

# RCPsych INSIGHT



## Contents

4-5

### Action now

RCPsych's strategy to help tackle systemic racism

6-7

### "I could not stay quiet"

Three senior psychiatrists on racism and the future

8-9

### Generations together

COVID-19 draws trainees and retirees into new roles

10-11

### Virtual RCPsych

Moving the College online

12-13

### Building a better future

Calls for government spending on the mental health estate

14-15

### Facing up to our responsibility

Taking a stand on climate and ecological issues

16

### Combatting conspiracies

Action on coronavirus conspiracy theories

17

### The international outlook

The College's first-ever international strategy

18-19

### Potentially lifesaving

When other treatments fail, ECT can be a lifeline

20

### Room service

Keeping homeless patients safe during the pandemic

## Your Insight

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# COLLEGE NEWS IN BRIEF

## Recruitment drive pays off



Old age psychiatrist Dr Manraj Bhamra in a Choose Psychiatry film

New figures show that recruitment in psychiatry has hit another high, with the number of applicants for core training reaching almost 100% of the positions available. The success is in large part thanks to RCPsych's Choose Psychiatry campaign, now in its fourth year.

In 2017, with the percentage of places filled in England standing at just 67%, the College embarked on a recruitment campaign with support from Health Education England. "We began with focus groups and were surprised that psychiatry still got a bit of a bashing from other areas of medicine," explains RCPsych's head of external affairs, Bex Couper. "The other issue was that students had little idea of the breadth of psychiatry or the

range of places you could work."

The result of these discoveries was a series of online films showcasing psychiatrists' work with the military, homeless and refugee communities, in low-secure units and in the community. Each featured real psychiatrists who make "great ambassadors" for the profession, explains Couper.

The campaign has elevated the profession not just in Westminster and the media – with members making frequent TV and radio appearances – but also in medical circles. The College's Choose Psychiatry Committee has ensured there's an active engagement network across the UK. And having previously struggled to attract enough trainees, this year psychiatry overtook general practice, paediatrics, obstetrics and gynaecology, and emergency medicine in terms of the percentage of places filled. "The films are highly engaging and emotive," says Couper. "They remind us that this is an incredible area to study, where you do really make a difference."

## New school of medicine

Psychiatry in Northern Ireland has been given a boost with the announcement that a second medical school will open in the province at Ulster University in September 2021. RCPsych has supported the proposal throughout the General Medical Council's rigorous approval process and is now ensuring that mental health is at the heart of the curriculum.

"This news is to be greatly welcomed," says Dr Richard Wilson, Chair of RCPsych in Northern Ireland. "It will help place mental health at the core of teaching and develop a generation of clinicians with an understanding of the inter-connectivity between primary, secondary, social and community-based healthcare."

## Restrictive practices fall

There has been a marked reduction in restrictive practices by wards that participated in the National Collaborating Centre for Mental Health's (NCCMH) Reducing Restrictive Practice Collaborative, which drew to a close on 10 September.

The 18-month programme reduced the use of restraints, seclusions and rapid tranquilisation by 15% across the 38 wards that took part from 26 provider trusts. Twenty-four of the wards have seen reductions ranging from 25% to 100% in one or more measures of restrictive practice.

Supported by quality improvement coaches from NCCMH, the wards were tasked with coming up with ideas, which were then tested and the impacts measured. They also collaborated with patients to improve practices. Even where there

was no quantitative improvement, wards showed significant qualitative improvements, including better physical space, a renewed focus on person-centred care and improvements to the culture on wards. Both patients and staff noted positive changes, with some wards reporting that patients felt their involvement in the project has supported their recovery.

The programme was the first to take a 'quality improvement' approach on a national scale within mental health services in England to tackle a complex safety issue. A second national collaborative is about to use a similar approach to improve sexual safety on inpatient mental health wards. More information on NCCMH's work can be found at: [www.rcpsych.ac.uk/improving-care/nccmh](http://www.rcpsych.ac.uk/improving-care/nccmh)



Member engagement with the College's virtual activities has soared in the pandemic. Find out more on pages 10-11.



