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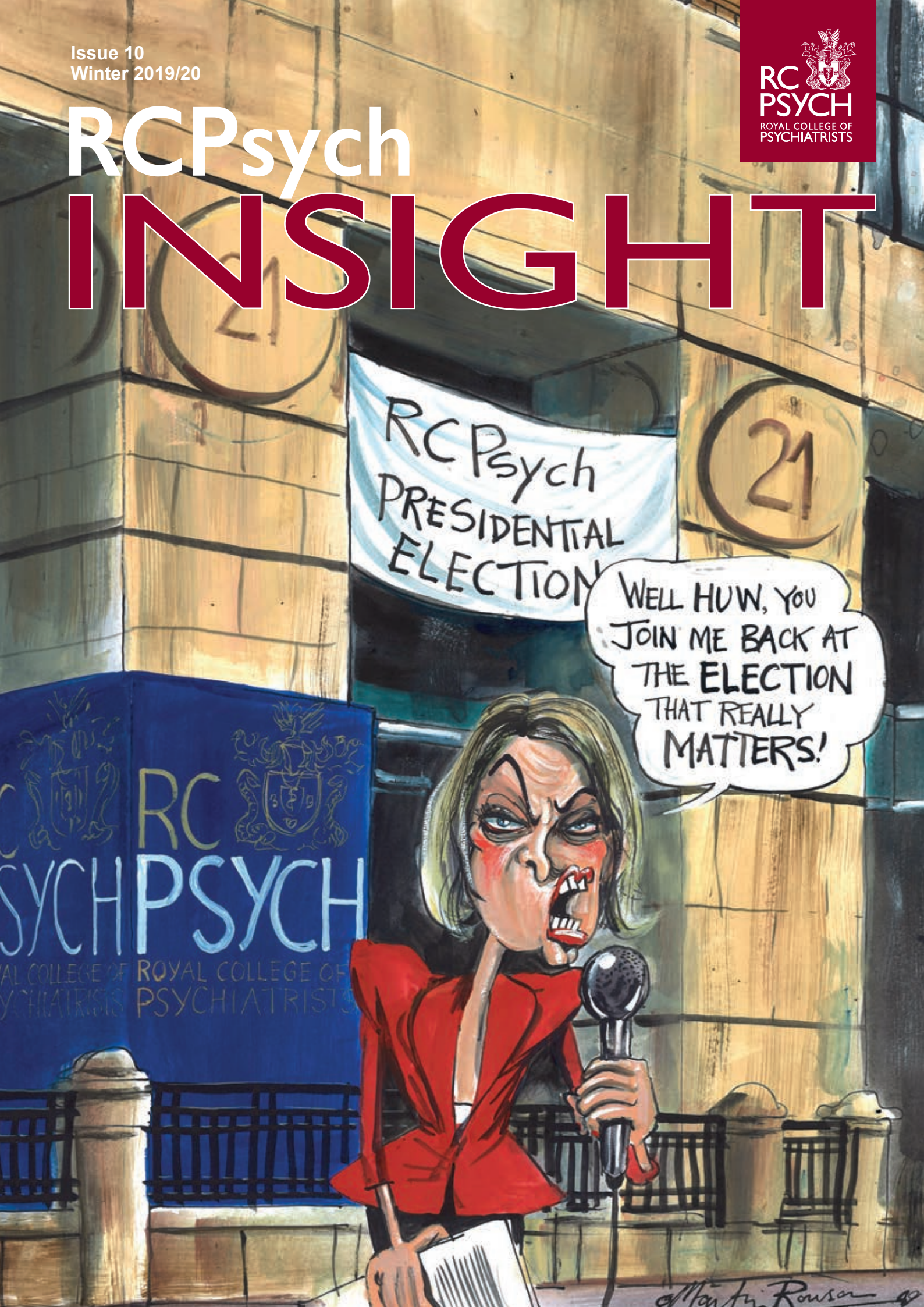
RCPsych INSIGHT



Contents

COLLEGE **NEWS IN BRIEF**

First in Europe

College HR Director Marcia Cummings and Council member Dr Raj Mohan (second and third from left) receiving the award

The College beat strong competition to be crowned Charity of the Year at the European Diversity Awards in November. The award recognises RCPsych's outstanding work in the field of equality, diversity and inclusion.
Ever since the launch in 2018 of its values – Courage, Innovation, Respect, Collaboration, Learning and Excellence – the College has sought to ensure that they underpin everything it does. 'Respect' means taking decisive action to ensure diversity and inclusion across its membership, staff and wider mental health services.
Action taken includes nearly tripling the number of new fellowships for ethnic minority psychiatrists to 49% of the total awarded. The judges also noted RCPsych's position at the forefront of promoting equality on gender, race and sexuality in healthcare.
Paul Rees, CEO of RCPsych, said the award "recognises the tireless work we have done to embed our College values in everything we do".

Election time

With the general election behind us, voting has now opened to decide who will be RCPsych's next president. There are three candidates: Professor Kam Bhui, Dr Adrian James and Professor Pamela Taylor.
Members, Fellows and Specialist Associates are all eligible to vote and will have received an email with a link to the voting site. Voting closes on Wednesday 8 January 2020.
For the first time, RCPsych held a hustings event in October, where members had the chance to quiz the candidates, and a video of the event is available on the website for those unable to attend.
A written and short video statement from each candidate can be viewed by searching 'meet the candidates' at **www.rcpsych.ac.uk**.
If you are eligible to vote but have not received the email, please contact **elections@rcpsych.ac.uk**.

Improving isles

Diagnostic rates for dementia vary significantly across the four nations, with the rate in Northern Ireland being the highest at 73%, while in Wales it sits at just over 50%.
Things are about to change, however, thanks to an innovative way of diagnosing some types of the disease. A PET scanner at the University Hospital of Wales, currently used to detect cancers and carry out research, has now been made available for patients with suspected dementia or Alzheimer's. Extra funding from the Welsh government was secured for the programme by RCPsych in Wales, Aneurin Bevan University Health Board and Cardiff University.
Dr Chineze Ivenso, chair of the Old Age Faculty in Wales, described how the country has "lagged behind for quite some time" without access to PET scanning for dementia. "It is very important we now have a way of making a quicker diagnosis in complex cases, so patients and families get the support they need faster."
There is good news too for older people in Northern Ireland. In October, Belfast Health and Social Care Trust became the first in the country to be accredited by the College for its dementia care. Its Older People's Dementia and Mental Health Service was awarded for completing the Memory Services National Accreditation Programme (MSNAP), an achievement described as "fantastic news" by Dr Gerry Lynch, chair of RCPsych in Northern Ireland.
"After 18 months of hard work, the staff commitment and achievements for people accessing this service have been fully recognised. Well done to all involved."

Find out more about efforts by the College to improve psychiatrists' wellbeing at work on page 12.

Cannabis concerns

A new RCPsych Position Statement sets out the College's view on cannabis-based medicinal products. It details the lack of high-quality evidence for their use in the treatment of mental illness and calls for more research in all health settings.
Search 'Position Statements' at **www.rcpsych.ac.uk** to read the full text.

