

Issue 7
Spring 2019

RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

RCPsych INSIGHT

WHERE IS
EVERYONE? I THOUGHT THEY
CALLED THIS **SOCIAL**
PRESCRIBING!



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COLLEGE NEWS IN BRIEF



President's update

Professor **Wendy Burn**

Welcome to this Spring issue of *Insight*. As usual, it is packed with interesting articles.

Since the last issue, we have seen the release of the NHS Long Term Plan and you can find out more about it here. This followed months of hard work by College staff and members to influence the content – and our work bore fruit. Many years of underfunding of mental health services have now been recognised, and we have been promised that investment in our services will grow faster than in the rest of the NHS. We won't be sitting back now that it is published but will be working hard to make sure that the promises are kept.

We also have an update on social prescribing. Of course, you can't cure a serious mental illness with this alone, but I have met patients who have really benefitted when it's used alongside medication and psychological therapies.

So, find a bit of time to relax, sit back, and enjoy the read.

Scotland plays host to President's Lecture

January saw the first ever President's Lecture take place in Scotland, described as a "historic moment" by RCPsych President, Professor Wendy Burn. Over 130 College members, fellows, trainees and medical students gathered in Glasgow to hear Professor Peter Mathieson, Principal of the University of Edinburgh, talk about his career spent broadening the opportunities of higher education and the challenges of creating a sense of community at the University. Professor Mathieson, who was a

renal physician before moving to academia, acknowledged that a 'sense of belonging' was also often lacking for staff within health bodies. He talked of his commitment to staff and student wellbeing, a theme that was echoed in earlier presentations by psychiatrist and former Chair of Healthcare Improvement Scotland, Dr Dame Denise Coia, and former Chair of the Royal College of GPs, Professor Clare Gerada. The President's Lecture can be viewed online at: <https://youtu.be/jJkk5nQxyg4>

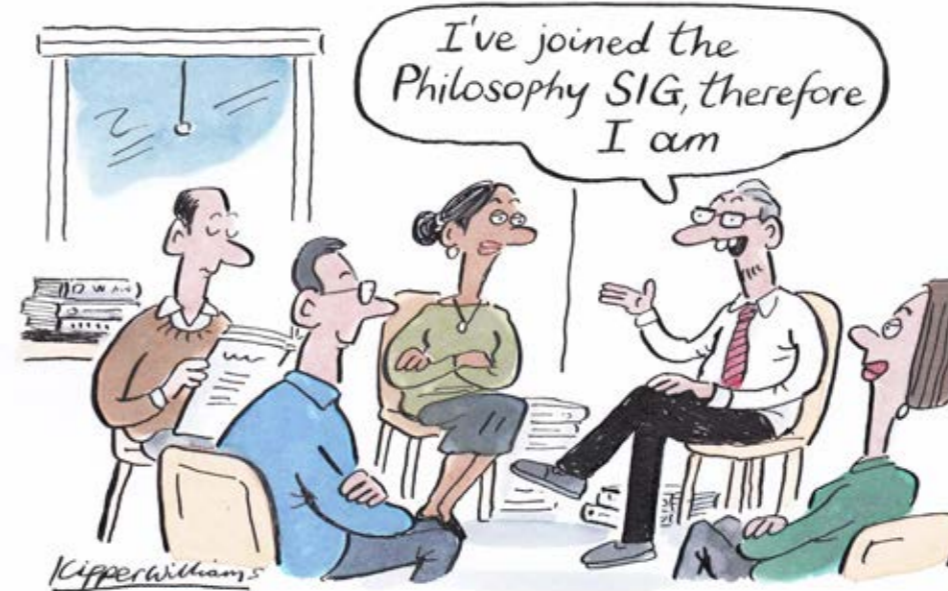


The RCPsych in Wales' artist in residence, Patrick Jones

#ThisIsMyTruthTellMeYours

The lived experience of people with dementia is the subject of a new arts project between the RCPsych in Wales and poet, author and playwright Patrick Jones. **#ThisIsMyTruthTellMeYours** will see Jones create new works from the thoughts, stories and aspirations of people affected by dementia. These are being gathered through creative writing workshops with carers and people living with dementia in venues across Wales. Members of the public are also invited to contribute poems, reflections or

short stories through the project website (thisismytruthtellmeyours.co.uk). "The feelings that come from creating a poem, a picture, a song can carry us somewhere else," says Jones. "In the fog of dementia these 'other places' can bring respite from the fear and loneliness this condition can cause." The project will culminate in the production of a series of spoken word features, monologues and a song-cycle, to be published and performed with leading Welsh musicians.



Find out more about the work of the College's 15 special interest groups (SIGs) on pages 8–9

New guidance on valproate

The RCPsych's Psychopharmacology Committee issued new guidance in December relating to prescribing decisions for valproate-containing medicines in women of childbearing potential. The guidance is in response to recent regulatory statements designed to minimise *in utero* valproate exposure. The RCPsych's guidance 'Withdrawal of, and alternatives to, valproate-containing medicines in girls and women of childbearing potential who have a psychiatric illness' (PS04/18) can be found at: <https://bit.ly/2GI1XiD>.

Mission: prevention

A growing awareness of the need to tackle the causes of mental health illness has led to a change in the RCPsych's mission. Alongside promoting excellent mental health services and being the voice of psychiatry – as well as our remit in training, quality and research and standard-setting – the College now has the aim of 'supporting the prevention of mental illness'. The new mission was incorporated as part of the RCPsych's new Strategic Plan, which can be read at: <https://bit.ly/2TW0LuK>. This is in line with our work with partners, such as the Equally Well initiative, which works to prevent and treat physical illness among people with mental health conditions.

Nominate your stars of 2019

Do you know of an outstanding team or individual who is making a real difference to mental health services? Nominations for the RCPsych Awards 2019 are open until

midnight on 12 April. Entry forms can be found on the 'About the College'/RCPsych Awards' section of www.rcpsych.ac.uk

Your feedback



"When I discovered the College was launching *RCPsych Insight* my initial thought was 'Is this something we need?' But, now the magazine has been coming out for the last two years it is clear that there was a gap in the market for something like this – and it now plays a key role in the life of the College."

Dr Owen Bowden-Jones
FRCPsych MSc (Imperial) MBChB
consultant psychiatrist

"The magazine is potentially a great way to spread the word about what's happening in psychiatry. I'd like to see more articles on personality disorders, which is my speciality."

Dr Pamela Peters, consultant psychiatrist

"I like hearing about what other people are doing, for example, in my trust. It helps to put a name to a face."

Dr Charlotte Scott, psychiatry specialty doctor

"*RCPsych Insight* provides an informal, relaxed way to learn about what's happening in the College and the world of psychiatry."

Dr Eduardo Iacoponi, consultant psychiatrist

"It's a useful way to find out what other people are up to in their careers. I recently sent an article to a student who was interested in a slightly different path."

Dr Dasal Abayaratne, higher trainee

Please send your feedback to magazine@rcpsych.ac.uk or tweet us with hashtag [#RCPsychInsight](https://twitter.com/RCPsychInsight)



Prime Minister Theresa May launching the government's ambitious plan to transform the NHS in January (PA images)

The future of mental health care within the NHS

Thanks to work undertaken by the Royal College of Psychiatrists, the **NHS Long Term Plan** is committed to improving mental health services. But what does that mean in practice?

