safe distancing or getting set up for more remote working where practical. Many of us have also been involved in establishing



and running off-site mental health crisis assessment units, which has taught us to work in new ways.

As a Faculty, we took the tough decision in March to cancel our annual conference, but hugely popular weekly liaison webinars have since been ably co-led by the Faculty's service user representative. One of the things we are most proud of is the way we have committed to coproduction with experts

by experience: all of the Faculty's COVID-19-related guidance has had service user and carer input.

Working through the pandemic has further demonstrated the imperative for integrating physical and mental health care and I'm confident that we can continue to adapt and lead change while preserving the core and quality of what we do.

Dr Jim Bolton and Dr Annabel Price



Addictions

From the first week of lockdown, community addiction services faced the challenge of delivering opiate substitution therapy to thousands of people who were no longer able to collect their medicine daily. Many staff in hospital alcohol teams were also redeployed. The Faculty quickly made sure guidance was available to help non-specialist staff in acute and mental health services manage complex, co-morbid patients.

Across the general population, more people consumed alcohol at higher levels and, as lockdown eased, services saw an increase in the number of referrals for alcohol problems. At the same time, community services' ability to offer medically assisted withdrawal was reduced to almost zero – and continues to be very limited. With only five NHS inpatient addiction units left in the country, the options for people in need of treatment are limited.

The future could be brighter, though. With the publication of Dame Carol Black's recommendations for addiction services due before the end of 2020, we see a big opportunity to ensure addiction services are properly funded, to fix the broken commissioning model and to bring the clinical part of treatment back into NHS hands.

Professor Julia Sinclair and Dr Emily Finch

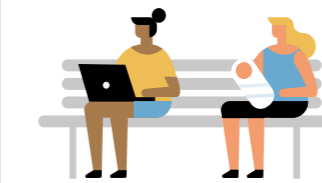
Perinatal

Expectations surrounding a birth have been turned on their head by the pandemic: expectant mothers shielded and some experienced isolation; partners were excluded from key moments and family visits banned; and there have been no routine home visits to offer help in those early days. The emotional impact, including on babies born during this period, shouldn't be underestimated.

Mothers with pre-existing mental illness still needed specialist help and some became seriously ill during the pandemic, requiring admission to mother and baby units. Here too, contact between women and their families has been limited, which can be detrimental to mother and child.

Adapting to the changes, community teams learned very quickly how to work remotely using video consultations and telephone reviews. For some very rural or anxious mothers, this remote working has been positive, but we have concerns about some of the limitations of video consultations, including noting a woman's physical health, ensuring she can speak freely and confidentially and observing the mother-baby relationship. Perinatal psychiatrists continue to create the safest, kindest and most family-focused care possible under the current restrictions.

Dr Joanne Black and Dr Cressida Manning



Child and adolescent

COVID-19 has presented additional challenges to already overstretched services. The latest figures show a surge in probable disorders, and we are concerned about additional economic impacts from the pandemic and the effects of lockdown on children in families where there may be violence or abusive situations. Cuts in other support services are also impacting on children and young people, contributing to crisis presentations and difficulty in discharging from inpatient units, particularly for the most vulnerable.

In response, services have moved rapidly to using technology, which is often a huge advantage in some situations and helpful to families who may struggle to attend in person. Increased technology use among young people, however, has given our RCPsych paper on the potential harms of technology more urgency and we are consulting with OFCOM on regulation.

The year ahead brings ongoing concerns about demand, capacity and funding. This requires investment in prevention, particularly for the under 5s, working with parents with mental illness and investing in support before children and young people fall into crisis.

Dr Bernadka Dubicka and Dr Jon Goldin

Mental health disorders constitute one of Palestine's most prevalent, but least acknowledged, health problems. After decades of conflict, displacement and poverty, a third of its population of 5 million are thought to need treatment for mental illness. Stigma, however, is a big issue and religious beliefs lead some to seek relief from faith healers rather than mental health services.

Stigma has also contributed to a chronic shortage of psychiatrists, especially women. Right now, there are only five psychiatric trainees in total in the whole of Palestine, all undertaking four-year residencies at the Bethlehem Psychiatric Hospital in the West Bank, an adult inpatient centre with four psychiatrists treating only patients with the most severe psychiatric conditions.

Dr Shefa' Ballout and Dr Saja Alkhdour are final year trainees who hope they can bring much needed change to Palestinian mental health services and attitudes. When they qualify, they will need to go into the community equipped with the skills to treat common disorders.

To broaden their knowledge of mental health conditions, they and their fellow trainees have received supplementary training and mentorship from RCPsych through a project facilitated by British charity Medical Aid for Palestinians.

Alongside fellow technical partners Georgetown University and George Washington University in the US, the College provides supervised twice-monthly online sessions on topics from geriatric psychiatry to self-harm and anxiety disorders, as well as giving the trainees access to its vast online resources through Trainees Online (TrON) and free pre-membership psychiatric trainee registration. Two trainees are also paired with RCPsych mentors – both bilingual English and Arabic speakers – for twice-monthly sessions where they can discuss any ethical, clinical or personal dilemmas they face.