President's **update**

Welcome to the last issue of *Insight* this year. As always, there is plenty to read. In October we held an event at the College at which we heard stories of the past from some of our most senior members. As an old age psychiatrist, this was right up my street. In this magazine, we include thoughts from retired consultant psychiatrists on the changes they witnessed and helped to shape.
We also highlight the work we have done on service capacity and the shocking numbers of people who are admitted to beds far from their homes. I really hope we can soon bring this awful practice to an end.
Our workforce piece highlights the cultural transformation which the health service needs to undergo to become more inclusive for staff from diverse backgrounds. During my time, I have seen this improve but there is a long way still to go.
Don't forget to read the article on what the College is doing to improve your wellbeing – this is something we are increasingly focused on. With Christmas just around the corner, I hope you will have some time to take a break and to get some rest and relaxation.

Professor Wendy Burn

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Your Insight

To send us your Insights email magazine@rcpsych.ac.uk or tweet using #RCPsychInsight

Insight articles cover such a myriad of topics. Kudos to the team.

Dr Sidra Chaudhry CT3 Yorkshire and Humber

A report on Congress' cannabis debate (*Congress Conversations*, Autumn 2019 issue of *Insight*) correctly reported a majority against legalisation after the debate.
Not mentioned, however, was that a majority were in favour of decriminalising the recreational use of cannabis. Also, the use of mobile phones to vote turned out to be highly unsatisfactory.

Professor Philip Graham FRCPsych (Hon)

You are right that the audience voted for decriminalising recreational use and it was misleading not to have reported this. This was an issue of space and not policy. RCPsych has reviewed its stance on recreational cannabis use and will publish a forthcoming Position Statement. We acknowledge that the technology piloted at Congress meant that only some votes were captured. This will be resolved for Congress 2020.

It is dangerous to encourage sufferers to quit smoking (*Time to Quit,* Autumn 2019 issue of *Insight*), or to advise nurses to encourage it, without reminding them that stopping smoking immediately is a risk to medication serum levels, and to relapse.

Dr David Yates FRCPsych

We did fail to stress that tobacco smoke stimulates the production of the CYP1A2 enzyme, speeding up the metabolism of some medications, which may decrease plasma levels. Smokers using these medications should be advised that changes to their usual smoking routine will require careful monitoring of plasma levels to inform required changes.

RCPsych President Professor Wendy Burn

Ending the **beds shortage**

New independent research commissioned by the College has found that in-patient adult mental health services across England are struggling to cope with demand. With consequent harm to patients, and staff put under intolerable pressure, RCPsych is calling for immediate and longer-term action to help end the crisis.

Care in the community has been the stated aim of government since the 1980s. As a consequence, in the past 30 years, the number of adult in-patient mental health hospital beds in England has fallen by an astonishing 73%, from 67,100 to 18,400. But, in the same period, there has not been a corresponding increase in community care services. The upshot is that bed occupancy now exceeds 90%, reaching 100% in some parts of the country. Many people in crisis are waiting far too long for a bed to be free; others are sent 'out of area', far from home. And caught in the middle, under immense pressure and often struggling to cope, are members of RCPsych and their fellow mental healthcare professionals.

"People have got sicker or have attempted suicide while waiting for a hospital bed"

What's particularly unsettling is that the problem has been known about for years. In 2015, RCPsych set up the Independent Commission on Acute Adult Psychiatric Care in England. The commission published its report in 2016, recommending urgent action. But in the intervening years, very little has changed despite intensive efforts nationally and locally. The NHS Long-Term Plan, published in January, does include a firm commitment to end out-of-area placements by 2020/21 and to greatly increase community care services by 2023/24, but action is also needed now.

Professor Wendy Burn, RCPsych's president, knows only too well how the present crisis is affecting acutely ill people. "I've heard some horrible stories about what's happened to patients while they've been waiting to go into hospital," she says, "people who've got sicker, people who have attempted suicide while waiting for a hospital bed.

"There are around 750 patients at the end of each month who find themselves miles away from where they live, so they can't be easily visited by their loved ones or their community teams, which we know can really set back patients' recoveries. On top of this, we're wasting money: we've cut the beds in people's own local hospitals and then we're spending money, often in the private sector, miles away from home."

People who do get a bed don't always get the care they need. In wards running at full capacity, there may be barely enough staff to go around. And then, patients may be discharged early, leading to a relapse and the need for readmission.

Professor Burn talks about people who have gone to A&E, where they're assessed as needing a bed, "but there isn't one, and they'll live in A&E. They don't have proper access to food. They don't have washing facilities," she says. "It's just awful. I also know of a patient who was waiting in A&E and eventually got so frustrated he attacked a security guard, injuring them quite severely."

RCPsych is calling for immediate action to help tackle the crisis. It commissioned a report, published in November, which sets out a three-point plan that seeks to improve capacity across the system. *Exploring Mental Health Inpatient Capacity* is based on in-depth research and interviews with members of RCPsych. It identifies those parts of the country where the problems are most acute, with persistently high numbers of out-of-area placements and high bed occupancy. The report proposes an immediate increase in beds, concentrated on these priority areas, to provide a 'breathing space'.

"In five years' time, when the community services have been enhanced and all the money is flowing, there will be less pressure on, and need for, additional in-patient beds," says Professor Burn. "But in the short term, we certainly do need them."

An immediate increase in bed numbers where they are needed most will help but won't end the crisis. More beds need more staff and that requires current and projected staff shortages to be addressed. At the same time, the commission's report found a wide variation in admission and discharge criteria, admission rates and average length of stay.

In the next two years, RCPsych is calling for more focus on ensuring that all time spent in hospital by patients adds therapeutic value, and for local areas to better understand how well their services can meet demand. And over the next two to five years, the focus needs to be on investment to increase the capacity and capability of community mental health services, in line with the NHS Long-Term Plan.

The crisis in acute care for adult psychiatric patients is a complex problem that requires action on several fronts. RCPsych has set out how it can be done. But now, politicians and national and local health services need to take action as a matter of urgency. With so much competing for their attention and focus, we need to make sure our voice is heard loud and clear – it's time for action.

What the data tells us

- Since 1987/88 the number of mental health beds in England has fallen by 73%.
- Seven Sustainability and Transformation Partnerships (STPs) report particularly high levels of inappropriate out-of-area placements (after adjustment for population size and needs): Bristol, North Somerset and South Gloucestershire; Devon; Lincolnshire; Norfolk and Waveney; Nottinghamshire; Lancashire and South Cumbria; and Hampshire and the Isle of Wight.
- In just one year, patients were sent approximately 555,000 miles to get treatment that should have been available locally. That's the equivalent of going around the world 22 times.

The full independent report, and RCPsych's response to it, are available from: **www.rcpsych.ac.uk/servicecapacity**

Dr Dora Black

Leading **the way**

In October, RCPsych invited some of its most senior members to recount and record their memories of the profession and its practices. Here, retired consultant psychiatrists Dr Dora Black and Dr John Bradley share their thoughts on the changes they witnessed and helped to shape.