In January, NHS England published its Long Term Plan which sets out its priorities for the next five to 10 years and how it will allocate its funding. The RCPsych submitted ambitious proposals to NHS England to influence the Plan and ensure that mental health receives the attention, funding and reform it needs. The RCPsych called for a significant expansion of access to mental health services, the biggest across Europe, and for an increase in both the amount and proportion of funding going to mental health services. To ensure that the money is well spent, we called for mental health leaders to be given the power to develop future services, and for mental health to be made a top priority in the system's new integrated care models.

Running through the College's submission was a focus on equality – across age, ethnicity and socio-economic status – and it proposed that people with severe and enduring mental illnesses receive the same attention as those with common mental health problems. All of the ideas we set out require a strong and resilient workforce, and so we called for more staff on the ground, including psychiatrists. The RCPsych's proposals – the quality and detail of which were remarked on by NHS England CEO, Simon Stevens – have influenced key funding and policy commitments in the Long Term Plan. Significantly, mental health will now receive a growing share of the NHS budget, worth at least a further £2.3bn a year in real terms by 2023/24.

The rise in children and adolescents suffering from mental health disorders has now been made a priority. Funding for these services will grow faster than both overall NHS funding and total mental health spending. Under the Plan, by 2023/24 an additional 345,000 children and young people will be able to access support via NHS-funded services, and school or college-based Mental Health Support Teams. Over the coming decade, the goal is that 100% of children and young people who need specialist care can access it. The Long Term Plan commits the NHS to a number of mental health targets in other areas highlighted by the College. For example, the number of people with severe mental health problems whose physical needs are met will increase, as will the number of women with perinatal mental health problems receiving specialist help. Professor Wendy Burn, President of the RCPsych, welcomed the Plan's much-needed focus on mental health and the commitment to spend a bigger

Making the plan a reality

Kate King, who experienced depression for many years, is a member of the core working group on the Independent Review of the Mental Health Act. Here she shares her service experience and gives her views on the Long Term Plan.

"I had suffered from depression since I was a teenager, but it got worse after I had my children. I ended up in hospital and was then sectioned. I repeated this cycle on and off for seven years until 2011.

"For me, there were two main problems. First, there was nothing available to help me until my condition deteriorated to the point where I needed hospitalising. Second, when I was released from hospital, there was no aftercare to support me back at home.

"The NHS Long Term Plan is looking

at integrating social and community care, which should improve support for people at home. It is also aiming to improve access to psychological therapies and reduce waiting times. If people can go to their GP, or call 111 and receive support earlier, that would make a big difference.

"Increasing funding is a real step forward too. When I was in hospital, it was clear there was huge stress on the system, which is not good for patients. If you put more money into services, you can improve training, boost the morale of staff, and stop skilled people from leaving.

"Although this is a 10-year plan, it needs to be seen as just the start. Patients, staff and organisations all need to work together as equals if we are going to see genuine, long-term improvement."



Kate King uses her lived experience to advise on the Review of the Mental Health Act

share of the NHS budget in this area. "We have worked hard to have this included and are very pleased that we have been listened to," she said. Although the Long Term Plan represents a huge step forward for mental health care, there is still much to do to see the proposed changes put into action. "In order to fulfil these promises," says Professor Burn, "we must have the skilled mental health workforce to deliver the help patients need." Since the Plan's

publication, the College has been working to help make sure it is successfully implemented. "We will keep a close eye on how effectively these plans are being delivered," says Professor Burn. "We will hold decision-makers to account to ensure that promised money reaches frontline services.

"The mental health sector has been striving to put mental and physical health services on an equal footing and we will continue our fight for that over the long term."

Prescription for life

The **Merseyside** approach to social prescribing offers structure and hope after mental illness.

Two years ago, former actor Ben Harris hit rock bottom after two periods of acute, in-patient treatment for severe depression, psychosis and self-harm. Back home in Liverpool, he found himself cut off from friends and family, afraid that his partner would leave, and on high doses of prescription drugs that only lessened his mental pain. The 37-year-old could not see a future until his support worker persuaded him to visit one of the City's libraries for a coffee. The library in question was the Life Rooms in Walton, a building saved from dereliction and converted by Mersey Care NHS Foundation Trust into a mental health hub. It is one of three hubs in the area dedicated to helping people rebuild their lives after major illness through an extensive programme of social prescribing. That initial cup of coffee at the Life Rooms was Ben's first step in a self-help process, one that has led to him securing a full-time job helping young people, halving some of his medications and, most importantly, viewing his future with hope. Mersey Care put social prescribing at the heart of its mental health programme five years ago after speaking to patients across Merseyside. It was clear users wanted recovery services that were more focused, as well as a say in what was provided. They didn't like the stigma associated with some NHS services, they said. They did like libraries. The result was Life Rooms Walton, which has seen 38,000 people through its doors since 2015 and acts as a base for a range of activities, as well as still functioning as

“A project like the Life Rooms equips people with the tools they need to rebuild their lives”

Dr Rebeca Martinez

the local library. It is home to the Recovery College, which provides over 60 courses, from anxiety management to choral singing and even stand-up comedy. Another of the hubs in Southport receives up to 1,200 visitors each month, and a third centre, which plans to develop resources aimed at young people aged 14–25, has just opened inside Hugh Baird College in Bootle. Social prescribing is not new – London's Bromley-by-Bow Centre has been operating for over 20 years – but it has recently had a spotlight shone on it by Health Secretary Matt Hancock. “Social prescribing can lead to the same or better outcomes for patients without popping pills,” Hancock told an audience at the King's Fund think tank last year. Acknowledging that it can also save the NHS money, he has promised £4.5m to social prescribing schemes. Community-based consultant psychiatrist, Rebeca Martinez, who has been involved with the Life Rooms from the start, is a strong advocate of social prescribing, but alongside evidence-based treatments. She does not believe that social prescribing – whether that's concert tickets or gym passes – can replace clinical interventions,

particularly for people with severe and enduring illness. This is also the position of the RCPsych. Since January 2018, the College has been working with MPs, NHS England and others to build a network of psychiatrists and other mental health professionals to support the development of social prescribing across the NHS. The crucial role it plays, Dr Martinez believes, is in offering users hope after a life-changing mental illness, as well as giving them a structure within which to create a new future. “You see people who have completed treatment and are no longer clinically depressed, but they are still unhappy,” she explains. “A project like the Life Rooms equips people with the tools to rebuild their lives.” Dr Martinez sees social prescribing as akin to behavioural activation in CBT. “A recovery-focused approach uses social prescribing as a way to help people achieve social goals, and ultimately reduce the impact of their illness on their lives,” she says. The problem in many areas outside Merseyside is that social prescribing is unstructured, meaning psychiatrists have no system into which they can refer patients. At

Life Rooms, referrals come from community psychiatrists and their teams, as well as from around 50 local GPs. People can also just walk into the Victorian building for a cup of tea and find themselves drawn in. There's no stigma, because the hub functions as a community facility too. Discharge from secondary care is often the point of contact. Dr Martinez has a card resembling a prescription that she offers to users, although she is alert to opportunities to initiate social prescribing activities earlier. Service users are then invited to create a recovery package alongside a pathways advisor. “The key is to tap into the individual,” says Michael Crilly, Mersey Care's director of social inclusion. “You have to start with their heart's desires, and it's then how you can organise that to make it happen.” It might involve a course on films, gardening, or even joining a massed choir alongside the Royal Liverpool Philharmonic Orchestra. It could be confidence-building classes, or one of the many wellbeing sessions, such as smoking cessation, weight management, or healthy eating. The aim is to tempt people into trying a large array of courses that will help them understand and manage their conditions better.