Professor Mohammed Al-Uzri, the College's Presidential Lead for International Affairs, says: "The project provides a unique opportunity to support colleagues training in psychiatry in challenging environments with limited resources. The benefit is mutual



Dr Shefa' Ballout



Bethlehem Psychiatric Hospital



Dr Saja Alkhdour

Meeting in Bethlehem

Two trainees from Palestine discuss the huge obstacles faced by the state's mental health services and how an RCPsych project is helping.

"We feel we aren't alone in dealing with mental suffering among our people"

as the College volunteers gain valuable insight into delivering mental health care in different cultures that will ultimately help us provide better care in the multicultural UK."

Both Dr Ballout and Dr Alkhdour describe the project as hugely beneficial, both to their training and ultimately to the Palestinian people.

"We feel we aren't alone in dealing with mental suffering among our people," says Dr Alkhdour. "This project has given us great access to knowledge, mentorship and possible future opportunities to continue our progress in this specialty."

"With no structure and few residents, it was always challenging to organise any educational activities," says Dr Ballout. "The project has been a great help – filling a gap in our residency programme."

Dr Ballout decided to specialise as a psychiatrist during her last year at medical school when certain incidents from her first clinical rotation in psychiatry stuck in her mind. In particular, there was an eight-year-old boy who was being wrongly treated for ADHD without ever being examined in person by a psychiatrist. "When he was seen

for just three minutes, again he was wrongly misdiagnosed – or stigmatised, even – with mental retardation!" she recalls. "I began to consider psychiatry more seriously after that."

Her mind was made up during an internship year at the Bethlehem Psychiatric Hospital where Dr Ivona Amleh, its then medical director, was supportive and encouraging.

While Dr Ballout's career choice was encouraged by her family and friends, mental health is still very much stigmatised for patients and mental health workers alike.

"A large percentage of the population prefer to go to traditional healers and it is much more acceptable for them to attribute their mental complaints to Jinn [supernatural beings] than to psychiatry and psychology," says Dr Alkhdour. In the village she is from in Hebron, she says, "a young man was tortured to death by a medicinal healer, while another man with PTSD died by suicide".

"Because of chronic, lifelong and transgenerational traumas, especially from the occupation, our community is used to

denying or minimising symptoms. While this in part increases resilience, it has a negative effect on the vulnerable who don't realise they, their children or relatives actually have a mental illness."

Dr Alkhdour sat the United States Medical Licensing Exam with a view to studying in Qatar and says the exam "opened her eyes to the core knowledge of psychiatry".

But her career choice was met with opposition from her parents, relatives and even doctors. Some claimed her patients would literally drive her insane. Her parents were eventually talked round and she took up a residency at the Bethlehem Psychiatric Hospital.

Work there is challenging and dangerous for the psychiatrists dealing with the most severe cases, including PTSD, severe OCD and schizophrenia. "In recent years, we've started seeing more patients with personality and substance use disorders admitted for their aggressive behaviour and on occasion, they have threatened us, but we receive little support," says Dr Ballout.

"Most days, just one doctor will be on call for 28 hours for an entire hospital spread across five buildings which can be quite exhausting. But ultimately, treating someone successfully is really rewarding."

A lack of research means there is very little data on the types of mental health disorders that ordinary Palestinians

experience, but Dr Alkhdour is certain that trauma-related psychiatric symptoms and disorders are common.

"There is a lack of continuous services for people who suffer from the consequences of trauma," she says. "Sometimes they reach our hospital with referral from outpatient psychiatrists, when actually our hospital is not the proper place for them, especially if they suffer from PTSD related to imprisonment."

Both women are hopeful that psychiatry is slowly bringing about change in mental health awareness among the Palestinian people and leading to less stigmatisation.

Dr Alkhdour, who, after qualifying, hopes to work abroad training in trauma, women's mental health and psychotherapy, has started writing about topics such as stigma on social media and blog sites.

"I've had a promising response from doctors who've become more interested in psychiatry and especially from younger generations realising how common mental disorders are and how important psychiatric intervention is," she says.

Despite the endless challenges, with the extra support from the project, Dr Ballout too remains hopeful that change will happen. "At this point, I can say I have no regrets, it was the right call to join psychiatry, and we'll be working to make the difference we came for," she says.

Lifesaving learning

Why training on eating disorders is a must for all doctors, not just specialists.

In November 2020, following inquests into the deaths of five women with eating disorders in Cambridgeshire and Peterborough, the assistant coroner called for improved eating disorders training among healthcare staff.

"[The news] hit me hard," says Dr Agnes Ayton, a consultant psychiatrist at the Cotswold House Oxford Eating Disorder Service and chair of the Faculty of Eating Disorders. "It is difficult to be positive when you see that people continue to die from a disorder which can be treated effectively."

In 2017, the Parliamentary and Health Service Ombudsman published a report – which drew on research by the Faculty – on eating disorders in medical training. The report found there was a serious lack of training for doctors on eating disorders.

"Quite often, when patients with severe eating disorders present with a life-threatening emergency, there is a lack of knowledge and confidence in doctors on how to treat these patients safely," Dr Ayton says. A new book published by the Faculty's executive committee called *New to Eating Disorders* is part of their efforts to address this. The book provides structured frameworks for clinical supervisors who have limited experience working in this area.