## President's update

It's my first issue of *Insight* as President, and I've had a busy and enjoyable three months engaging with members, policymakers, politicians and the mental health stakeholder group.

I'm very much aware of the huge impact that COVID-19 has had on our members and patients. Our everyday lives are transformed, and we are all working in a way we could never have foreseen. My thoughts are with all of you who have been most severely affected at home and at work. Some of you have experienced the most heart-breaking losses. I want to thank each and every one of you for your efforts and am glad that the commitment of our members is covered in this issue.

The pandemic has also shone a light on pre-existing inequities, none more so than for Black, Asian and minority ethnic psychiatrists and patients. Over the next four pages, the need to listen and respond with action to those who have experienced racism is highlighted as one of my priorities. COVID-19 also presents some opportunities to build back better and in a more sustainable way. We must learn, adapt and improve, whilst taking care of our own wellbeing and those we love and work with. Please read on.

Dr Adrian James

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# Action now on race equality

RCPsych's new Race Equality Taskforce is charged with creating an ambitious strategy to help tackle the systemic racism within healthcare. Focused on practical changes, its central aims are improved services for people from Black, Asian and minority ethnic communities and enhanced training for psychiatrists. The College's new Race Equality Leads explain all.

**T**he recent death of George Floyd and the subsequent escalation in Black Lives Matter (BLM) protests have shone a light on many areas

of our society, particularly those where racial inequalities are the most striking.

Several reports in the last few years have highlighted the significant health inequalities among BAME patients accessing psychiatry services. A systematic review published last year showed that Black patients, and to a lesser extent South Asian patients, are significantly more likely to be compulsorily admitted to hospital than their white counterparts. Studies have also shown that Black and Asian patients are much more likely to be diagnosed with mental illness and less likely to receive the support they need.

Dr Shubulade Smith, who, with Dr Rajesh Mohan, has been appointed RCPsych Race Equality Lead, notes that studies have shown that the rates of psychosis among Black and Asian people living in Black or Asian majority nations are much lower than among Black and Asian people living in the UK, USA and Europe.

She says that it cannot be pure coincidence that the area in London where she works, similar to Manchester and Birmingham, has some of the highest rates of mental illness in the world, including psychosis, as well as having one of the largest Black communities in the UK.

"In South London, psychosis rates are the highest not just in the country, not just in Europe but possibly in the world. So that tells you that there is something different going on in the UK compared with these countries."

Lots of hypotheses have been put forward to understand why this might be, but rarely has discrimination been investigated as a possible risk factor. Dr Smith emphasises that we must start to interrogate how the impact of daily racism plays a part in deteriorating mental health.

In 2018, a College position statement on Race and Mental Health acknowledged that race and racism plays a significant role in people's life circumstances and also mental health. But a recent letter to RCPsych's President – signed by over 150 psychiatrists and published in the *Guardian* – called for a more direct approach to tackling systemic racism.

Dr Adrian James made addressing racism within psychiatry an integral part of his campaign for College President. Yet, he acknowledges that we must start by looking beyond the problems within psychiatry:

"As I see it, we need to look at a variety of factors: going back to people's childhood, their experience of racism, of stigma, and how people have understandably been suspicious of seeking help, given the way in which

people with authority have acted towards Black people generally."

Dr James is also particularly aware of the toll race and racism takes on his colleagues. BAME psychiatrists feel less well supported by their organisations than their white counterparts, including being much less likely to achieve leadership positions within the NHS.

"Over the years, I have sat on various groups and have seen this issue analysed and actions proposed and yet, they seem to lose traction. I want this issue to have traction throughout the whole of my presidency and make sure we really look at actions rather than simply examining the issue, which is very obvious, very real and very much part of the experience of many of our members."