Ben Harris benefitted from social prescribing

A high priority of the Life Rooms is helping people back into work, with sessions to boost literacy and IT skills, and links to the local Chambers of Commerce and Lloyds Bank. Opportunities to volunteer at the venue are another way of setting people on the path to employment. Even helping in the café can provide marketable skills. “We don't want people to become stuck,” says Dr Martinez, warning that the hub shouldn't be seen as a comfort blanket. “We want people to see it as a stepping stone, not as an end in itself.” There is an abundance of qualitative evidence that the Life Rooms model works, which is why Mersey Care is

broadening its remit and trialling a pared-down version inside the high-security Ashworth Hospital. Quantitative evidence is harder to generate, and more work is needed, but initial evaluations suggest that users of the Life Rooms cost less in clinical interventions and require fewer drugs and admissions. For Ben Harris, whose mental health problems date back to adolescence, the benefits are measurable. “Until I came to the Life Rooms, I had never thought that my condition was something I could do anything about, myself.” Since arriving, Ben has taken courses designed to help him understand his condition, alongside creative writing, walking groups and he has even performed stand-up. It has given him structure, friends, and an outlet for his feelings. With new confidence, he volunteered at the Life Rooms, which led to his current full-time job. “Life is very good now,” Ben says. “Medication, CBT and psychoanalytic therapy have all had their place in taking the edge off the extremes of my illness, but the social prescribing side has been dominant, because it really moves the recovery along.”

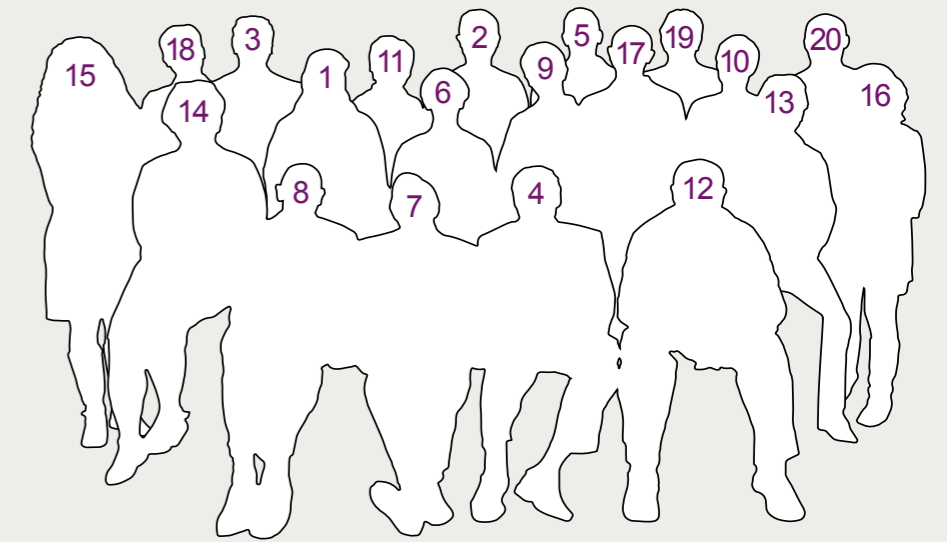


Cooking class at the Life Rooms (Image provided by Mersey Care NHS Foundation Trust)



Who's who in the special interest groups?

- (Not pictured): Dr Abdi Sanati, Chair, **Philosophy SIG**
1. Dr Heidi Hales, Chair, **Adolescent Forensic Psychiatry SIG**
 2. Dr Peter MacRae, Joint Chair, **Arts and Psychiatry SIG**
 3. Dr TBS Balamurali, Joint Chair, **Arts and Psychiatry SIG**
 4. Dr Riadh Abed, Chair, **Evolutionary Psychiatry SIG**
 5. Dr Dan Beales, Chair, **Forensic Psychotherapy SIG**
 6. Dr Claire Hilton, former Chair, **History of Psychiatry SIG**
 7. Dr Tom Berney, Chair, **Neurodevelopmental Psychiatry SIG**
 8. Professor Neil Greenberg, Chair, **Occupational Psychiatry SIG**
 9. Dr Lesley Haines, Chair, **Private and Independent Practice SIG**
 10. Dr Máire Cooney, Chair, **Rainbow SIG (LGBT)**
 11. Dr Alison Gray, Chair, **Spirituality and Psychiatry SIG**
 12. Dr Alan Currie, Chair, **Sport and Exercise Psychiatry SIG**
 13. Dr Shahid Latif, Chair, **Transcultural Psychiatry SIG**
 14. Dr Beena Rajkumar, Co-Chair, **Women and Mental Health SIG**
 15. Dr Ruth Reed, Co-Chair, **Women and Mental Health SIG**
 16. Dr Claire Wilson, Academic and Events Lead, **Women and Mental Health SIG**
 17. Dr Brad Hillier, standing in for Dr Sophie Thomson, **Volunteering and International Psychiatry SIG**
 18. Catherine Langley, Team Administrator and PA, RCPsych
 19. Dr Adrian James, Registrar, RCPsych
 20. Paul Rees, CEO of RCPsych



One of the key functions of SIGs, however, is to further the knowledge and skills of psychiatrists, and provide extensive opportunities for members to learn from peers and others. The largest of the groups, the Philosophy SIG, has spent the past quarter of a century bringing philosophers and psychiatrists together from around the world. Meanwhile, attendees of a recent conference on gangs organised by the Adolescent Forensic Psychiatry SIG heard insights from MPs, the police and

academics, and also someone with lived experience of gangs. The popularity of SIGs means that we now have the maximum number allowed under the College's Bye Laws. Through their variety and scope, they provide a welcome home for members wanting to explore their interests and become more actively involved in their profession and practice, in policy development and public debate. Find out more about the SIGs at: www.rcpsych.ac.uk/members/special-interest-groups

My first aim was to create a forum – a safe haven – where psychiatrists could express their views, without fear of criticism, on the relevance of spirituality to psychiatry,” says psychiatrist Andrew Powell, of his resolve in 1999 to establish a special interest group within the College dedicated to spirituality. Back then, when its members met in the friendly, if cramped, College HQ in Belgrave Square, spirituality in healthcare was still widely seen as “either irrelevant, or as a sign of eccentricity”, he explains. The relevance of spirituality has since emerged as a subject for study and discussion across both physical and mental healthcare. And two decades later, Dr Powell, who chaired the special interest group (SIG) until 2003, notes that the group today “could feel almost – if not quite – mainstream”. Its membership has grown to over 3,600, making it one of the largest and most active of the College’s 15 SIGs. For practitioners with an interest in a particular area of psychiatry outside of the main specialties covered by the College’s faculties, these groups provide a wealth of benefits. They create valuable networks, encourage research, disseminate knowledge, develop skills and stimulate discussion. For some, such