In October 2020, Dr Ayton and colleagues also released a position statement to attack the problem at a system level. Among its recommendations are improvements to eating disorders training in medical undergraduate and postgraduate education. RCPsych is now working to enhance training in this area for medical students and junior

"Changing medical education is really about changing hearts and minds"



Dr Agnes Ayton

doctors through their curriculum revision.

Dr Ayton adds that there are other inexpensive and easy ways to increase knowledge. For example, "if we introduce the topic of eating disorders into life support training, then all doctors will

know about them. Eating disorders are a lot more common than anaphylactic shock, and we teach anaphylactic shock every year to all doctors. So, why not teach eating disorders for 20 minutes?"

Dr Ayton also recommends the introduction of eating disorders psychiatry credentialing. This would provide an additional training structure to ensure that all specialist psychiatrists are competent and sufficiently trained for the field in which they work.

"Changing medical education is really about changing hearts and minds," says Dr Ayton, "but it kind of feels like trying to turn an oil tanker."

She argues that many people do not recognise the scale of the problem. One reason for this, she explains, is that "many people who don't work in this area believe that it is a rare condition because a lot of the time people don't seek help and are brought to services in a life-threatening situation."

There are also very high thresholds for hospital admission, a factor that was a point of distress for Lorna Collins, an artist, writer and peer support worker for Oxford

Health Foundation Trust. She developed an eating disorder aged 18, following a traumatic brain injury, and spent the following 19 years as a "revolving-door patient" with repeated admissions to acute wards and eating disorder units. Collins explains how she would try to lose even more weight after being told that she was not thin enough to meet the admission threshold. It seemed that the only way to get help was to lose weight.

"It's really hard to get into an eating disorder unit," says Collins. "It's like having to pass an exam because places are so few that eating disorder units can't allow patients to be admitted unless they're about to die from malnutrition. So, it became a competition – a destructive competition – how thin can you get to deserve treatment?"

"When I was finally admitted, I was distraught – thinking I didn't deserve treatment because I wasn't thin enough. Each time I was discharged, I was conditioned to relapse because I was either still severely underweight or faking my weight by water loading. In no way was I physically or mentally well."

Things finally changed for Collins in 2017 when she was admitted to Cotswold House Oxford Eating Disorder Service. There, the care

she received addressed the multiple layers of her illness, including her comorbid mental disorders and the impact of her brain injury.

This outcome isn't a given. "I've seen and known at least seven fellow patients who have died," she says. "That fact is as horrifying as it is potentially avoidable."

Collins attributes her recovery to the holistic care she received. "It's not just about weight; people need help even if they aren't about to die from malnutrition," asserts Collins. "[During treatment], I built tools to be well, and I did that through my art and my creativity... I was able to imagine what I could be, something I could not do before."

Collins' story is all too common. There has been no population-based study to estimate UK prevalence rates. Still, international data suggest the lifetime prevalence of anorexia nervosa is 0.5%, bulimia nervosa is 1–2% and binge-eating disorder is 2–3%. "Do you have another disorder which affects 6% of the population but is so neglected?" says Dr Ayton.

Stigma is part of the reason why change has been slow. "With eating disorders, we have this myth that this is a lifestyle choice by spoiled rich girls and that people

will grow out of it," Dr Ayton adds. "But it affects people across their lifespan; it affects all genders."

Admissions for eating disorders are up for all ethnic groups, but there is a notably large rise in admissions for people of mixed and Pakistani heritage. The data suggest that certain ethnic minority groups may face additional barriers to care, which Dr Ayton argues is worsened by the underfunding of eating disorder services.

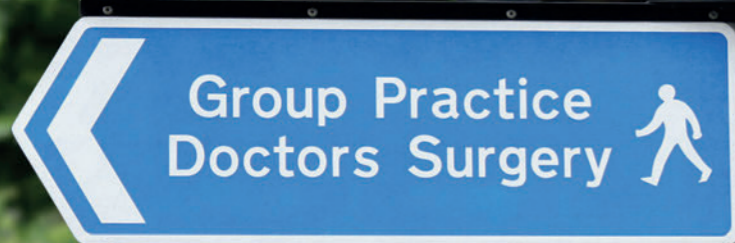
"The chronic underfunding of the service is discouraging people from seeking help even though we have evidence-based treatment which would be helpful," says Dr Ayton. "Let's say I have bulimia, and I spend about five years deciding whether to seek help for this or not. Then if I am faced with another 18 months of waiting time, I will say, 'Well, what is the point?'"

In the absence of more funding for services, better training is crucial. Dr Ayton stresses the urgency of the situation. "We need to have action, rather than wait another three years for further tragedies."

"We know what needs to happen," says Ayton. "So, let's do it."



Lorna Collins, peer support worker



Physical matters

To tackle the disproportionately poor physical health outcomes among people with severe mental illness, we examine the challenges of supporting this group and increasing their uptake of annual health checks.

It is a truth too often unacknowledged that people with severe mental illness (SMI) die on average 15 to 20 years sooner than the general population. Two thirds of those premature deaths, according to estimates from NHS England (NHSE), are from physical illnesses that can be prevented, such as cardiovascular disease, respiratory disease and hypertension. Rates of smoking are much higher among people with SMI, as are cases of undiagnosed type 2 diabetes. And yet, annual health checks for people with SMI are the exception rather than the rule.