While Dr James is aware of the racial disparities within his field, he acknowledges that as a white man with no direct experience of racism, he will be using his role as President to listen and respond to others.

As Racial Equality Lead, Dr Rajesh Mohan is particularly keen that the College not just acknowledges the

colonial history of psychiatry, but also takes practical steps to improve and develop the curriculum. He wants all trainees to understand there are multiple social, cultural and racial factors that may be at play in someone developing mental illness, including the effect of microaggressions.

"We want to make sure that every trainee and every professional working in mental health thinks 'Why did this person get to this point?' And that brings in a level of cultural humility and a deeper understanding that then helps them to work with that individual." Dr Mohan recognises that people will need support to develop their own understanding. He also wants to see more research on the effects on people of living in a racialised and discriminatory society.

"There's some research that shows that people who have been exposed to discriminatory experiences, especially racial discrimination, tend to develop a paranoid thinking style. To me that is completely understandable."

Both Dr Mohan and Dr Smith are intent that practical steps are taken to address discrimination and inequality. For example, it is remarkable, says Dr Smith,

that we readily ask patients about their experiences of bullying and harassment, but a typical psychiatric history rarely includes questions on racial trauma.

Dr Smith also sees a need to actively engage local communities, with many unaware of local services, and to focus on their specific needs. Their plans include establishing skilled Race Equality Champions – drawn from trainees right through to senior consultants – who can drive change at both local and national level.

Psychiatry has also been too quick to homogenise people from ethnic minority groups that belong to diverse cultures and traditions, says Dr Mohan. The specific stressors that people from different demographics face need to be better understood, he says, and interventions should be personalised.

The combined impact of COVID-19 on BAME communities and the escalation of the Black Lives Matter protests make this a possibly unique opportunity to tackle inequality in psychiatry, which the Race Equality Taskforce is keen to seize. For his part, Dr James is committed to turning these words into action.



RCPsych Race Equality Leads Dr Shubulade Smith and Dr Rajesh Mohan

## BAME healthcare staff and COVID-19

In response to the high and disproportionate numbers of deaths of BAME healthcare staff due to COVID-19, and taking into account survey responses from College members, RCPsych has produced guidance on risk mitigation to be urgently implemented across all UK mental health care organisations. The guidance is being reviewed and adapted as the pandemic evolves.

Immediate steps include ensuring adequate PPE is available to staff, that BAME staff have priority testing, the possible redeployment of older male and BAME staff to lower-risk areas and consideration given to greater home working. Additional support should be given to engaging BAME staff about any concerns and accessing psychological support or safe spaces for sharing concerns.

Organisational changes could also include ensuring compassionate and inclusive leadership, an audit on the impact of interventions implemented to mitigate risk, and monitoring of staff absence by racial group.



Dr Pearl Hettiaratchy



Professor Femi Oyeboade



Dr Tim Ojo

“If we'd had the money to fly back, we would have gone,” laughs Dr Pearl Hettiaratchy, former RCPsych Vice President. In 1968, Dr Hettiaratchy and her husband moved to the UK, leaving their infant daughter in Sri Lanka while they tried to adjust in a new country. When she began her consultant post in Winchester, Dr Hettiaratchy became their first saree-wearing female consultant in any specialty. “I faced a lot of discrimination and racism, but at the time, I did not realise it.”

Professor Femi Oyeboade, an RCPsych Honorary Fellow and winner of a Lifetime Achievement Award, was born in Nigeria in 1954. Attending a private school with pupils of multiple nationalities, his background was not underprivileged. “But we were born into a colony, and in our own country there were places we couldn't go because of who we were,” he explains.

Dr Tim Ojo, RCPsych Associate Registrar for Policy Support, was born in the UK but also spent his formative years in Nigeria. On returning to the UK in the early 1990s, he worked as a psychiatry registrar in South London during a time of heightened racial tensions following Stephen Lawrence's death. He recalls a conversation with a residential patient with mild learning disabilities. “We were having a review session, and she was stroking my hand saying, ‘Tim, I like you a lot, but I feel sorry for you’. I asked her why. She said, ‘You're Black.’”