Shared interests

The College’s 15 special interest groups provide a wealth of benefits to psychiatrists, policy-makers and patients.

as psychiatrists in independent practice, membership of a SIG can also be an important bridge into the College, as well as provide support from peers. With groups covering topics as varied as the arts and psychiatry, evolutionary theory, and volunteering, the SIGs are also a good reflection of the diverse interests and enormous scope of the profession. “The SIGs allow people to explore important, cross-cutting areas in psychiatry, which opens up new opportunities for members,” says College Registrar, Dr Adrian James. “Without doubt, the work of these networks has led to considerable benefits for the profession and patients.”

With each operating independently under the umbrella of the College, there is also great variety in the activities of the SIGs. Take the Women and Mental Health SIG, which has the joint aim of improving the mental health of women and supporting the working lives of women psychiatrists. Its recent ‘Women in Mind’ series of public events invited leading women – from politicians to practitioners – to talk about their views on, and experiences of, women’s mental health. As well as kickstarting an important debate, the events have helped build a formidable network of people campaigning for improved services. The SIG now has over 3,500 members and is frequently sought

out for its expertise, including by the All-Party Parliamentary Groups on mental health and domestic abuse. By contrast, the History of Psychiatry SIG has a particular focus on research, which is reflected in its events programme and biannual newsletter. Perhaps more surprising, though, is the group’s creative use of social media. Its Twitter timeline (@rcpsychHoPSIG) is a fascinating and media-rich dive into everything from the design of asylums to 20th-century media portrayals of mental health. Its outgoing chair, Dr Claire Hilton, who has just become the College’s Historian in Residence, explains how a grasp of the history of psychiatry can be useful to the profession: “It can help us question and reframe our understanding of current health service dilemmas,” she says. “Researching history is also fun,” she adds. Special interest groups provide opportunities too for members to share their expertise with the wider world. Rainbow SIG, formerly the Special Interest Group in Gay and Lesbian Mental Health, is one that has advised many external organisations over the course of its 17-year history, including the Church of England. It has also lectured on issues concerning LGBT mental health and discrimination as far afield as Jordan, Chile and Australia.



Intellectual disability psychiatrist Dr Nwamaka Uchendu

Beyond intellectual disability

Diagnosing mental illness is rarely straightforward. But when a person has an intellectual disability, it can be overlooked altogether.

“It isn't always easy to recognise when a person with an intellectual disability is mentally ill,” says Dr Nwamaka Uchendu from the Lewisham Mental Health Learning Disabilities (MHL) team in south London. “The problem is one of diagnostic overshadowing, where everything is attributed to the intellectual disability and perhaps not enough time is taken to understand the behaviour itself. You need to remove the history of intellectual disability and just look at what the person is presenting with and be curious about what else it could be.” That is why families and carers are so important. “A few people do refer themselves to our service – mainly those with mild intellectual disabilities who are able to advocate for themselves,” says

“We work not just with the patient but with the support system around them”

Dr Uchendu. “Mostly though, referrals are made by GPs after being alerted by carers or family members, who are very good at noticing if there's a difference. Especially if they've known the person for a long period, they will tell you these are not their characteristic behaviours.” Those who know the person best can also help with any communication

difficulties. Dr Uchendu herself is trained in Makaton, a system of communication that uses signs and symbols, which some of her patients understand. “It may also be that if you are left alone to spend time with them, they will tell you something,” she says. “Some that can't speak, can write, and some can use pictures or items of reference. So a patient who wants a drink might pick up a cup and then you have to work out what kind of drink they want.” She can also call on the expertise of speech and language therapists.

Dr Uchendu's team sees a range of conditions. Psychosis and anxiety disorders are particularly common, as is depression. As for treatment, Dr Uchendu says, “the first port of call should be psychological therapy, a behavioural approach. Sometimes psychotherapy is used alone, sometimes with medication.” But medication is always used with care. “These days, there's a huge emphasis on stopping the over-medication of people with intellectual disabilities.” The RCPsych's Faculty of Psychiatry of Intellectual Disability, of which Dr Uchendu is a member, supports the STOMP campaign (Stopping the Over-Medication of People with Learning Disability and Autism). Faculty Chair Dr Ken Courtenay welcomes the fact that intellectual disability has been supported as a clinical priority in the NHS Long Term Plan. “We're also pleased that GPs will now offer annual health checks to people with intellectual disability,” he adds.

“When they do get treatment, a large number of people respond,” says Dr Uchendu. “Some though, may not. In a complex case, you need to keep an open mind about what may be happening with this person. Sometimes, underlying physical illness could present as mental illness and it's important to rule that out.” Treatment works best when families and carers are involved. They can check that the person they care for is taking their medication; they can support them to attend appointments. “They help keep them stable and care for them when they're not able to care for themselves,” says Dr Uchendu. “And that's why we work not just with the patient, but also with the support system around them.”



Clinical nurse specialist Polly Murray, consultant psychiatrist Dr Tara Lawn and mental health midwife Wendy Carter

Building bridges

In perinatal mental health, community organisations that can connect women to mainstream services are vital.

The number of women experiencing mental health problems during their pregnancy and in the first year after birth stands at around one in five in England. Many, however, will not seek professional help. A survey reported by the Royal College of Midwives, for example, suggests that almost half of women with symptoms of depression in pregnancy will not tell their doctor for fear of being labelled mentally ill. In January, NHS England committed to boosting perinatal mental health services in its Long Term Plan. While the greater investment in services is vital and to be welcomed, stigma and other barriers can mean that women are not getting the help and treatment they need. This is where community-driven efforts to open up services can be invaluable.

Bikur Cholim, a voluntary organisation at the heart of the ultra-Orthodox Jewish community in East London, builds bridges between women in its community and mental health services. Its chief executive, Yocheved Eiger, says: “We recognised that some in the community don't have confidence in, or feel very stigmatised by, mainstream services.” Her organisation, which provides help for people with poor physical, or mental health, supports women with perinatal mental health problems to access the services they need. The organisation also makes sure that the professionals working with women in the community understand their cultural needs. For its part, the perinatal mental health team based at Homerton Hospital in East London has worked hard to establish

a relationship of trust and mutual understanding with the community. It has worked closely with Bikur Cholim, including running events to increase awareness among families of the services and support the team can offer.

The concerns of women in the community are also being addressed by the multi-disciplinary team. “Consistency in the professionals they see is very important,” explains Dr Tara Lawn, the team's consultant psychiatrist. “We try to ensure that women see the same person every time, so they develop a relationship.” “Confidentiality and other people knowing that someone has been seen by mental health services is also a major concern,” says Dr Lawn. The stigma faced by new mothers experiencing mental health problems is present everywhere, but it can be felt more keenly in close-knit communities.