In 1956, at the age of 24 and newly graduated, Dr Dora Black found herself in charge of 500 chronic patients in Napsbury Hospital on the edge of London. Despite the daunting challenge of daily rounds, she describes life at the mental health facility as "very comfortable".
"We had a fine time," she recalls. "We lived in a communal house with staff and were very well looked after. We even had a croquet lawn." For the many, mainly sedated patients, she adds, the institution was home where some would spend time tending the gardens.
"They weren't unhappy," she says, "but treatment was very limited."
"The old mental hospitals did offer real asylum for many very vulnerable people," agrees Dr John Bradley, who was medical director of Friern Hospital, another of outer London's institutions.
Dr Bradley recounts the limitations of the treatments and practices that he was exposed to in his early career. "When I qualified in 1953, padded cells were still in use," he says. He remembers too the 'camisole de force', or straight-jacket, from a brief spell working in Paris. As a young psychiatrist in the RAF, he was also put in charge of a deep insulin unit "the theoretical basis of which has always remained a mystery to me," he quips.
Both agree that the arrival of neuroleptic drugs in the mid-1950s was a transformative moment in psychiatry.

A newly graduated Dr Dora Black in 1955

"I remember when they were first introduced," says Black. "Patients who had been in an almost zombie-like state for years suddenly woke up."
Besides the advent of effective drugs, Bradley also points to the huge impact that various pieces of legislation – not just mental health laws, but parliamentary acts on suicide, abortion and homosexuality – had in "liberalising and humanising treatments of the mentally ill".
The shift of services away from mental institutions to general hospitals was another positive development Black witnessed. It meant, in purely practical terms, that other doctors "learnt that I could be useful to them" (a shift in thinking that she attributes, in part, to eating with them in the common room). "Change happens through people," she says. "You have to be in a certain place at a certain time." Her capacity to see – and seize – these moments meant that later on, while a consultant at the Royal Free, she succeeded in getting medical student teaching time in child psychiatry.
Black's journey to becoming a leading authority on child bereavement, particularly in cases where one parent has killed the other, charts another development in psychiatry. Early on in her career she became involved in a local group for widows run by the Watford branch of the charity Cruse. Once a month they provided group counselling, she explains, through which she "learnt a lot about bereaved children".
At the time, family therapy was in its infancy in the UK, so Black decided to conduct some research. "I wrote to GPs and asked them to send me their bereaved children," half of whom she then provided with family therapy.
"It was a very important piece of work," she says. Black went on to chair the Institute of Family Therapy and was founder-director of the Traumatic Stress Clinic in central London for psychologically traumatised children.
By the end of her career in 2015, Black and her team had seen over 700 cases of children bereaved by one parent killing the other.
"Nobody listened to the children before," she says. "That's been a big change."
Dr Bradley's 60-year career as a psychiatrist has taken him to Zurich – where he heard an 82-year-old Carl Jung present a paper on schizophrenia – to Paris and New York, where he worked alongside a pioneer in the use of antidepressants. Back in London, he worked for a period under Dr William Sargant and "learnt a great deal about various forms of physical treatment, many of which I later rejected as a consultant".
His interest in medical negligence led to a long association with the Medical Protection Society, including as chairman of council.
" 'Doctor knows best' doesn't wash now," he says. "People rightly question much more." He celebrates the fact that the profession is "much, much more open today".
Black and Bradley are optimistic about the future of psychiatry, both viewing advances in neuroscience and psychological treatments as "very important" to our understanding of mental illness and the development of treatments. It is thanks to efforts by them and others that psychiatry has already come so far.

Dr John Bradley appeared on the cover of a medical publication in 1953

In October, Dr John Bradley and Dr Dora Black were among a number of speakers at a 'witness seminar' on psychiatric hospitals in the UK in the 1960s. A transcript of the discussion will soon be published on **www.rcpsych.ac.uk**

Dr John Bradley

Class **acts**

Schools can play a vital role in improving the mental health of children and young people. Innovative work in Oxford and Greater Manchester shows how it can be done.

Children taking part in the Mentally Healthy Schools pilot study in Greater Manchester

The mental health of children and young people has long been a major concern. The scale of the problem was laid bare in a government survey of children in England published in 2018. It found that 12.5% of five- to 19-year-olds and 5.5% of two- to four-year-olds had at least one mental disorder when assessed. The study also reported an overall increase in the prevalence of mental illness among five- to 15-year-olds in the past 20 years.

The response to these figures has been a widespread call for better access to Child and Adolescent Mental Health Services (CAMHS) and, in particular, for schools to have a role in providing such access. Schools are seen as well placed not just to promote good mental health, but also to prevent problems later in life.

A central recommendation of the 2016 report by the Values-Based Child and Adolescent Mental Health System Commission, of which RCPsych is a member, was that schools should teach their pupils about mental health "in the same way they teach them about literacy or numeracy".

So, what does this look like in practice? One area of the UK that has blazed a trail in working with schools to improve mental health provision for children is Oxfordshire. Consultant child and adolescent psychiatrist Dr Mina Fazel explains how it began 15 years ago through working with refugee children. "It came about by chance," she says, "because a third-sector organisation approached us, interested in developing ways to improve access to mental health services. They asked us to provide a mental health service within schools." Dr Fazel and her colleagues set about trying to find the best ways of supporting the refugee children and their families, holding regular meetings in schools with staff, initially without the formal involvement of mental health services, but making referrals to CAMHS where necessary.

"Schools should teach their pupils about mental health in the same way they teach them about literacy or numeracy"

"We had a complete shift in our understanding of working in schools," says

Dr Mina Fazel

Dr Fazel. "At the end of our meetings, the staff would say: 'Thank you very much; that was really helpful. But now can I talk to you about the 20 other children in school that I'm worried about?' So, we approached our mental health services and then the commissioners and said: 'Actually, we need to provide a service for all kids, not just refugee kids.'

"Now, through our School In-Reach programme, all secondary schools in Oxfordshire get specific CAMHS time. From a really small project with a select group of vulnerable children and families, we've been able to think a lot more about the needs of all vulnerable kids, no matter where they're from, and about the role that schools could potentially play in enabling us to better help these young people."

This way of thinking is fast spreading throughout the rest of the country. In 2018, RCPsych joined forces with NAHT Cymru, the school leaders' union in Wales, to explore collaborative ways of working, understand each other's challenges and share best practice. Their first joint conference was held in December last year in Cardiff.

RCPsych has also developed a mental health pack for schools, a collection of 14 factsheets that cover a wide range of disorders, explaining how to recognise them and what can be done to help. They are much in demand, with Hertfordshire Council, for example, supplying them to every school in the county.

The government is also pressing ahead with its plans to fund new Mental Health Support Teams in schools. Led by NHS children and young people's mental health staff, these are designed to provide extra capacity for earlier intervention and ongoing help.

From this year, the support teams will start work in 25 areas across England, the largest of which is Greater Manchester. Leading on the project for the Greater Manchester Health and Social Care Partnership is consultant child and adolescent psychiatrist Professor Sandeep Ranote. The work of her mental health support teams, already in training, is being informed by a four-month pilot undertaken in 2018.