At the time, Dr Ojo laughed and reassured her that his role was to support her, and that he was happy being Black. “Her concern stemmed from a sense of superiority to me despite my role in her care,” he explains. “While others would have censored these views, her lack of social filters meant she shared them with me.”

While much public attention is given to overt displays of racism, Dr Ojo explains that “it is what's hidden, what's not stated, that can be as dangerous as

## “I could not stay quiet”

RCPsych President Dr Adrian James has promised to listen and respond with action to those who have experienced racism. Here, three of the College's most senior psychiatrists share their experiences, frustrations and optimism for the future.

**“It is what's hidden, what's not stated, that can be as dangerous as the hostility”**

the hostility and the aggression you might face from someone on the streets”.

Dr Hettiaratchy currently works as a second opinion doctor for the Care

Quality Commission and attests to this. “I am picking up cases where no one is racist, but there is racism, there is discrimination. It's not conscious, it is unconscious.”

Professor Oyeboade explains that it is essential to look at history to understand the “invisible assaults” Black people face. “The experiences of enslaved peoples are not far away,” he asserts. “And for many of us, our experience of colonisation is as recent as the 1960s.”

These demeaning and dehumanising

structures and rhetoric persist today, he says, giving the example of academia. “With an anthropology text, you have to steel yourself to read it because anthropology is an imperial project. On every page is an assault on your self-esteem, while another person will not see an assault there.”

Professor Oyeboade adds that Black people also experience invisible assaults by proxy from the mistreatment of public figures like Meghan Markle to the recent murder of George Floyd. “In most circumstances, your best defence against these attacks on the self is to ignore them and not give value to a destructive force because they are disruptive to your inner life.” However, recent events have made ignoring these assaults more difficult.

“George Floyd's death has made matters more visible that were in the background and generally ignored. I've lived in this country for 40 years,

but if you had stopped me six months ago, I don't think I would have been as conscious of how demoralising the climate has been.”

Professor Oyeboade adds, “Many of us are troubled by the fact that we have children and grandchildren, and we didn't expect that these kinds of assaults on us would continue.”

For Dr Hettiaratchy, recent events brought to mind one particularly unpleasant encounter. “Sixteen years ago, on a cold September night, my car was pulled over by the police and I was asked to step outside on a busy motorway. I was treated in a very aggressive, intimidating manner. I was breathalysed even though I never drink and drive, and one of the officers was [overtly] racist. I had almost forgotten that chapter, but when I saw what has happened this year, I could not stay quiet.”

“When you are out there, on the Tube, you are not Dr or Sir or Professor. That's why we have that barrister who was stopped and searched nine times. When he goes out there, he's a Black man. When I go out there, I'm a sareed woman. I'm not Dr Pearl Hettiaratchy.”

She continues: “It is really unacceptable that we are still waiting for change. In 1987, I worked on the College Committee on Psychiatric Practice and Training in a British Multi-Ethnic Society. That was

33 years ago, and we said then what everyone is saying today. I'm tired that that agenda we addressed hasn't been met.”

Still, Dr Hettiaratchy acknowledges that things have improved since she was the only saree-wearing honorary fellow among a sea of pin-striped suits. “The College is different. There are lots of things happening. I'm hopeful that in the next few years we will see a tangible change, not just for doctors and staff and at the College, but more so for our patients. It is they who are suffering.”

“The world my sons inhabit is more tolerant,” Dr Ojo agrees. “But is it perfect? No. Is there more that can be done? Absolutely. We need to work a lot harder, a lot faster, and a lot smarter, but things will get better.”