“If you have a significant mental health problem,” says clinical nurse specialist Polly Murray, “there's the worry that people might question your ability to be a mother. It's upsetting for that information to be known in the community,” she says.

Another member of the team, perinatal mental health midwife Wendy Carter, explains the reluctance among some women to admit to experiencing problems. “When women are pregnant, they want to feel excited and it's supposed to be a positive time,” she says. “Even if they, or others in their family, have had mental health problems associated with childbirth, it's not something that people want to think about, or bring up.”

“There is a lot of stigma around asking for help,” says Dr Lawn, which can be down to a worry about what family members or others in the community think. “It's about feeling judged,” she says, “but it helps when families are aware of the support that the NHS can offer.”

Esther, a woman from the Orthodox Jewish community who was hospitalised for six months after giving birth, describes her experience as positive and one where she felt like her religion and culture were, for the most part, respected. Bikur Cholim's role in this and in making her feel supported by her community was crucial. “It was literally my backbone,” she says. Today, Esther is well on the road to recovery.

Helping offenders with mental health problems

Professor Pamela Taylor calls on psychiatrists to engage with Mental Health Treatment Requirements – an effective alternative to prison.

Finding ways to manage the mental health needs of offenders has never been a bigger priority. Self-harm incidents in prison are rising sharply and the latest Ministry of Justice figures reveal that, of the 325 deaths that occurred in prisons in 2018, about a third were self-inflicted. There is now strong evidence of very high rates of mental disorder among prisoners. Professor Pamela Taylor, Chair of the College's Forensic Psychiatry Faculty, advocates the increased use of Mental Health Treatment Requirements (MHTRs). These allow offenders with pre-existing mental health problems to access appropriate treatment and support while they serve a community or suspended prison sentence. She believes that psychiatrists need to be more aware of MHTRs, which she says are "a solution that can make a difference... to keep people safe, out of prison and help them stabilise their lives". Under the Criminal Justice Act 2003, a magistrate or judge can customise a community or suspended sentence by adding one or more requirements. An MHTR is one of the 13 requirements from which they can choose. It requires the offender to agree to receive regular mental health treatment. The sentence with requirement therefore takes the

"Offenders viewed the MHTR as mostly helpful in achieving health, not reoffending, and 'having a life'"

form of a three-way contract between the offender, the probation officer and the clinician, usually a psychiatrist. Because this is a contract, there are consequences if it is breached that could, in extreme cases, lead to re-imprisonment. Despite the benefits, MHTR uptake has been low. In 2016, they were included in fewer than 1% of community sentences. Part of the problem, according to Professor Taylor, is that not enough psychiatrists are coming forward to help. "It is essential that all College members are aware of the MHTR option," she says, "and how to work with patients and criminal justice agencies to resolve the instabilities this group worry about." New research by College members shows how valuable MHTRs can be in helping offenders to fix their mental health problems and get their lives on

track. The paper, 'Serving a community sentence with a mental health treatment requirement: Offenders' perspectives' by Professor Taylor and colleagues Dr Abigail Manjunath, Dr Rebecca Gillham and Dr Chiara Samele has recently been published in *Criminal Behaviour and Mental Health*. It featured interviews with offenders who talked about how chaotic their lives had been prior to receiving an MHTR. "They didn't want their lives to be like that, but for whatever reason they had not been accessing help," says Professor Taylor. One offender described how he would "get a bit paranoid about getting my head kicked in", and how this would lead to thinking that he should carry a knife "not to use it, but to protect myself". Another said that she felt that the authorities would only see the crime she had committed (arson). "They're not gonna see that this woman was suicidal, and it was a suicide attempt." With an MHTR, offenders explained how

their situation began to improve. "It's good to talk to people, because I bottle things up," said one who described how he now had a social worker, a community psychiatric nurse and two psychiatrists "looking after" him. Another offender expressed relief at "finally having a diagnosis" and feeling understood. Interviewees did have concerns, however. Some worried that an MHTR was stigmatising or were anxious about the consequences of being found in breach of it. "I don't like to tell people," said one offender. On balance though, all understood the risks of breaching the MHTR and saw it as an important part of getting their lives in order. "They felt able to stabilise," says Professor Taylor. "They viewed the MHTR as mostly helpful in achieving health, not reoffending, and 'having a life'." All the same, Professor Taylor acknowledges the concerns that many of her colleagues feel about working with the criminal justice system in this way.

One difficulty is the sanctions imposed on offenders who breach their MHTR. "Psychiatrists obviously have concerns that this involves them in punishment," says Professor Taylor. For her it's about good communication and getting a good understanding of what offenders need in order to be able to comply with their MHTR. It's often simple. For instance, an offender may have missed appointments because they couldn't afford the bus fare due to delays in benefit payments. "If there is a good working relationship with the offender manager, the psychiatrist will have help to resolve these things," she says. To overcome some of these issues and increase the use of MHTRs, the government has launched a new programme called the Community Sentence Treatment Requirement Programme. Test bed sites have been created across England, mainly in

primary care, led by project manager Mignon French. Professor Taylor welcomes this as a way of starting to get the right resources to the right people. While more money is needed to increase the uptake of MHTRs, Professor Taylor believes awareness among psychiatrists also needs to grow. "It is essential that all College members are aware of the MHTR option." To raise awareness and support psychiatrists, the College is planning to publish a position statement on the issue later this year. With a rising prison population in England and Wales, with such high death and self-harm rates, and high reoffending rates after short-term prison sentences, the need for effective alternatives to custody is obvious. "We need to keep people out of prison, give them structured relationships to help them stabilise their lives and treat their mental disorder," says Professor Taylor. "An MHTR is a good solution."



Professor Pamela Taylor, Chair of the College's Forensic Psychiatry Faculty

Late last year, NHS England published some startling statistics. The use of restrictive interventions in secondary mental health, and autism and intellectual disabilities services in the year to the end of March had increased by almost a quarter over the previous year. The biggest increases were seen in the use of physical restraint and seclusion. The figures coincided with the reporting in October of the shocking story of a 17-year-old woman with autism and extreme anxiety, known as 'Bethany', who had been kept in seclusion for almost two years at St Andrew's Hospital in Northampton. Just weeks later, royal assent was given to the Mental Health Units (Use of Force) Act, also known as 'Seni's Law' in memory of Olaseni Lewis, who died in 2010 after being restrained by 11 police officers in London's Bethlem Royal Hospital. Among other things, the Act requires mental health hospitals in England to take steps to reduce the use of force.

All of which adds urgency to an innovative programme recently launched by the RCPsych. The initiative – the national quality improvement collaborative to reduce restrictive practice – plans to cut by a third the use of physical restraint, seclusion and rapid tranquilisation by April 2020. It is the first in a series of initiatives – the second will be about sexual safety – that constitute the Mental Health Safety Improvement Programme (MHSIP), commissioned by NHS Improvement, which oversees foundation trusts and NHS trusts. It is led by the National Collaborating Centre for Mental Health, a research arm of the RCPsych, in response to concerns raised by the Care Quality Commission.