'Mentally Healthy Schools' involved 31 primary and secondary schools across the conurbation. In collaboration with the NHS, it saw four local third-sector organisations deliver on-site training of staff and pupils. That was the best use of resources, says Professor Ranote. "We don't have sufficient staff in CAMHS to send to the schools; we need to be here, providing our service. If you had a child that had self-harmed or you were worried that they had an eating disorder, you'd want to get access to specialist CAMHS teams, including a child psychiatrist, really quickly. So, we need to work better as a system in partnership to support our schools and use our workforce more wisely."

Professor Sandeep Ranote

The pilot clearly worked well. A total of 690 pupils took part in 'active workshops' led by athlete mentors – good physical health being a key component of good mental health – and over 150 were trained as young mental health champions. In addition, 113 members of staff received mental health first aid training and, crucially, more than 60 senior leaders were taught how to respond to the mental health needs within their school.

RCPsych's lead on schools, professor Tamsin Ford welcomes the new support teams. "We know that only one in four of the children with clinically impairing difficulties are seen by the current mental health provision," she says, "and for each of these children there are probably several others who are struggling, if not so severely affected. This makes the provision of additional staff to work closely with schools to support these children, as well as the teaching staff who are working with them, unquestionably essential."

RCPsych's mental health factsheets for schools can be ordered via the College website. You can also email **leaflets@rcpsych.ac.uk** for more information.

Cllr Jacqui Dyer, mental health equalities adviser to NHS England

Breaking **barriers**

Junior doctor and co-editor of the *Colour of Madness* Samara Linton explores how workforce barriers stand in the way of racial equality in mental health.

The health service needs to undergo a "cultural transformation" to become more inclusive for staff from diverse backgrounds, the NHS's lead on workforce race equality, Yvonne Coghill, recently told *Nursing Times*. Progress on culture change in the NHS had "flatlined", she said.

Coghill is director of the Workforce Race Equality Standard at NHS England and NHS Improvement, which was introduced in 2015 to expose and help close the gaps in workplace inequalities between Black, Asian and Minority Ethnic (BAME) and white staff in the NHS. It came on the back of a report that revealed discrimination in NHS governance and leadership and its potential impact on patient care.

The latest data backs Coghill up. While the proportion of BAME staff in very senior manager positions has increased slightly, it is still significantly lower than the proportion of BAME staff working in NHS trusts. Worse, the percentage of BAME staff reporting discrimination increased last year; fewer BAME staff believe that their trust provides equal opportunities for career progression and promotion; and BAME employees continue to be at higher risk of disciplinary action than their white peers.

This, at a time when research shows disproportionate levels of mental ill health in BAME communities, particularly people from Black ethnic minority backgrounds, compared with the general population.

Race inequality in the NHS workforce is connected to mental health outcomes among BAME communities, says mental health equalities adviser to NHS England, Jacqui Dyer.

"Wherever you're located, you need to look at the demographics of the people entering mental health services and whether the workforce represents that demographic makeup," she says. "When it is representative, you have more of a chance of engaging with these communities and in a way that better addresses their needs."

Dyer, who spoke at a recent RCPsych conference on combatting discrimination, continues: "Our mental health experience is a symptom of wider decision-making – social, economic and political – that impacts, in particular, on African and Caribbean people in a detrimental way."

Keisha York, founder of BAME in Psychiatry & Psychology

Rates of involuntary detention among Black or Black British populations, for example, are over four times those of the white population. They also have poorer recovery rates following psychological therapies. The 2016 Five Year Forward View for Mental Health showed persistent inequalities in early intervention, crisis care and lengths of stay in secure services.

New thinking

To address these inequalities, however, requires new ways of thinking and working, Dyer says. "Psychiatry and psychology normally rely on theories based on Eurocentric ideas and philosophies," she adds, "not African, Caribbean, Asian or other minority ethnic insights or ideologies. And how can we get to recovery when you are not dealing with our issues?" she adds.

Dyer, who is also chair of Black Thrive, which works to improve Black mental health and wellbeing through co-creation with affected communities, says the answer lies in much greater attention being given to the views of people from a BAME background – both mental health professionals and at a community level.

"I am wary of people who engage in these dialogues who don't come from an experiential position," she says. BAME staff "hold that differential experience to some degree in their own worlds and they should use that expertise to influence the services in which they work."

On the need to co-create services, she adds: "Until the groups that are experiencing the worst outcomes are represented at leadership levels where they can articulate what the real challenges are – around racism and discrimination – we will not be able to create a response appropriate to the magnitude of the problem."

The importance of co-creation is reflected in the Patient and Carers Race Equality Framework. Born out of the Mental Health Act Review, this is a practical tool to help organisations understand the steps needed to achieve improvements for individuals of diverse ethnic background. These include national competencies, such as reducing the use of restraint, but also changes co-produced at a local level.

Dyer, who chairs the framework's steering group, explains how – by working alongside service users, carers and communities, especially those from African and Caribbean backgrounds – a mental health service can become "more accountable to the population it serves".

"It's about improving the very negative experiences of Black people in mental health services," she says, and "no more deaths."

Research matters

Research by Black academics is playing a crucial role in this shift to services that are more responsive to BAME communities. Leading the way are projects like the Culturally adapted Family Intervention (CaFI) study, led by Professor Dawn Edge at the University of Manchester, which is testing new forms of talking treatments to meet the specific needs of people of Black African and Black Caribbean heritage with schizophrenia and their families.

More research of this nature is needed, however, and more needs to be done to ensure that students from BAME backgrounds can pursue their research interests. Keisha York, a recent graduate of King's College London in Organisational Psychiatry and Psychology, agrees.

Last year she founded BAME in Psychiatry & Psychology, a network of BAME practitioners and students that organises events on issues around BAME representation and advancement in mental health professions.

York notes that it can be a struggle for students from a Black and minority ethnic background to pursue research that looks at issues of race and mental health. "Academics may feel unequipped to supervise research projects which address topics outside of their cultural and ethnic backgrounds," she says. While York managed to find a supervisor with an interest in cultural diversity, she argues: "It's important that individuals of all ethnic groups learn about and be exposed to ethnocentric models and therapies and begin to consider them as legitimate approaches."

Representation is another important factor, says York. "I was elated when first taught by a Black identifying lecturer," she says. "It was inspirational to see someone from my background working in my desired field." He later became York's mentor.

Professor of Child and Adolescent Psychiatry at the University of Glasgow, Helen Minnis, says the lack of diversity in psychiatry research "matters hugely".

"For me, it's about the questions that get asked. Academia has been dominated by white men for centuries. Not to diminish the findings that they've produced, but inevitably they are coming from a certain perspective."

Being a Black, female academic, and not in that group, has shaped the way that she thinks, Professor Minnis says. It has also brought benefits in terms of skills and ways of working: creativity, thinking laterally and "ending up with really well-evidenced work".

Being overlooked for opportunities early on – the "invisibility cloak", as she describes it – also meant that she "could get on with what I wanted to do."

"We need lots more people like me," Professor Minnis concludes. "When we've got genuinely diverse science – when psychiatry is genuinely diverse – we will ask the right questions."