“The difficulties we are having at present is the last hurrah of imperialist Europe trying to stop what is inevitable,” says Professor Oyeboade. He foresees a globalised world and a complete change in ideas of borders, nationality and control. “Humans have always travelled, for 200,000 years since humans came up from the plains of East Africa, and they're not about to stop doing it.”

“This is the moment of change, we've got to grasp it,” says Dr Hettiaratchy. “The time for talking is over. It's the time for action. We've got to move forward.”

**D**onning scrubs and clogs, Dr Alex Beadel prepared for another day in A&E at Dumfries and Galloway Royal Infirmary. The patients were the usual mix – a teenager who'd fallen off his skateboard, a baby with a fever, an elderly woman with a broken hip.

Just weeks earlier, Dr Beadel had been a CT3 trainee in outpatient CAMHS at Midpark Hospital but in early March he found himself one of a number of trainee psychiatrists across the UK redeployed outside of his speciality to help the NHS cope with the pandemic.

The 32-year-old received an email from his health board announcing all outpatient appointments were being cancelled due to COVID-19 and staff moved to where they were most needed, especially in acute, respiratory and emergency medicine.

Any trainees with particular skills were needed to help out and, having spent a year in emergency medicine in Australia in 2015/16, Alex was sent to work in A&E. "I didn't volunteer but I was flattered that my skills had been recognised and was happy to help out," he says.

"I went over with another core psych colleague and in a four-day induction, the A&E consultants took us through everything including the newly devised COVID protocols."

His usual workwear is simply trousers and a shirt, but suddenly he was back in scrubs, this time, with full PPE.

"Luckily we didn't have any problems getting hold of PPE. Seeing suspected COVID cases I wore goggles, surgical mask, apron and gloves. For any higher-risk patients where CPR might be needed, I was in a full surgical gown, FFP3 mask and a face shield.

"I also dealt with lots of wounds – I hadn't seen blood in my job for a while! But I felt very well supported by the team when I wasn't sure of something. I had forgotten a huge amount of emergency medicine, even anatomy which I'd once taught, as I don't use it on a daily basis."

But as the expected surge in COVID-19 patients did not occur, coupled with the public being too scared to go into hospital, A&E attendances were down and he was allowed to return to psychiatry in early May.

"The experience made me understand the process that a psychiatric patient might go through when they present at A&E before being referred on to psychiatry," he says.



Dr Alex Beadel

# Generations together

As COVID-19 hit hospitals around the country, both trainees and retired psychiatrists suddenly found themselves deployed in new roles.

**“Three of my four children are in healthcare and were doing their bit in the pandemic, so I decided to go back”**

Trainee psychiatrists weren't the only ones that found a role during the pandemic. After a 35-year career, Professor Diana Day-Cody had been enjoying retirement for four years when her local trust wrote to her and other retired physicians asking if any would be prepared to go back to work.

"Up until then I hadn't thought about working again," says Professor Day-Cody who was formerly Vice President of RCPsych and Chair in Northern Ireland.

"I was very active doing Crossfit, and

training to be a riding instructor for disabled people. I had also taken my name off the GMC register. But three of my four children are in healthcare and were doing their bit in the pandemic, so I decided to go back as a locum consultant psychiatrist."

Once CRB/DBS checked, Professor Day-Cody decided to upskill herself. The main challenge, she admits, was about confidence.

"While I had used Zoom before at home I had to learn a whole new IT system for online consultations. I was pleased that paper entries are now done electronically, which is a change for the better!"

"I contacted colleagues who brought me up to date on the latest guidelines and found the College CPD material, including webinars and podcasts, invaluable. I hadn't been prescribing for a few years, so I needed to be more confident with doses and side effects."

In early July, Professor Day-Cody started at the South West Acute Hospital in Enniskillen four days a week, doing daily online outpatient consultations and thrice weekly clinical meetings. Day to day she wears scrubs – a new experience for her – in case she has to visit patients on the ward.

"It felt like starting a new job. Some staff – and patients – are still here so it's been interesting to see where they are on their journey."