"The programme has been in the planning stage for nearly a year," says Dr Amar Shah, the national quality improvement lead for MHSIP. It was designed by an expert group comprising service users, clinicians, academics and others, and in autumn last year, a call was put out for wards to volunteer to take part. More than a hundred applied, which were then whittled down to the 42 with the greatest use of restrictive practices.

The chosen wards represent 27 of England's 54 NHS mental health trusts, covering almost every region. "The biggest proportion are intensive care units," says Dr Shah, "where you would expect to find the most unwell



The team at Rowans Psychiatric Intensive Care Unit (at St Michael's hospital in Warwick) planning their first change idea

Reducing restrictive practices

The use of restrictive practices on mental health wards has long been a matter of concern. Now, an innovative new programme, led by the RCPsych on behalf of NHS Improvement, aims to reduce the incidence of physical restraint, rapid tranquilisation and seclusion.

"Quality Improvement is about involving people closest to an issue to try to discover solutions"

and distressed patients. But we also have acute admission wards – both male and female – adolescent wards, forensic wards, an eating disorder ward and a dementia ward." Each participating ward has a core team dedicated to the programme. The teams are encouraged to meet regularly

to discuss what's working and what isn't, and to review progress. They also receive support from the national team of four quality improvement (QI) coaches. And every two months, the teams from all 42 wards get together to share their experiences. This is Quality Improvement in action.

"QI is about involving people closest to an issue to try to discover solutions," says Dr Shah. "It is best used for complex problems to which we don't really know the answer. It involves testing and learning what might work in a given context and it brings in a much more diverse group of people than usual. So, we're involving service users, the most junior staff, even admin teams and domestic staff on wards, together with the doctors, nurses and psychologists to think about what might help prevent the use of restrictive practice.

"And we're not just looking at the data at the end of the programme in April 2020 to see if it worked," explains Dr Shah, "because if it didn't work, we would have wasted a lot of time. We're looking at data in real-time, to see what's working, how it's working, and adapting accordingly. The use of data is very different. It's really asking the question 'Are we improving?' as we go." Chris Warren is a staff nurse on Lark Ward, a 10-bed, mixed-sex intensive care



Mary Ryan, programme advisor with lived experience of mental health services

unit in Woodlands, a specialist mental health unit based at Ipswich Hospital. All the service users have been detained under the Mental Health Act and, says Chris, restrictive practices are commonly used.

In the first two months of the programme, Chris has already noticed changes. "We have seen an improvement in the atmosphere on the ward," he says. "The staff are motivated to try new interventions, and with the service users' involvement, we have seen incidents reduce. Service users are more engaged, and we have a daily mutual help group that gives them a

forum to raise any concerns and requests. It is also an opportunity for all attendees to give thanks and update individuals with any news or changes on the ward.

"We have a core team involved in the QI project, including nursing staff, the psychology team, occupational therapy staff and the psychiatrist. The service users and visitors have contributed, and we have regular meetings involving the housekeeping staff and others, such as family members, maintenance and people involved in advocacy."

Mary Ryan and Chris Lynch have lived experience of accessing services and are actively and passionately involved in the MHSIP. "A lot of what we do," says Mary, "is telling and sharing stories." Chris talks of the fear engendered by restrictive practices. For him, when he fell ill, "knowing that restrictive practice happened meant that I ran away and lived in a tent for a month until I got well enough to just be an out-patient."

"I have experienced restrictive interventions," says Mary, "and I have experienced how traumatic they are, how degrading they are, and how they strip you of the fundamentals of being a person. And that is why I want to be a part of making them an extreme rarity, or a 'never event' – something that just shouldn't happen. Surely, together, we can do better than this." They both acknowledge that mental health services are underfunded, which can put huge pressure on staff. Wellbeing is important for staff and service users alike, says Chris: "Things need to improve for us all."

"It's often very small changes that make a difference," says Mary, "the tiny things that don't cost anything: kindness, a smile, gentleness, encouragement, an explanation."

Full details of the national quality improvement collaborative on reducing restrictive practice, including all the tools and interventions that are being tested, can be found at:

www.rcpsych.ac.uk/improving-care/nccmh/reducing-restrictive-practice
#MHSIP





Dr Jenny Drife, the College's new advisor on homelessness

Homing in on a growing problem

The number of people sleeping rough is on the rise. But Dr Jenny Drife, the College's new advisor on homelessness and mental health, is still optimistic that the profession can make a difference on this complicated issue.

Dr Jenny Drife rarely spends her working day in any one location. As consultant psychiatrist in a community mental health team for

homeless people, a lot of her work is conducted in the places occupied by south London's rough sleepers.

It is clear that homelessness is a growing issue across the country, although the true extent of the problem is difficult to quantify. On one night each autumn, head counts are conducted of all those sleeping outside in hotspots across England, providing a snapshot of the situation. In 2018, the figure was more than 4,600, representing an estimated 165% increase since 2010.

"It's really obvious the number of homeless people is going up," says Dr Drife.

"Whenever you go outside, you see it."

Approximately half of those sleeping rough are thought to have a mental health problem and similar numbers have either drug or alcohol problems.

It is in this context that Dr Drife has been named the Royal College of Psychiatrists' advisor on homelessness and mental

"Homelessness touches on such different areas of psychiatry, and on all the different College faculties"

health. It is a role that she feels will involve collaboration with people across the profession. "Homelessness touches on such different areas of psychiatry, and on all the different College faculties," she says. Despite the growing demand for support, and the challenging nature of her work, Dr Drife retains a largely positive outlook. Part of that is down to her team, she says. "Whenever I go to work I feel very optimistic because there's such a lot of good work being done."

Dr Drife is a member of the START community mental health team for rough sleepers, run by South London

and Maudsley NHS Foundation Trust. Founded in 1991 by Dr Philip Timms – one of the first champions on the issue of homelessness and mental health – it is among the few teams set up in the 1990s, the last time there was a homelessness crisis, that is still in existence.

As attention now falls on the commitment in the NHS Long Term Plan to invest an extra £30m in mental health services for rough sleepers, Dr Drife stresses the need for, well, some proper long-term planning. "There needs to be a lot of thought put into how that money is spent, and making sure that it is sustainable," she says.