As part of the *Five-Year Forward View for Mental Health*, published in 2016, NHSE expects Clinical Commissioning Groups (CCGs) to ensure that 60% of those on the GP SMI register – 280,000 people – receive a “full annual physical health assessment and appropriate follow-up care”. It’s proving to be a difficult goal to reach.

“It’s really important to continually bang the drum”

“We were one of the very few CCGs that just about hit the 60% target last year,” says Dr Angela Moulson, associate clinical director of mental wellbeing at Bradford & Craven CCG in West Yorkshire. It has taken four years of hard work to get there.

It’s a similar story in north-west London: “This is work we have gradually embedded over four to five years,” says Dr Annabel Crowe, Chair of Hounslow CCG. “We’re one of the top in the country, but we’ve still only reached 60% of the local SMI population.”

Bradford and Hounslow have supplied local GPs with a digital template that prompts them to complete a range of health checks – including BMI and blood pressure measurements, tests for blood glucose and lipid levels, and records of alcohol intake and smoking. It also prompts them to start making a recovery and stay well plan. GPs receive a fee for each patient with SMI who receives such an assessment.

But it’s not always easy to get people to attend a check-up. “They may not come because they’re anxious,” says Dr Crowe, “and they may be quite severely disabled as well. Financial incentives on their own don’t make this happen.” Often, what GPs really need is time and confidence that they can have an impact, which is why Hounslow has set up an enhanced GP service to give them just that.

In Bradford, the CCG works closely with the local voluntary and community sector to get across to people with SMI the importance of regular physical health checks and to provide support in attending appointments. “We have found peer support to be very effective,” says Dr Moulson.

However, the virus has meant that progress has stalled. In March, Hounslow had its most successful month ever, reaching 64% of the local SMI population, but things have since gone backwards. It’s the same in Bradford. “It was all going swimmingly,” says Dr Moulson, “but then COVID intervened.”

For Dr Peter Byrne, RCPsych’s lead for public mental health, the failure of so many CCGs to meet what he says is a “modest target of 60%”, even before the pandemic, is a sure sign that things aren’t working. More work is needed to increase the take-up of physical health checks, but there is also a need to tackle wider inequalities in society. “Poverty is the biggest killer,” he says.

Dr Byrne highlights the work of Equally Well, an organisation that seeks to promote and support collaborative action to improve physical health among people with a mental illness. Hosted by the Centre for Mental Health, it is supported by many of the royal medical colleges, including RCPsych, and is run jointly by an expert-by-experience group and a clinical group chaired by former RCPsych president Professor Wendy Burn.

Equally Well has published a charter for equal health that includes a rousing call for action. NHSE expressed an interest in their work during a recent conference call with RCPsych President Dr Adrian James.

A renewed national effort is clearly needed. As Dr Crowe says, “It’s really important to continually bang the drum, because the minute you start, the number of checks goes up a bit. And when you take your finger off, they drift away again.”



Women in mind

As RCPsych’s Women and Mental Health Special Interest Group celebrates its 25th year, its co-chairs talk about the history of the group, how it has adapted during the pandemic and their plans for its future.



Dr Beena Rajkumar

“Solidarity and sisterhood can help you get things done”

At the beginning of 2020, members of the RCPsych Women and Mental Health Special Interest Group (WMHSIG) had no idea that its 25th anniversary celebrations would be waylaid by COVID-19, but they remain determined to mark the occasion.

Coordinating the events are Dr Beena Rajkumar and Dr Ruth Reed, who have co-chaired the group for the past two years. It’s appropriate that the role is shared as it was the need for flexible work arrangements that motivated the creation of the group.

“In 1994, I was unable to negotiate part-time working or job sharing in my consultant post after I had my fourth child,” recalls the group’s founding chair, Dr Anne Cremona. “Although part-time consultant posts or job sharing were possible, they were very rare. I was determined to improve the situation and, with support from the College’s first woman president, Dame Fiona Caldicott, I set up the Women in Psychiatry SIG.”

As well as advocating for better services for female patients, the group began by championing flexible working for women psychiatrists and ensuring practical changes were made. “It set up a job-share register and offered support to female psychiatrists who had gender-related problems at work,” explains Dr Cremona.

The remit of the group expanded over the years with the focus, in the 2000s, on promoting single-sex inpatient services and the needs of women patients in secure services. More recently, WMHSIG has worked with RCPsych on issues such as domestic abuse and, at the same time, ensured the voices of women psychiatrists are heard within the College.

Raising public awareness of the issues that affect women’s mental health is another central aim. In 2015, the group, then chaired by Dr Nicola Byrne, began an ongoing series of public events – Women in Mind – in partnership with the Institute of Psychiatry, Psychology and Neuroscience at King’s College London featuring politicians, artists and other prominent women. This year saw an online discussion with psychotherapist Susie Orbach and comedy writer Abigail Burdus on the effect of quarantine on women’s sense of self.

COVID-19 has brought extra challenges to women’s mental health, such as the shift to homeworking and the division of labour. “The unequal distribution of caring responsibility remains very significant,” says Dr Reed. “Helping people of all genders to access opportunities for a different work-life balance is in everyone’s interest.”