Many of her patients find the online consultations less disruptive and less time-consuming. Attendance is excellent, she says. "I work with nurse practitioners who can visit patients and take photos or videos of any issues which they send to me and I can then prescribe for."

The main difference for Professor Day-Cody, is doing clinical as opposed to management work. "It brings you back to what your initial motivation was. Having both skills is empowering."

Professor Day-Cody and her team have seen more referrals, with some people having difficulties in coping with the very real losses they have experienced in lockdown. "We are also seeing over-50s presenting with psychotic illnesses," she adds. "Some have had a very difficult time in isolation with no access to day care and social support. Traumatized by the fallout, they have developed paranoia."

Professor Day-Cody hopes to stay on

working part time, saying: "I had forgotten how good it feels to be involved."

Dr Alex Beadel has recently started as an ST4 trainee in child and adolescent psychiatry at The Willows in Dumfries and hopes he won't get redeployed again now he is in higher training. "But it was good to have the experience and refresh those skills," he says.

Since the coronavirus outbreak, the College's coaching and mentoring network has been offering support to redeployed trainees and retirees returning to work through practical assistance and signposting to resources.

Dr Jan Birtle, the College's specialist advisor on coaching and mentoring, adds: "Both Dr Alex Beadel and Professor Diana Day-Cody were able to draw on and rapidly update their previous skills and knowledge and engaged others to ensure they worked effectively."

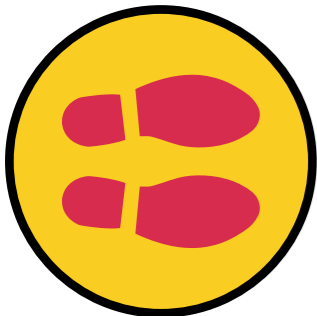


Professor Diana Day-Cody

# Virtual RCPsych



Former RCPsych President Professor Wendy Burn and Dr Abimbola Fadipe taking part in a members' webinar



**E**fforts to limit the spread of the coronavirus have resulted in serious disruption to our lives and the organisations we rely on. RCPsych, which is used to welcoming thousands of visitors from around the world to its offices every year, was swift to respond, taking the difficult but necessary decisions to cancel or postpone events, exams and award ceremonies. But it was also determined to migrate the vast majority of its services online, including its International Congress. As a result, and somewhat astonishingly, engagement with the College has seen a 100% growth as members continue to embrace a virtual College. Here are just some of the highlights.

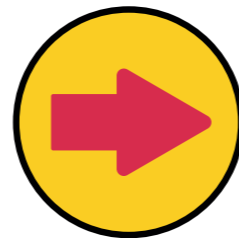
## Essential viewing

While 'Zoom fatigue' is something most are now familiar with, the convenience of virtual events has meant that members are viewing RCPsych webinars in significantly higher numbers than is possible at in-person events. In the six months since the College moved online on 13 March, RCPsych's programme of webinars have attracted over 45,000 views.

Nearly 3,000 members watched RCPsych's first webinar, almost 1,000 of whom tuned in live on 3 April, less than a fortnight after the UK went into lockdown. The webinar focused on helping members cope with the new circumstances, how psychiatrists could support colleagues across the NHS, and the ethical challenges to mental health posed by the crisis. A virtual training update at the end of the month recorded similar figures, as did a webinar on changes to exams.

The webinar series includes everything from practical advice for frontline staff to the pandemic's impact on Black, Asian and minority ethnic communities, from wellbeing tips to international perspectives on COVID-19. The College's Centre for Quality Improvement has also created a useful hub of free webinars sharing information on changes to practice brought about by the crisis. The remote learning series replacing RCPsych's International Congress has attracted 10,000 webinar bookings to date.