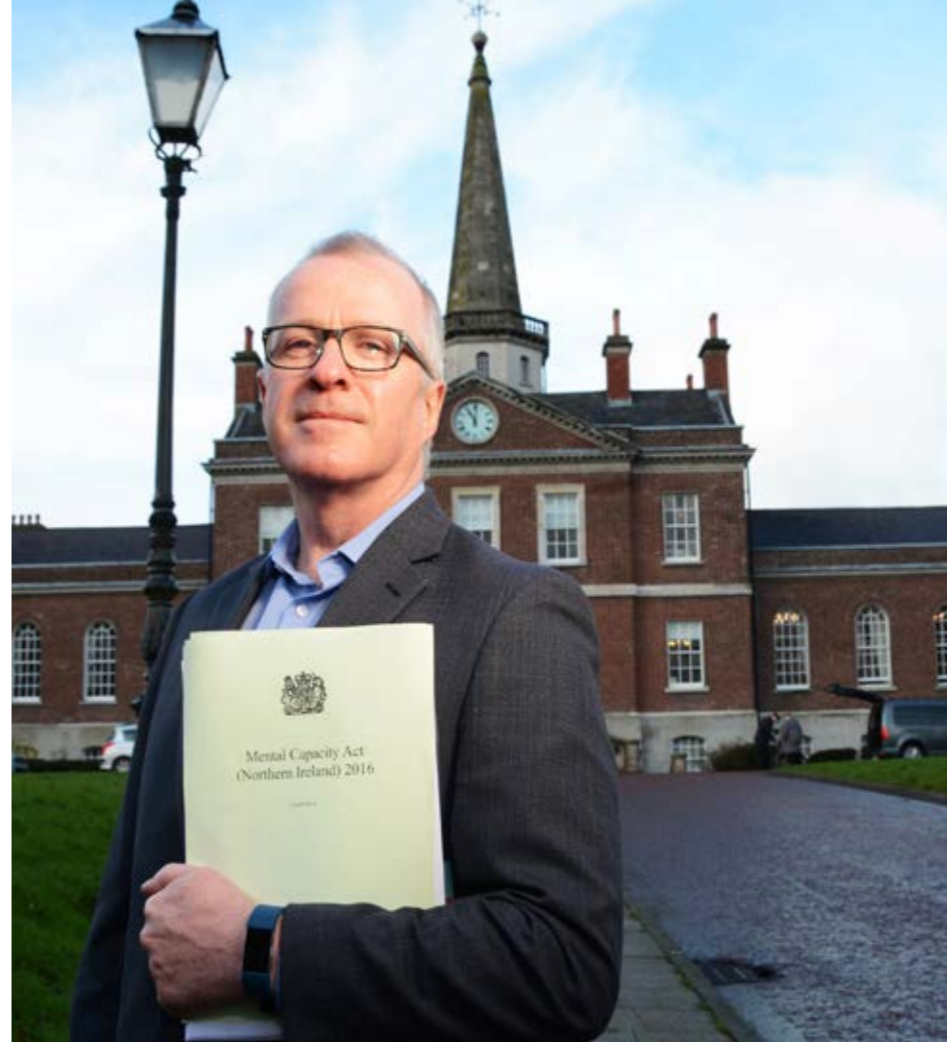
"Teams can't be set up to then fall by the wayside, or close down. This needs to be ongoing work."

Specialist services aren't necessarily the whole answer, according to Dr Drife. "Specialist services like mine are few and far between, and it's unlikely there's ever going to be one in every area," she says.

It's more achievable, she believes, for people in standard mental health teams to think how they can ensure that homeless people aren't excluded from their services.

"It's great that there's this commitment in the Long Term Plan," she says, acknowledging that "the will is there".

For Dr Drife, it is now up to the profession to make it happen. "It's why I'm really pleased to have this role. It feels like a way to turn that commitment into a reality."



Dr Gerry Lynch, Chair of the RCPsych in Northern Ireland

Capacity for change

Northern Ireland is pioneering a new approach to mental health legislation, and the RCPsych is in the vanguard.

The Mental Capacity Act (Northern Ireland) is a ground-breaking example of 'fusion legislation' that brings together laws governing

mental health and mental capacity. Once it comes fully into force, it will dispense with the need for separate mental health legislation.

Dr Gerry Lynch, Chair of the RCPsych in Northern Ireland, explains the Act's underlying principles: "It is fundamentally about treating mental and physical illness within the same legal parameters. It is more compliant with the European Convention on Human Rights and the UN Convention on the Rights of People with Disabilities. The question will be not whether a person is mentally ill, but whether their mental illness has led to a loss of capacity. Decision-making can only



Dr Gerry Lynch with Dr Catherine Taggart

be taken away from them because of a lack of capacity, not because they have a mental illness.

"Restrictive practices are still possible under the Act, but the regulatory authorities will have to be assured that the conditions are met. There will have

to be a clear statement of incapacity and of proportionality, as well as a statement that restrictive practices of any kind should only be used when they are necessary to prevent harm."

The Mental Capacity Act (MCA), which applies to people aged 16 or over, was 14 years in the making. In 2002, Northern Ireland's Department of Health commissioned a wide-ranging independent review of the "law, policy and provision affecting people with mental health needs or an intellectual disability". The Bamford Review reported in 2007, but the MCA, which is based on its recommendations, did not become law until May 2016.

The MCA will not come into force until its detailed workings are fleshed out by a comprehensive code of practice and accompanying regulations. The envisaged timescale takes us to 2020, whereupon the existing legislation, the Mental Health (Northern Ireland) Order (1986), will be repealed and replaced by the MCA.

But there is a problem: there is currently no government in Northern Ireland following the collapse of the power-sharing executive in January 2017. Until government is restored, formal approval of a code of practice cannot be granted.

"There is a draft code of practice that has been informally consulted on by relevant stakeholders, including ourselves," explains Dr Lynch. "But it has to go through a formal consultation process and that requires a minister to sign it off. There also needs to be awareness-raising, extensive training and the identification of resources, but a clear timescale has been held up by the lack of an Assembly. We're thinking that implementation by 2020 is increasingly unlikely."

While the Act remains in limbo, however, the RCPsych's work continues. "We're very committed to making this work the best that it can for clinicians and for patients," says Dr Lynch. "We've formed a Royal College working group which is going through the code of practice and drawing up clinical scenarios."

The working group includes many who have been involved in the development of the legislation, including consultant psychiatrist Dr Catherine Taggart, who has written widely on the MCA. Once the Act is implemented, the code of practice will, says Dr Lynch, be kept under regular review. "It is modifiable as we go along. That's why it's so important."



Dr Amanda Poynton (right) communicating with a patient (centre) through interpreter Munawara Ali (left)

Lost in translation

Manchester-based interpreters and psychiatrists come together to break down language and cultural barriers in mental health.

The patient, an older Indian woman with limited English, has her head turned away. She is pointedly ignoring the approaches of the Manchester mental health team. That is until an interpreter, who is sensitive to her culture, suggests that they address her with the respectful title used in her community. They call her 'Aunty-ji', not Mrs X. "Have you learned your lesson now and decided to give me respect?" the patient says through the interpreter, turning at last to face the clinical team. They are now communicating. The psychiatrist is able to assess her and determine a course of treatment.

This patient story from central Manchester

"As psychiatrists, we are so reliant on interpreters"

Dr Amanda Poynton

dates back to the inception of the local linkworker service two decades ago. But it still reflects something of the daily challenges faced by psychiatry professionals working in the most linguistically diverse conurbation in Western Europe, where more than 200 languages are spoken. To do their job,

psychiatrists need qualified interpreters who have an understanding not only of mental health but also of the nuances of culture.

Working in central Manchester – home to thousands of students, with significant numbers from overseas, and an area with a large local south Asian population and accommodation for many asylum seekers – consultant psychiatrist Dr Amanda Poynton often requires an interpreter twice a day. She counts herself lucky to be able to draw on a small team of in-house, mental health-trained interpreters – covering Urdu, Farsi, Punjabi and Arabic – and a bank of around 50 languages from Spanish to Hindi.