Professor Helen Minnis of the University of Glasgow (Photograph: Herald and Times Group)

Dr Mihaela Bucur, associate registrar for wellbeing and retention

How are you, **doctor?**

Wellbeing is defined as 'the state of being comfortable, healthy and happy'. Here's how the College plans to deliver on its commitment to improve psychiatrists' wellbeing at work.

Heavy caseloads and endless paperwork; a manager who's unsupportive or worse; less and less time for contact with peers or career development. These are the most common scenarios described by psychiatrists struggling to cope with ever increasing challenges. The result can be exhaustion, low morale, feeling undervalued, and ultimately compassion fatigue and burnout. Beyond the personal cost, the implications for the profession are significant.

This is why RCPsych recently renewed its commitment to workforce wellbeing. Alongside its crucial work to influence policy and improve working conditions, the College has created a wellbeing strategy to make sure that practical, meaningful change happens on the ground.

Responsibility for the work lies with a dedicated Workforce Wellbeing Committee, which since January has been led by Dr Mihaela Bucur.

"The first and most important thing is that the College recognises wellbeing as a key priority," says Dr Bucur, who admits the task is a "big challenge".

"Throughout the healthcare workforce there is a high rate of burnout. Like other doctors, psychiatrists are deciding to leave the profession," she says. The rate of unfilled NHS consultant psychiatrist posts in England has doubled in the last six years, with one in ten posts vacant.

In addition, a survey in May by the College's Mental Health Watch project (mentalhealthwatch.rcpsych.ac.uk) revealed 45% of RCPsych members felt morale across their team had worsened in the previous three months.

RCPsych is here to help support its doctors which, in the first instance, means listening to their concerns. Dr Bucur's team is focused on building contact with frontline staff, she says. Delegates at the College's International Congress in July were also asked what they perceived to be their main causes of work stress.

"Over the last few months we have identified three areas where we need to guide and support our members, so they feel valued, safe and able to thrive at work," says Dr Bucur. "First, we want to look at how doctors struggling with burnout and other challenges can be best supported and given access to help. Second, we plan to train local 'wellbeing champions' across the different career grades to listen to frontline psychiatrists, but also raise awareness of factors affecting wellbeing. Lastly, we will look at how we contribute as a College to transforming the overall culture in the profession."

Dr Bucur believes that psychiatrists can also develop a practical approach to improving their wellbeing at work. Her committee has developed a stepped wellbeing model that can be used to enable practical change. The College also ran a 'wellbeing and resilience' course in October looking at the different avenues of self-care, such as yoga or mindfulness.

In addition, the College has joined a national anti-bullying campaign to help address another identified cause of stress in the profession. It also intends to build on RCPsych's existing Psychiatrists' Support Service (PSS), which currently offers free, confidential advice on everything from transitioning to new roles to whistleblowing to support after patient suicide.

"The College recognises it needs to do more on a practical level"

"The College recognises it needs to do more on a practical level," says Dr Bucur. "Our focus now is on implementing our plans."

Look out for the new dedicated wellbeing page coming soon at **rcpsych.ac.uk**, with advice and tips for psychiatrists. To contact the PSS, call 020 7245 0412 or email **pss@rcpsych.ac.uk**

Navigating **change**

The urgent need to improve mental health systems around the world requires a collaborative, equitable and above all practical approach to research.

Coordinating the work of an international team of colleagues is a challenging proposition at the best of times. But when you are based in a prosperous country and your collaborators are in low- or middle-income nations, there can be a whole extra degree of complexity.

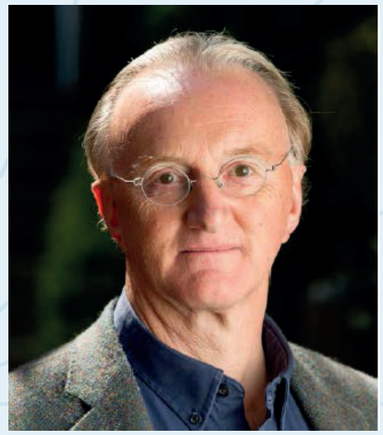
As principal investigator for the Emerald programme, this is a challenge with which Professor Sir Graham Thornicroft is well acquainted. The five-year EU-funded project began in 2012 and has centred on enhancing mental health outcomes in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda. Graham, professor of community psychiatry at King's College London, says that meant confronting the loaded legacy of colonialism.

"The history over many hundreds of years is of the northern countries exploiting the southern countries. So, one of the challenges for me in coordinating this project was to do it as far as possible in a way that involves all the participants fairly and equally."

Since the aim of Emerald was to strengthen the performance of health systems in each of the countries, capacity building – of healthcare professionals, policymakers, and service users and carers – was a huge focus. But it was an effort that also extended to the researchers.

"What I enjoyed most was the constant learning process," says Nicole Votruba, who was Emerald's programme manager before transferring to study for a PhD within the project. She describes the "incredible amount of capacity within the team" and its knowledge "both on mental health issues and scaling up and strengthening health systems". "It was really amazing to see the capacity building being implemented in the countries," she reports, "but it really played out among the researchers too".

It is a point echoed by Dr Shalini Ahuja, who worked on the project in Sehore, India and then started a PhD at King's College London immediately after. She says the opportunity to move from a practice to a research domain was a fascinating one. "I could see the story from both sides – what was happening in the field, and what was happening at a consortium level."



Professor Sir Graham Thornicroft

That ability to understand issues from two related but separate perspectives has always appealed to Graham as well. Continuing with clinical work alongside his research, he is currently practising as a consultant psychiatrist in the early intervention in psychosis team at South London and Maudsley NHS Foundation Trust. "Inhabiting both worlds, you can try to form bridges to actively help the knowledge that we have to better inform more effective practice."

He does emphasise that those bridges can take time to build. "Quite often, research is very frustrating – sometimes you can't recruit the people you want, or it takes a year just to gain ethical approval.

"On the other hand, you can – with hundreds or thousands of other people across the world, contribute towards increasing the sum of human knowledge. I want to focus on the sum of actionable human knowledge – evidence that can actually lead to better treatments, better experience of care and better outcomes for people with mental illnesses."

The **Emerald research programme**

In every country around the world, people with mental disorders are failing to get the treatment they need. Governments and others, driven to improve mental health systems, need strong evidence about both how to provide effective treatments, and how to deliver these treatments within robust health systems. The Emerald research programme – standing for 'emerging mental health systems in low- and middle-income countries' – has contributed enormously to how this can best be achieved. The academic project, which has produced some 50 papers to date, has supported doctoral students in three continents and developed teaching resources to build capacity. It has explored how best to finance mental health systems, how to integrate mental health into mainstream services, and the use of indicators to measure performance – all with a focus on the practical application of their findings to improve treatment and care.

An eight-paper series summarising the Emerald project's scope and significance was published in September by *BJPsych Open*. The papers can be read at https://www.cambridge.org/core/journals/bjpsych-open/emerald-series

Combatting **loneliness**

Social isolation doesn't have to lead to mental and physical illness in older people. Psychiatrists have a role in advocating for services to tackle and prevent loneliness.