Lockdown also saw a rise in domestic violence. Dr Rajkumar explains that one of the main focuses of the group is trauma-informed care and creating awareness around domestic abuse and sexual violence. The group has a domestic violence working group and has raised these issues in the media and contributed to the College’s view of the Domestic Abuse Bill.

COVID-19 has also brought unexpected positives. Events have become less London-centred with a more accessible online platform, and the committee has members from Glasgow to Cornwall representing a broad range of the profession, including trainees who run the group’s Twitter account (@womeninmindUK).

With a membership of more than 3,000 behind them, Dr Reed and Dr Rajkumar want to see more recognition of women psychiatrists’ achievements, whether this is with the National Clinical Excellence Awards – where women are dramatically under-represented – or in leadership roles. Dr Reed says: “People can feel unable to apply for leadership roles when they work part time, and employers need to be creative about opening up these roles.” They also plan to give the winner of the group’s essay competition a ‘visibility reward’, such as a place on the panel at the group’s annual conference, as well as a financial one.

To mark its quarter century, WMHSIG is planning a celebration of ‘25 women psychiatrists’. These will be unsung heroes of the profession nominated by members, as Dr Rajkumar explains: “We want to celebrate frontline women psychiatrists who don’t have a platform, and women psychiatrists from all grades and different backgrounds.”

With ‘Empowering Women in Society’ as the theme of its annual conference that took place in early December, WMHSIG is thriving. As Dr Rajkumar says: “Solidarity and sisterhood can help you get more things done. Women coming together is very important; we are wired that way.”



Dr Ruth Reed

Centred on jobs

While our collective focus has rightly been on saving lives, the pandemic has created other serious problems, among them levels of unemployment not seen in the UK for decades. What role can psychiatrists play in preventing this from impacting on mental health?

Delivering his Spending Review last month, Chancellor Rishi Sunak warned that the “economic emergency” caused by COVID-19 had “only just begun”. Hundreds of thousands of people have been laid off since March as lockdown and social distancing measures hit businesses, with the number of jobless now standing at about 1.6 million. This is predicted to rise to 2.6 million people by the middle of next year.

“We need to recognise that COVID-19 has an impact beyond the disease itself,” says Dr Trudi Seneviratne, RCPsych Registrar. “The pandemic has meant people have lost jobs and the social contact that goes with that, and for many the government support offered is not enough to survive on.”

“As psychiatrists, we know that people’s social needs, such as for a decent job, good housing and a support network, are factors in triggering and perpetuating mental illness,” she adds. “For those with a serious mental illness already, these basic needs are tremendous factors in them continuing to feel ill. It’s an enormous psychological

“Psychiatrists need to be part of conversations around prevention”

stress, which means that they just can’t recover.”

Earlier this year, mental health practitioners from South London & Maudsley NHS Foundation Trust (SLAM) – where Dr Seneviratne is a consultant adult and perinatal psychiatrist – came together with local authority chiefs, GPs, charities and community groups, as well as residents and people with lived experience of mental illness, to kick start a conversation about how the area could better cope with the mental health impacts of COVID-19. A key concern is how rising unemployment – and with it declines in income, debt problems and poverty – will affect people living in South London, an area with high rates of mental illness pre-pandemic.



Dr Trudi Seneviratne, RCPsych Registrar

June’s Urgent Mental Health Prevention Summit featured discussions on a range of topics, including mental health and employment, and began to sketch out a programme of prevention and community capacity building across South London. “We’re thinking about how we can empower people to look after their mental health much better,” says Dr Seneviratne. “It’s about enhancing the resilience of the community from the ground up.”

A second virtual summit in November described the progress made, including a public campaign – ‘Free Your Mind’ – to support people to take care of their mental health, linked to local voluntary organisations; a package of digital mental wellbeing courses for all residents delivered through the SLAM Recovery College; and a programme of work with schools and faith and community groups. Local authority chiefs are also supporting local businesses and encouraging major employers in the area to recruit locally.

“Psychiatrists need to be part of these conversations around prevention,” says Dr Seneviratne. Changes to how services are organised will make it easier, she believes, as psychiatrists begin to work much more with primary care mental health teams. “With mental health much more embedded in communities, conversations would open up. We know that we can never prevent all mental illness from happening, but there are things we can do around stigma and making sure people come forward for help,” she says.

Dr Seneviratne would like to see more involvement, however, by psychiatrists in the public mental health agenda. “Psychiatrists have a role in making sure systems are in place to properly support what we call the social determinants of mental health.” It is a view shared by Dr Adrian James, RCPsych President. In a recent article on poverty and inequality in *BJPsych*, co-authored with Dr Peter Byrne, the College’s lead for public mental

health, Dr James describes the unique position psychiatrists hold as “clinicians with public health knowledge who understand the environments in which our patients live. And die.”

“Other health professionals need to know what we know,” he writes. “Do our GP letters communicate the individual drivers of someone’s misery (inadequate housing, precarious income, indeterminate status to remain, no locally available stop-smoking services, the pressures of raising children when a parent has mental health or substance issues, etc) or is it easier to write about medications and risk?” Dr James and Dr Byrne ask colleagues: “What will you do to achieve a wider societal dialogue?”