Her situation, however, is not replicated

across the NHS nationally. Many trusts are reliant on translation via telephone or video, which can mean that interpreters do not have mental health training. Even across Greater Manchester Mental Health NHS Foundation Trust, not all areas have fully developed linkworker services, although the trust is working to extend these across its whole footprint.

Dr Poynton believes that specialist linguistic resources are not prioritised enough in psychiatry, a clinical speciality that relies heavily on verbal communication. "Psychiatry assessment depends on evaluation of both language and behaviour," she says. "The treatment that you receive depends on my understanding of what is going on in your mind. Even when a person is very unwell and the treatment is initially focussed on medication to prevent serious harm, how that is assessed is modulated by language."

Approximately 8% of the UK population speak a main language other than English. Not all NHS trusts require interpreters equally, but across primary

care NHS England puts the total costs of interpretation and translation at between £3.5m and £5m, although they acknowledge this is likely to be an underestimate.

Using an interpreter changes a psychiatric session. It will be longer – up to three times as long – but it opens doors that would otherwise remain closed, such as informed consent. Having a professional interpreter also avoids problems encountered when a family member is drafted in to interpret for a patient. It is not uncommon, say psychiatrists, to find that the relative acting as the mouthpiece of a woman in a domestic violence case is her abuser. Relatives may also distort, or omit information to protect family honour, or because certain subjects are culturally taboo.

At other times, patients, clinicians and trained interpreters need to work together to decode what are sometimes presented as physical symptoms, but which are in fact mental health problems. In some communities in sub-Saharan Africa, for example, there is no term for depression.

"As psychiatrists, we are so reliant on interpreters," says Dr Poynton. "The most important aspect is their ability to build up a rapport with somebody. If that's done well and you have the same interpreter for that patient, together you can build up a much more detailed picture of the situation," she says. "Many people with mental health problems will feel alienated to some extent and, of course, this is likely to be intensified by a language barrier."

Dr Poynton does not think that video or phone translation services are adequate, particularly for an assessment. "The nuances of communication, the non-verbal aspects, are more limited, and so the ability of the clinician and patient to have an effective dialogue is reduced," she explains.

Munawara Ali, who coordinates central Manchester's interpreters through the mental health link worker service, believes specialist training for interpreters is vital. That means not only having a proper grounding in psychiatric terms, but also knowing how to observe body language, speech speed and words used, and how to convey this information appropriately to clinicians.

Mrs Ali, who speaks Urdu and Punjabi, says: "It is about giving Black, Asian and minority ethnic (BAME) people access to mental health services. If we were not there, many people would not come forward to get help."

Even with an interpreter, translation for some conditions can be difficult. If a patient is experiencing delusions, for instance, or if they become very agitated. This is where interpreters' training and experience counts. Mrs Ali's team also receive supervision and support. As she says: "When clients are talking about their distress, and interpreters are using the same words, they can feel the same emotions." A psychiatrist, who does not want to be named, gives an example. A French-speaking client from Rwanda was recounting her harrowing history of surviving massacres in her country. The interpreter was from France and had no such life experience, or mental health expertise. Midway through the session, the psychiatrist called a halt. The interpreter was in tears and clearly traumatised.

NHS England has worked with professionals and the public to try and determine what good quality interpreting services look like in primary care. In the past two years, it has produced guidance for commissioners. Many health professionals now believe the same needs to be done for acute settings and, in particular, psychiatry.

A spokesman for the mental health charity Mind said: "Discussing your mental health with a healthcare professional can be a challenging and deeply personal conversation. Attempting that conversation in a language other than your mother tongue only adds to that challenge." According to the charity, even when people do seek support, often mainstream mental health services fail to meet particular cultural or language needs. This, it says, can lead to incorrect diagnosis and inappropriate support. "Mental health services need to recognise that every community is unique and every person deserves access to the right support," it says. Having professional interpreters trained in mental health, and services that are culturally appropriate is essential, Mind believes, to ensure that all patients are able to play an active role in their care.

A screenshot from the video game *Hellblade: Senua's Sacrifice*

Game changer

The award-winning video game pitching a Celtic warrior against her own world of psychosis.

Peering over the shoulder of a young woman in a canoe, the game player hears voices coming from all directions. At times they murmur discouragement, then they warn of danger, before uttering the shattering words: "Do not forget your story, because it comes from hell."

What follows in video game *Hellblade: Senua's Sacrifice* is an interactive journey with Pictish warrior, Senua, through an 8th-century Viking land of the dead to find her lover. Along the way, she encounters blazing bridges, landscapes littered with gallows and moments of surprising beauty. What makes it stand out from other video games is that Senua's battles are all in her mind, reflecting her severe psychosis. *Hellblade* is a game changer. Not only has it sold more than 1.5 million copies, but it has won its creators, Cambridge-based developers Ninja Theory, five video game BAFTAs, as well as the title of Psychiatric Communicator of the Year in the Royal College of Psychiatrists' 2018 awards. The game's unlikely success is down to the meticulous care with which *Hellblade's* developers created an accurate world of psychosis. According to Paul Fletcher, Professor of Neuroscience at Cambridge

Developers honing *Hellblade's* striking visuals

University and a consultant psychiatrist who acted as an advisor to the project, the game provides a new and powerful way for people who suffer in this way to share and explain their reality.

"The fact that the gaming context demands that the player fully engages with the experience really excites me," says Professor Fletcher. "It provides a great opportunity to demonstrate that all of us are creating our own worlds and realities all the time. If you play it seriously, you can't help but sympathise with the character." As a small player in a crowded market, Ninja Theory was looking for a way to stand out. After Tameem Antoniades, Chief Creative Director, read a book on psychosis, and news broke of the archaeological discovery of a newly

identified Celtic goddess in Hertfordshire called Senua, a risky decision was taken to create a heroic journey into the mind of a person experiencing serious mental illness. Ninja Theory's commercial director Dominic Matthews explains: "We see *Hellblade* as an allegory. Inside this compelling adventure is a message that will help people understand the world of loved ones and friends."

The developers soon realised the project needed expert input. A simple request for advice turned into an 18-month-long collaboration with Professor Fletcher. This involved spending a considerable amount of time with people with experience of psychosis from Recovery College East, part of Cambridgeshire and Peterborough NHS Foundation Trust, supported by the Wellcome Trust.

The voices heard within the game were recorded by actors in such a way that game players hear them as three-dimensional sound. The inspiration for the imagery – both disturbing and beautiful – came from people with lived experience of psychosis, who also verified that everything was portrayed as authentically as possible. Sales rocketed, and the overwhelming majority of buyers are people with no experience of psychosis. Professor Fletcher, who now uses the product as a teaching tool, is currently working with Ninja Theory to explore new ways to combat stigma surrounding mental illness. Some might question the ethics of using the experience of mental illness for commercial gain, but this is countered by the positive reaction to *Hellblade* from people with psychosis. Says Recovery College East manager Tracey Bartlett: "The game shows that, despite all that Senua has been through, her experience is valid and it is something we should all be talking about."