Dr Amanda Thompsell, chair of the Old Age Faculty

Imagine you like to run but find it difficult to stick to a schedule. One charity, GoodGym, has come up with a solution that also contributes to improving the quality of life of socially isolated older adults. Volunteer runners are matched with older people, or 'coaches' as they are referred to. Then, at a prearranged time, the volunteer runs to the older person's home, pays them a social visit (and has a rest) and then runs home afterwards. In addition to making a rewarding personal connection, volunteers feel highly motivated to adhere to their running schedules and the coaches benefit from spending time in the volunteers' company, that otherwise would have been spent alone.

Half a million older people go at least five or six days a week without seeing or speaking to anyone, according to Age UK, and there are an estimated 1.2 million chronically lonely older people in the UK. While the subjective experience of loneliness is, of course, not in itself indicative of pathology – rather, a natural reaction to unmet social needs – it has very serious health consequences that should not be overlooked.

"Far from being a trivial concern, loneliness is associated with an increase in mortality on a par with smoking and worse than obesity," says Dr Amanda Thompsell, chair of RCPsych's Old Age Faculty. Being lonely is also predictive of mental distress, with the potential to increase both psychological and physiological stress levels, increasing the likelihood of heart disease, dementia, anxiety, depression and suicidality. "And critically, among older people," she adds, "it has been shown to be a risk factor for the progression of frailty."

"Far from being a trivial concern, loneliness is associated with an increase in mortality on a par with smoking and worse than obesity"

The College's Old Age Faculty has produced a joint Position Statement with the British Geriatrics Society on loneliness and social isolation. Among their priorities is the need for increased identification and prevention. But reaching lonely individuals in the first place is one of the key challenges.

Taking full advantage of people's existing points of contact with healthcare services is a practical starting point. A 2018 study found that older patients who live on their own are heavy users of health services. "This means that we, as healthcare professionals, have opportunities to intervene and stop patients' physical and mental health from deteriorating. But very often, no one is picking up on loneliness – yet it could be so easy," says Dr Thompsell.

Bereavement – particularly of a spouse – poor health, reduced mobility, frailty and any limits placed on independence are clear things to watch out for. And existing mental health problems, by their nature, can create and add to loneliness and social isolation, exacerbating the condition.

Dr Thompsell points to the fact that older bereaved people are less likely to seek help and less likely to be referred for bereavement support than younger people, on top of being more likely to have worse mental health as a result of bereavement. "And yet, talking therapies can be highly effective for older people," she says.

Fewer than one in five people aged over 60 have received counselling following a death even though NHS guidance states that "older people, especially those with depression, are as likely to benefit from talking therapies as everyone else". In fact, recovery rates for those who have been through the Improving Access to Psychological Therapies (IAPT) programme are often better for people aged 65 and over than those who are younger. "It is essential that we ensure that ageism does not prevent older people from accessing the services they need," says Dr Thompsell.

Social prescribing is another important strategy for tackling loneliness. But not all provision is suitable for older people, and appropriate consideration must be made of an older person's mobility or ability to handle large group-based activities, in addition to their personal preferences and demographic. Anecdotally, programmes that promote the feeling of making a difference to others seem to have the most impact. The Downshall intergenerational project in Ilford, for example, sees older people visiting a primary school and helping the children with their reading and other activities.

Increased prioritisation of loneliness is included in the NHS Long-Term Plan, which Dr Thompsell welcomes, but she and the Old Age Faculty are concerned about the provision and continuity of services. The Plan aims to put 1,000 social prescribing link workers in place by the end of 2020/21. But many social prescribing and befriending schemes are in the hands of small local charities. "Sometimes, these services close after only a matter of months," says Dr Thompsell. "By the time you've printed out the leaflets, they're already out of date."

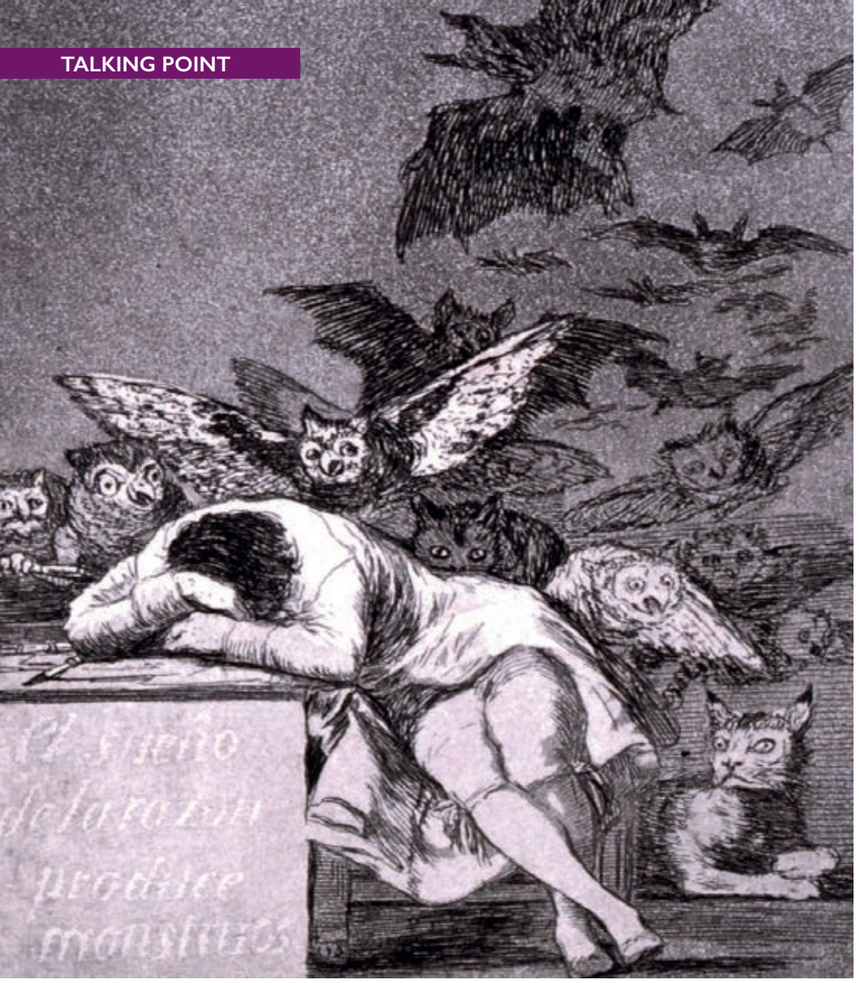
Continuity of services and the ability to plan are fundamental. "Psychiatrists have a role in advocating for these wherever they can and explaining to local commissioning groups that short-termism for loneliness services simply isn't helpful," says Dr Thompsell.

Psychiatrists can also play a part in prevention by promoting awareness of the needs of older people who are experiencing, or are at risk of, mental health problems. Although the impact of loneliness on mental and physical health is gaining increased political and media attention, it is yet to be embedded in many everyday healthcare considerations, and more broadly in the culture. Psychiatrists can help just by having a conversation with their multidisciplinary and multispeciality colleagues, as well as with medical students and trainees.