For its part, RCPsych is involved in a number of initiatives that address social factors which can trigger or exacerbate mental illness. It recently supported, for example, the successful campaign by the charity Money and Mental Health

to put an end to intimidating letters being sent to people with problem debt. The College is also a partner in Equally Well, a collaborative that has been set up to support the physical health of people with a mental illness. RCPsych also provides resources and advice on employment issues, including on Individual Placement and Support services and how best to help people with mental health problems gain and keep paid employment.

Dr Seneviratne is clear that she would like to see more focus on public mental health and prevention, not least because of increased pressures on services. “Unemployment as a determinant of mental health impacts on most specialties, because it can affect anyone, young or old.” She cites addictions and the impact that joblessness can have on a person’s drinking. “One thing we do know,” she says, “is that we don’t have enough services to deal with this.”



(Image: Odra Noel)

Altering perceptions

According to psychiatrists investigating the benefits of psychedelics in the treatment of mental illness, prohibitive laws are impeding research and patient access. They ask: is it time for drug policy reform?

While a medical student, Dr Ben Sessa had what today might be described as a side hustle. He worked as a DJ, his disc-spinning days coinciding with the emergence of rave culture and the 'second summer of love': a period in which many young people recreationally experimented with psychedelics, just as their parents had in the 1960s.

Dr Sessa became fascinated by these substances in the context of his day job. If psychedelics changed perceptions of oneself and the surrounding world, could they perhaps help those whose mental illness had trapped them in highly rigid thought patterns?

It was a question that had also been posed by his psychiatrist forebears. In the 1950s and 60s, much research found that psychedelics had real therapeutic efficacy.

But that work sat alongside investigations centred on potentially nefarious use of the drugs, including military applications, and it was those studies that garnered headlines. "They very much demonised the area," explains

psychiatrist Dr Tim Williams, clinical director at Avon and Wiltshire Trust, and a psychedelics researcher.

The result was strict frameworks which classified the likes of LSD, MDMA and psilocybin as dangerous and illegal, many would argue with reason. The consequent side effect, however, was the shelving of any investigation of their potential therapeutic value in mental health.

Until, that is, the end of the last decade. Spearheaded in the UK by Professor David Nutt of Imperial College London, a new band of psychiatrists has begun to not only validate but also build on the original studies. Initial results are highly promising, suggesting for instance that psilocybin can lead to reduced depression symptoms for up to six months.

But all such research has been conducted within a legal framework that the researchers argue is outdated, unscientific and unhelpfully prohibitive. "The narrative from governments of the harm of these drugs doesn't tally with the evidence base," argues Dr Sessa, now a psychedelics researcher at Imperial College

London and a consultant psychiatrist. "Yet they are banned substances, and that makes them hard to research as therapeutics."

In all such research, the treatment protocol remains broadly similar. The patient takes the drug in a calm environment with the therapist on hand, having previously had separate psychotherapy sessions and group follow-on sessions afterwards.

"It's using psychopharmacology as an adjunct to improve psychotherapy," explains Dr Sessa. "The drug is this kind of catalyst that allows the patient to access repressed emotional memories in a safe way."

For Dr Williams, it's akin to restarting a computer program that has become stuck. "Essentially, with a psychedelic you're switching the brain off and on again, and encouraging it to switch on in a more therapeutic way."

As for what that experience is like, it's possible to ask Dr Sessa, who, as part of a research study, became the first person since the 1960s to be legally given a psychedelic drug in the UK. Yet he pauses when the question is posed. "One of the core features of the psychedelic experience is ineffability," he explains. "But my personal experience is that I feel deeply privileged to have experienced those mental states."

It is a privilege that Dr Sessa, Dr Williams and others in the field are keen to offer to more patients. To that end, a big part of their work is using research evidence to encourage the Home Office to consider drug policy reform – as well as encouraging colleagues to get behind such efforts.

And in January, three decades after he first became interested in psychedelics as a student, Dr Sessa will become chief medical officer of AWAKN, the world's first medical psychedelic clinic. His hope is that it will help establish these substances as psychiatry's next big thing – definitely this time.



Dr Arun Enara

An important test

September saw hundreds of psychiatric trainees sit the College's first ever online CASC. We talk to one, Dr Arun Enara, about why it was so important that the exam went ahead.

"I know it was just an exam," says Dr Arun Enara, an Indian psychiatrist selected onto the College's Medical Training Initiative, which enables international graduates to train in the NHS. "But with everything that's happened over the past year, it started to mean something bigger. I looked at that exam as a sort of validation of the choices I'd made and struggles I've had."

Dr Enara came to the UK last autumn and started working at Hertfordshire Partnership Foundation NHS Trust soon after. Having been a senior registrar in

"I looked at the exam as a validation of the choices I'd made"

India, not only did he have to settle into a new role in the NHS, but also adapt to life in the UK. He had anticipated the differences in geography, culture and people, and received support from the Trust, he says,

"but I still remember there was no light, it was cold, I couldn't drive so was taking public transport, and I was building a new social circle and finding my way around the NHS. The first couple of months were a struggle. I was like an infant learning to walk." Then the pandemic arrived. The extra strain at work and a feeling that he should be with his family in India, led him to question his decision to train in the UK.