With the College anticipating that it will not be able to fully reopen its buildings until the second half of 2021, RCPsych's autumn programme of events has all now been migrated to either online courses or webinars. Programme details and information on how to register can be found at [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)



## Testing times

It has been all hands to the pump in the College's exams team to ensure that trainees are able to progress and take exams during the pandemic. With both March and June's written papers cancelled, as well as the May CASC due to be held in Singapore, RCPsych accelerated its digitisation plans to allow for online written papers and testing.

The digital changeover, originally planned over two years, has been achieved in just six months, with the College successfully delivering the largest remote OSCE ever run by a UK medical royal college in early September. While some of the 500 candidates and examiners experienced IT glitches and delays, 98% of candidates successfully completed the online CASC. The College will also hold digital written exams later this year.

## All aboard the AGM

RCPsych's Annual General Meeting has typically attracted few members alongside College officers and staff. But not this year. With the AGM taking place virtually over Zoom, over 300 tuned in to watch the event live.

As well as record attendance, the AGM attracted a global audience, with members dialling in from India, America, Qatar, Bangladesh, Bermuda, Canada, Pakistan, Nigeria, Serbia, the UAE, Saudi Arabia, Malaysia, Germany, Iraq, Greece, Sierra Leone, and Ireland. The technology also allowed members to have questions addressed live by College officers, which included Dr Adrian James for the first time in his role as President.

Certain important aspects of the AGM were sadly missed by attendees, including the presentation of new Honorary Fellows and Presidential Medal Winners. While the names were read aloud, there will be a separate occasion to mark these prestigious awards and properly celebrate the achievements of those recognised.

The papers from the AGM can be found on the College website: [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)



## And finally...

June marked the end of Professor Gerry Lynch's time as Chair of RCPsych in Northern Ireland, which posed a dilemma for colleagues. Their solution for his send-off was to create a video tribute in secret. 'Project X' was embraced with gusto, with contributors going the extra mile to ensure that Gerry's leaving was marked appropriately. The resulting video was shown at June's Devolved Council meeting with colleagues from across the UK joining a very surprised and flattered Professor Lynch.

# Building a better future

After decades of underfunding, England's mental health estate – its buildings and other infrastructure – is crumbling. RCPsych is calling on the government to announce a major spending programme to tackle the crisis.

**T**he NHS mental health estate in England is in a state. A report last year by the Care Quality Commission found that many mental health wards are unsafe, providing poor-quality care in old and unsuitable buildings. More than a fifth of mental health facilities were built before the NHS came into being in 1948. Today, the COVID-19 pandemic is putting this already creaking infrastructure under even more strain.

In a recent survey of RCPsych members, almost a third of respondents reported that the care they have been able to provide to their patients during the pandemic has been negatively or very negatively affected by the quality of the buildings in their organisation. One clinician said that they had “no place to do proper donning and doffing of PPE. No hands-free handwash like in theatres and acute hospitals. No space for social distancing. No space for patients to isolate. Our mental health setting was basically a disaster waiting to happen when the pandemic struck us.”

Over a third of respondents felt that the mental health buildings they work in are unsuitable for safely separating patients with suspected or confirmed COVID-19, as exemplified by this comment: “COVID-19 spread rapidly on my ward in March. Six patients and multiple staff tested positive. Most patients were in bays. Only one side room has an en-suite.”

Following intensive lobbying by RCPsych, the government has taken the first step towards improving

**“Fewer than a quarter of A&E departments have safe and private psychiatric assessment rooms”**



Dr Jim Bolton

inpatient facilities by setting aside £250m to replace dormitories with single-occupancy, en-suite rooms. As of last year, there were 1,176 beds in dormitories, 7% of all NHS England's mental health beds. Not only do dormitories offer an unsuitable environment for treatment and

recovery, they also make infection control nigh-on impossible.

But replacing dormitories, although welcome, is only the start. The College has called on the government to ring-fence £3.26bn in the forthcoming Autumn Spending Review, to be spent on improving England's NHS mental health estate. This is in addition to the £2.3bn uplift in spending promised by 2023/24 to deliver the improvements in mental health services set out in the Five-Year Forward View for Mental Health, the NHS Long Term Plan and the Review of the Mental Health Act.