"Arming ourselves with the facts on loneliness, keeping up to date with what services are available locally, and building and maintaining strong relationships with providers are some of the best ways we can contribute," says Dr Thompsell.

"Of course, not everyone who is lonely needs to see a psychiatrist. But if an older person has risk factors for loneliness, we can do more to offer support and encourage our healthcare colleagues to do the same. Asking simple questions such as: 'Are you seeing people as much as you'd like? Do you feel lonely? Does that bother you?' could open up a conversation that otherwise might not have happened."

RCPsych's joint Position Statement with the British Geriatrics Society on loneliness and social isolation will be available from both **www.rcpsych.ac.uk** and **www.bgs.org.uk**



The Sleep of Reason Produces Monsters (1796–98) by Goya (Image: Wellcome Collection)

Life after **truth**

Do we live in a post-truth world, where beliefs matter more than facts? And what does that mean for our mental health?

In 2016, the year of the Brexit referendum and Donald Trump's election as US president, Oxford Dictionaries declared that its word of the year was 'post-truth', defining it as "relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to emotion and personal belief".

In September, the RCPsych Philosophy Special Interest Group's biennial conference discussed the impact on mental health of 'post-truth' and its comrades-in-arms, 'fake news' and 'alternative facts', with presentations from Derek Bolton, professor of philosophy and psychopathology at King's College London, and Dr Andrew Shepherd, clinical lecturer in psychiatry at Manchester University.

Professor Bolton characterises the 'post-truth' world as one where social consensus is breaking down. "There's a problem with defining truth merely as correspondence with the facts," he says, "because the facts can be as contested as the truth. They stand and fall together." Truth requires agreement, he argues; there has to be some kind of shared understanding if truth is to hold.

But such understandings and truths that we once may have held in common are fracturing. Bolton points to a multitude of causes, including the decline in respect for authority, the rise of populism, growing economic inequality across classes and generations, the destabilising effects of globalisation and worries about the impact of climate change. And any resultant anxieties are, he says, "amplified by social media and the internet, where everybody has an opinion and some people very quickly get thousands or millions of followers, and off we go".

"There's a loss of coherence as to what might be considered real, what might be considered true," says Dr Shepherd.

"I would argue that a large portion of what might be called healthy psychological function is devoted to maintaining a positive sense of who we are in the world. But the symbols that we use to represent that identity are becoming diffuse, shifting in their meaning. Does a Facebook friend, for example, hold the same psychic significance to you as a friend that you meet on a weekly basis?

"As the things that we've always believed seem to be falling down, there is a growing uncertainty around that construct of who we are. And that opens up anxiety, which then leads to complications in terms of mental health."

Professor Bolton concurs. "Post-truth probably is bad for your mental health, but being more stressed, especially for young people, is part of a whole package of changes. The same set of phenomena that is giving rise to 'post-truth' is also giving rise to an increase in anxiety and other stress-related conditions."

How bad have things become, then?

"There's no doubt whatsoever that there's been a big increase in demand for child and adolescent mental health services," says Professor Bolton. However, allowing for factors such as earlier and better diagnosis, the underlying increase in the prevalence of mental illness may prove to be relatively modest. In any case, he says, these may be anxious times but they're not the worst of times: "I don't have any view of a golden age nor that this trouble and strife is, in some way, new or worse." Ask anyone who has lived through a war or under a totalitarian regime about 'post-truth', he says, and you'd get a very different perspective.

For more information on the Philosophy Special Interest Group and its events, search 'Philosophy' on **www.rcpsych.ac.uk**

Dr Katherine Kennet, sustainability scholar

An existential **crisis**

Dr Katherine Kennet, a member of the College's Sustainability Committee, talks about the role psychiatrists can play in creating a fairer, greener world.

In September, a group called 'Doctors for Extinction Rebellion' joined thousands of others in the capital to highlight government inaction on climate change. The following month, Richard Horton, editor-in-chief of *The Lancet*, upped the ante, calling on health professionals to "engage in all kinds of non-violent social protest. The climate emergency is the most important existential crisis facing the human species," he said.

The message couldn't be clearer, but what we can do as individuals, as a profession and as a College is still a work in progress. Fortunately, action is being taken at all levels to try and address the many environmental and social challenges we face.

Leading the way for RCPsych is the College's Sustainability Committee, which was established in 2016 and is led by associate registrar, Daniel Maughan. Meeting quarterly, it is a resource for interested members wanting to understand more or to share what they know. It also acts as a path into other campaigning health organisations.

Crucial to the committee's work are the College's sustainability scholars. These are advanced trainees who work on projects of their choosing relating to the committee's four priorities of prevention, empowering individuals and communities, improving value, and considering carbon.

Dr Katherine Kennet, a higher trainee in child and adolescent psychiatry currently based at the Tavistock, has been involved with the committee from the start and has focused on social prescribing in mental health. "I have been interested in the social side of green issues – so fairness and social justice – for as long as I can remember," she says. Her work with the committee, she says, "allows me to bring both of my interests together".

The connections between individual and planetary ill health are clear, she says, citing evidence of the impact of pollution on mental health. "We can't afford to think small," she stresses, which is why the committee approaches challenges "systemically". Through its membership of the influential UK Health Alliance on Climate Change, whose high-level advocacy is targeted and evidence based, the College has successfully lobbied on big policy issues, like air pollution.

"But we also try to give people tangible things to do as well," says Dr Kennet, pointing to the committee's 'Top ten tips for practising psychiatry sustainably,' which she strives to apply to her practice. "For me, medication is key as it brings the biggest carbon footprint through its production and shipping." She is adamant that this doesn't mean doctors shouldn't prescribe. "It's more about taking five minutes to talk to patients about taking their medication correctly. It's about cutting waste where possible and cutting out problems where we can by empowering patients."

Like the doctors who glued themselves to a government building in September, Dr Kennet thinks psychiatrists "have a role and responsibility" when it comes to climate change. "We don't yet have the data on climate anxiety but anecdotally I can see it, particularly among adolescents. There is a feeling that there is this impending threat." She encourages anyone with ideas, or who wants to know more, to get in touch with the committee. "We are always happy to hear from people. There's a lot of work to do."

The Sustainability Committee has produced a **'Top ten tips for practising psychiatry sustainably'** guide, which is available from www.rcpsych.ac.uk/improving-care/working-sustainably

To join the Sustainability Committee, please email Lesley Cawthra: **lesley.cawthra@rcpsych.ac.uk**

When mum or dad **is mentally ill**

How adult psychiatrists can do more to help the 'hidden' children caring for a parent with mental health issues.

Dr Roswitha Dharampal urges adult psychiatrists to 'think family'

They are hidden in plain sight – the children living with, and often caring for, a parent with mental illness. And there are as many as 3.8 million of them in the UK, according to the Children's Commissioner.

Many struggle in isolation, tasked with household chores and parenting themselves and their siblings, often stigmatised at school for having a mum or dad with a mental illness whose symptoms they don't comprehend.

But in the absence of proper mental health provision or practice, these youngsters aged five to 17 receive little or no support. Yet without intervention, they are at high risk of developing mental illnesses themselves in later life.