"When the Paper B exam was cancelled in March, it made me question lots of things," he says. "I really wanted to get that exam. I know it shouldn't have been a validation, but it was. So, when the College decided to take the CASC online, it made a huge difference. It gave my whole group [of trainees] a focus, which was really important."

Behind the scenes, the College's decision meant that the process of migrating exams online, which was anticipated to take two years, would need to be completed in just five months. The CASC operation is extremely complex: an examiner, invigilator and role player need to be ready in the system before each station can start. Twenty-four people are required for every eight candidates, all moving through the system in synchronicity – a daunting challenge when internet reliability and hundreds of volunteer College examiners working remotely are thrown into the mix.

While almost all of the 488 candidates completed their exam (98%), some did experience delays and technical issues. Being tested online also meant trainees had additional "internet connection anxieties" as Dr Enara puts it. The reduced formality that comes from being in people's homes also came as a shock. "I'd never taken an online exam before and was wearing a blazer, because it was a very important day for us. For some of the examiners it seemed like just another day. And there were dogs barking in the background!"

Having practised online beforehand with the mock CASC, Dr Enara says he knew what to expect and relaxed as the exam progressed. And even though he has reservations about online consultations, much preferring to talk in person to a patient (simulated or otherwise), he was able to adapt and passed all the stations. All the effort he put in – alongside the hundreds of people working to ensure the exams could take place – has paid off.

Help at the end

An exploration of the psychiatric needs of – and support available for – people coping with terminal illness.

In September 2019, Sarah Wilson died nearly three years after her first diagnosis with terminal cancer. Writing in *The Guardian* a few months later, her husband, Michael Addelman, described how her physical symptoms were horrible, but what made things much worse for those three years was “the deep depression and rampant anxiety that very quickly spiralled out of control [and] made her life – and the lives of those closest to her – so difficult”.

Wilson’s case was far from unusual. People react in very different ways, both to a terminal disease and, later on, to the prospect of approaching death. However, the Palliative Care Institute Liverpool, based at the Cancer Research Centre at the University of Liverpool, has looked at the existing literature, finding that around half or more palliative care patients experience anxiety or depression, and a significant proportion “will warrant specialist psychological or psychiatric intervention”. The Marie Curie charity estimates that at least 10% of suicides in Britain are linked to terminal or chronic illness. The age profile of terminal disease means that a significant number of these patients will also have some degree of dementia, whether or not they also have other mental health conditions.

“Some people are just very stressed about death itself,” says Hannah MacDonald, who now works in a hospice, after a number of years experiencing the mental health system herself. “We’ll have patients who are very avoidant of even talking about it, because that causes huge

“By helping patients make meaning of their life and death, you can make a significant difference”

distress for their family. Or the reverse happens, so that the person themselves talks about it but the family is really struggling with it. Or they focus on details, rather than the things they are really worried about.”

Palliative care psychiatry has only really emerged as a subspecialty over the past couple of decades. In recent years, provision has significantly improved, though mainly for people with cancer.

“Psycho-oncology is now accepted and embedded within many NHS cancer centres,” says Dr Wendy Neil, consultant liaison psychiatrist at Leeds and York Partnership Foundation Trust and co-author of RCPsych’s guidelines *Psychiatric aspects of end-of-life care*. There is some provision for other conditions too. “A range of excellent dedicated palliative care services have developed over the past few years, for example for patients with heart failure at the Chelsea and Westminster Hospital, for COPD in Sheffield and for HIV at the Cicely Saunders Institute at King’s College London. Translating the evidence into

practice has been more challenging when it comes to palliative care provision for people with dementia or with existing mental health problems, but some promising models are being developed.”

The evidence – including the first meta-analysis of clinical trials in this area, published in 2019 – is that brief psychosocial interventions do have an effect on improving the quality of life and reducing the distress of dying patients. Some researchers and projects are exploring specific approaches such as acceptance and commitment therapy (ACT), dignity therapy, meaning-centred psychotherapy and group and/or family therapy. There is some evidence, particularly for ACT and dignity therapy, that these can be useful in improving people’s quality of life and reducing their suffering.

Whatever the approach, though, Dr Neil and her colleagues stress the importance of supportive listening and focusing on what that individual patient wants and needs. “Invite conversations,” Dr Neil says. “By spending time with the patient, by listening intently, and by helping him or her make meaning of their life and death,

you can make a significant difference to the last phase of their life. It is important that we approach issues raised in a person-centred way. Studies have shown that blanket approaches which fail to take into account individual patient needs and expectations can lead them to feeling disempowered and devalued, with resultant poor outcomes.”

Life before death

Dr Neil’s advice applies equally to patients who practitioners are seeing specifically as the result of a diagnosis, and patients they were seeing before the diagnosis. However, most people are not engaged with psychiatric services at the point when they are diagnosed, and many of those – as Sarah Wilson’s experience demonstrates – remain unsupported for a considerable length of time.