So what measures are being taken to help these young people and stop the intergenerational cycle of poor mental health in families? And more importantly, what more can be done by the psychiatry profession?

RCPsych Fellow Dr Roswitha Dharampal recently carried out a literature review into parental mental illness and its impact on their young carers. What she found was that these children are being overlooked by professionals due to a lack of awareness, resources and time.

"Young carers are at an increased risk of having emotional and mental health needs, which could be mitigated by professionals recognising the young carer's role and including them in their parent's treatment plan," she says.

Dr Dharampal is one of a growing number of voices urging adult psychiatrists to 'think family' when treating a parent who is unwell.

"These children need the recognition of adult psychiatrists"

"These children need the recognition of adult psychiatrists," says Dr Dharampal, whose study is due to be published in *BJ Psych Bulletin.*

"A child of a parent with mental illness is often going to be involved in their care, helping with medication, looking after the home and possibly other siblings. Not only can this impair their academic achievement for which they may lack parental support, but their school may not even be aware. This all places a great toll on the child. It can also lead to attachment and relationship problems as well as substance misuse, if their parent is misusing substances."

Children of parents with a mental illness, or COPMIs as this group is referred to in Norway and Australia where they receive government support, aren't just at risk of mental illness. A recently published review of evidence relating to low- to middle-income countries found that children of parents with a mental disorder also have physical health disadvantages.

A UK survey further suggests that a higher proportion of young carers have special educational needs or a disability; are from Black, Asian or minority ethnic communities; and do not speak English as their first language.

While parental mental illness is acknowledged as one of the ten adverse childhood experiences considered to have the greatest impact on a young person's physical and mental health, it is rarely present in mental health policy and practice for children and young people.

"These children don't necessarily need to be referred to CAMHS," says Dr Dharampal. "But they do need the recognition of the adult psychiatrists treating their parent who should be making sure they are included in contact and future plans.

"If the parent is admitted, their psychiatrist should be making direct contact with the child and explaining their parent's condition, as well as alerting the child's school.

"The child needs to be empowered with knowledge about their parent's condition and also helped to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported."

Because of the pressures on time and resources in psychiatry, often in the initial assessment, there is only interest in the patient, says Dr Dharampal.

"The first thing to do is to establish if a patient has kids and then initiate contact with the child or children involved.

"Some parents and young carers are worried that they may be separated from each other, and some parents may hide the fact they have kids due to the stigma still surrounding mental health.

"Naturally, there are safeguarding concerns for patients with postnatal depression or psychosis. But for less serious, more common conditions such as depression, children may still need professional contact without being at serious risk themselves."

One charity, Our Time, is helping COPMIs with its pioneering parent–child workshop and school welfare programmes. It is currently supporting 250 children and young people and around 180 families at its KidsTime workshops where families can meet once a month in a safe space to share their experiences and learn how to communicate about mental illness through art and drama.

Our Time also runs 'Who Cares?', an informal intervention-based programme held in primary and secondary schools in which the average classroom has eight children with a parent experiencing mental illness. Teaching staff are given guidance to identify affected pupils and offer practical help, as well as to promote a culture shift to encourage greater sensitivity and understanding among all students.

The charity is calling for the children to be officially recognised as 'at risk' and the implementation of a national strategy with specialist teams to properly advise local authorities. They also want to see clinicians change the way they think, and move towards an approach which supports the whole family. This includes putting pressure on local authorities to get involved.

Our Time's communications lead Christina Clarke explains: "At the moment, the children aren't being picked up by adult psychiatrists. And while we offer the services we do, unless there is government policy to provide these children with support, nothing will change. "With intervention, their risk of developing mental illness is halved and the change we see in children using our workshops is phenomenal. It's as simple as listening and talking."

Clarke stresses the need for psychiatrists to think about the family as a whole and see that the child gets support, through CAMHS or other appropriate services.

"It's about ensuring there is a clear and direct pathway to getting help. And when psychiatrists are asking those questions, they're flagging to the local authorities that the provision to support these children doesn't exist and they need to put a plan in place," she says.

How professionals can work more closely together to support parents and children was one of the areas discussed at a major conference at the Royal Society of Medicine this December where speakers included RCPsych Hon Fellow Professor Sir Michael Marmot. Its main focus was the effects of parental mental illness on a child's brain development, cognitive function, and emotional and relationship development.

"Charities and groups like Our Time play an invaluable role," says Dr Dharampal. "But adult psychiatrists can do more to 'think family'. We all want the best for our families and by getting the children involved we help prevent a generation from repeating the same unhelpful mental health patterns."

Digital **distinction**

The creators of mental health app EMPOWER have set themselves apart by studying potential harms as well as benefits.

Dr Simon Bradstreet is well aware of the prevailing narratives about digital technology in mental healthcare. The lecturer in digital health interventions at the University of Glasgow says they tend to go one of two ways. Either they glorify digital mental health intervention, depicting it as a universal remedy, or they dismiss its value, claiming its suitability only applies to young, tech-savvy people with straightforward needs. Dr Bradstreet contends the reality lies somewhere in between, and it's an argument reinforced through the EMPOWER trial that he manages.

The trial has created an app enabling people with previous experience of psychosis to monitor their wellbeing. They answer a series of questions, with an algorithm identifying if those answers indicate a downturn and a possible risk of relapse, alerting healthcare professionals or peer support workers as appropriate.

That algorithm was the first digital mental health intervention to be regulated as a medical device by the Medicines and Healthcare products Regulatory Agency (MHRA). In a trial, the app was used even more widely than anticipated, including by non-millennials with complex needs, contrary to predictions in focus groups run at the outset.

But perhaps what really sets the app apart is a dedication to developing a nuanced view of its impact. "When you scratch the surface, people have all sorts of reactions to self-monitoring and using digital interventions," reports Dr Bradstreet.

EMPOWER has its roots in a 2014 call from the UK's National Institute for Health Research and Australia's National Health and Medical Research Council. The bodies wanted to commission a study into detecting and responding to early warning signs of relapse in schizophrenia.

That appeal immediately caught the eye of Andrew Gumley, professor of psychological therapy and Dr Bradstreet's colleague at the University of Glasgow.

He was particularly interested in creating an intervention for those with prior experience of psychosis, in which he says fear of relapse often prevents them from seeking help early. The notion of using a digital tool came early on. But, crucially, it was never seen as a solution in and of itself. "We wanted to design a system to enable not just the person to monitor their wellbeing but mental health staff to be able to respond in a timely way," explains Professor Gumley, who is chief investigator for EMPOWER.

There was also a strong desire to understand when the system wasn't working for someone. That – and the MHRA regulation – meant a robust approach to adverse events perhaps not typically characteristic of such work. "What we found was there was a reasonable number of adverse events once you looked for them," explains Dr Bradstreet. Discovering, for instance, that a user felt an anxiety-provoking pressure to answer questions immediately led the researchers to adapt the intervention to fit individual need.

"That's why I think monitoring adverse effects [of digital interventions] is a really useful thing for the wider field to be doing," says Dr Bradstreet. "Because it's improved our practices and it would improve a future intervention. Digital tools can have different effects for different people – not surprisingly."