Some provision does exist at earlier stages. The Macmillan Cancer Psychological Support (CaPS) Team at St George’s Hospital, for instance, is one that includes a consultant liaison psychiatrist. The British Geriatric Society also published guidelines in May 2020 for professionals dealing with

older people who are living with frailty as they face the end of life. The Society’s guidelines point out that this cohort is particularly prone to depression, and they stress the importance of social and psychological support.

Overall, though, even if some level of counselling is on offer, skilled psychiatric support can be very hard to access. When researchers from the Marie Curie Research Department, part of the Division of Psychiatry at University College London, surveyed members of the Association for Palliative Medicine, they found that almost all of them reported difficulties managing patients’ anxiety and most had difficulty accessing psychological and/or psychiatric services. Only a third felt they had adequate training in this area themselves and, tellingly, only 8% used psychiatric criteria for diagnosing anxiety.

Yet it is relatively easy to tackle. “Early identification is key here,” Dr Neil points out. “Combining an awareness of the prevalence and treatability of these illnesses with the use of simple screening questions, such as ‘are you depressed?’, can be all that is needed to enable non-

specialist practitioners to identify patients who may need to be connected to specialist psychiatric support.”

That is particularly significant because many people do not realise – or flag up to professionals – that what they are experiencing is in fact depression, anxiety or another condition, given the huge impact of a diagnosis which tells them effectively that their life is ending. In addition, MacDonald adds, “there’s a huge patient voice saying that patients don’t want a medical model, they want a social model and to look at the wider issues.”

Addelman was and remains very angry about the lack of specialist psychiatric support available to terminally ill patients, especially during the earlier stages of their illness. “Everyone who is diagnosed should have a regular assessment by experienced skilled professionals, and that just doesn’t happen,” he says. He and fellow campaigners are pressing for more action, including more research and more Parliamentary support. “We never saw a psychologist or a psychiatrist; not once,” he says.

“I hope, one day, that will change.”



(Illustration: Owen Gent)



Dr Chinwe Obinwa

Tapping into **talent**

The Association of Black Psychiatrists-UK, the first such organisation in this country, is just a few months old. We talk to its president and founding member, Dr Chinwe Obinwa.

Forensic psychiatrist Dr Chinwe Obinwa has always felt it was important to have a supportive network solely dedicated to Black psychiatrists. This summer, she started conversations with colleagues and Paul Rees, RCPsych's CEO, and, in a few short months, the Association of Black Psychiatrists (ABP-UK) was born.

With Dr Obinwa as its president, the Association held its inaugural meeting in October, Black History Month, a recording of which is available on RCPsych's website. The importance of promoting equality was outlined in presentations by Paul Rees, RCPsych President Dr Adrian James and five eminent Black psychiatrists.

"I'm pleased to say that we already have over 70 paid-up members," says Dr Obinwa. "I'm really humbled by the support we've had from senior and junior colleagues, but we need more people to come on board and drive the vision forward."

"There are thousands of us out there"

That vision is to support Black psychiatrists in their career progression and in taking on management and leadership roles, where they are under-represented. The group also wants to harness the experience and skills of its membership to "promote innovation and excellence in the delivery of high-quality care for patients with mental illness".

"We're aiming to encourage people to be the best they can," says Dr Obinwa, "because, fundamentally, we're all here for the patients. The only way you can be an excellent clinician and deliver excellent care is if you yourself are in a good place and fulfilling your own potential." To that end, ABP-UK

will be running a series of training webinars in the new year aiming to empower Black psychiatrists to achieve their full potential in areas of leadership, personal development, service innovation and improvement.

At the same time, Dr Obinwa wants ABP-UK to be there for new entrants into the profession. The proportion of Black medical students in the UK is lower than the overall percentage of Black people in the population. When resources allow, ABP-UK plans to set up a helpline to support trainees and established staff alike.

Dr Obinwa also wants to start a conversation with the wider profession about racism and its impact on practitioners. "We need to have the discussion comfortably, without blame," she says, "because that doesn't help anybody. It's not about blame, it's about understanding." Dr Obinwa recalled being racially abused by a patient. Later, the patient's carer said to her, by way of an apology, "well, you should be used to it." "Well, I'm not," says Dr Obinwa. "I'm really not used to it, and, you know, sometimes, no matter how resilient one is, when you keep getting the knocks, it does take its toll."

ABP-UK hopes to use the insights of its members to improve patient care. For example, there can be a lack of understanding of different cultures. Dr Obinwa cites the importance of religion in some communities – "faith can be very supportive," she says, "and we need to be creative and work with that".

And so, the organisation plans to collaborate with patients in the co-production of workshops aimed at addressing the needs of the Black population who use mental health services. The workshops will explore the impact of racism and trauma, as well as issues related to access and treatment outcomes.

ABP-UK has the active backing of RCPsych. "Black lives matter at the College," says Dr James, "and we need to support all our members to give of their best. Trust, honesty, open dialogue and challenge are key to making progress in this area, but so is action. I'm looking forward to working closely with the Association to help us realise this aim."

Dr Obinwa is passionate about her new organisation. "There are thousands of us out there," she says, "and I'm excited about tapping into all that talent."

ABP-UK's website: www.blackpsych.org.uk

ABP-UK is conducting a survey of Black doctors' experiences working in the NHS. You can complete it here: https://bit.ly/ABP_workplace_survey