The detailed case for the new spending is set out in an RCPsych report entitled *Next Steps for Funding Mental Healthcare in England: Infrastructure*, which was published in July. The money would fund immediate refurbishments and alterations to existing buildings, with a particular view to enhancing infection control. Recommendations include the elimination of mixed-sex accommodation and the equipping of all single-occupancy rooms with en-suite

facilities. Tackling the backlog of high-risk repairs, without which there is a danger of a catastrophic failure of care or serious injury, is another priority. In 2018/19, almost £13m-worth of outstanding high-risk repairs in mental health and learning disability sites were reported – an increase of over 150% on two years earlier.

Alongside these and other immediate actions, longer-term building projects are also envisaged. The report calls for £450m for new building and redevelopment schemes for community mental health facilities as part of the significant expansion of services outlined in the NHS Long Term Plan. And there is a proposal for a £1bn investment in 12 major capital projects to be completed by 2030.

The spending proposed in the report will not, of course, apply only to dedicated mental health facilities, but also to general hospitals and other clinical settings where mental health services are delivered. Consultant liaison psychiatrist Dr Jim Bolton contributed to the report as Chair of RCPsych's Faculty of Liaison Psychiatry,

which represents those who work in general healthcare settings at the interface between mental and physical illness. The issues he and his colleagues in liaison psychiatry face, though, are much the same as those affecting psychiatric hospitals and wards.

“A third of liaison psychiatry services didn't have appropriate facilities and team bases,” says Dr Bolton, citing the most recent review conducted by the Psychiatric Liaison Accreditation Network (PLAN), coordinated by the College Centre for Quality Improvement. “That may well include space to deliver outpatient appointments and patient care clinics as well. There often isn't ready access to a private area to hold discussions with patients on general hospital wards,” he says, adding that many wards are old and were not designed with that in mind. “The pressure on space is such that any available rooms where staff can meet with a patient or their family to discuss issues or to break bad news quite often gets used for other purposes. Holding such conversations in a

ward environment, where others can overhear, isn't conducive for people to discuss important, sensitive or potentially embarrassing information.”

There are similar problems in A&E departments, where, says Dr Bolton, “there is a longstanding requirement for the provision of a psychiatry assessment room which is equipped to meet national standards for safety and privacy. For example, there should be no ligature points, and conversations within the room should not be easily overheard by others. However, a survey that PLAN and I conducted of emergency departments in the UK found that fewer than one quarter had a room that met the necessary criteria for safety and privacy.”

The College is working hard to get across to government the urgency of its message, lobbying the Treasury and the Department of Health and Social Care. Members can also play their part by sharing their experience of how the available infrastructure affects their ability to deliver care to their patients, especially during the pandemic.



# Facing up to our responsibility

The current climate and ecological emergencies may seem remote to psychiatry. But, as members of RCPsych's Sustainability Committee explain, they are issues the College and its members need to not just recognise and understand, but lead on.

**W**ith the country in the middle of a public health crisis, it may seem to some like the wrong time for the College to focus on sustainability and tackling the twin threats of the climate crisis and biodiversity loss. But, as awareness grows of the links between the pandemic and environmental degradation, so too does our understanding that what's good for the planet is good for us as a species, both physically and mentally.

The impacts of the environmental emergency on mental health are both direct and indirect, explains Dr Lisa Page, one of RCPsych's two Associate Registrars for Sustainability. "People with mental health problems struggle in heat events like the one the UK experienced in August," she says of one obvious direct impact. Add in the "psychological impact" of floods and evacuations caused by other extreme weather events, as well as sea level rise and an increase in non-productive cropland leading to potential famine and migration, and "we will see the impacts, even if they're distant from the UK to begin with".

Dr Page is a member of RCPsych's Sustainability Committee alongside Dr Jacob Krzanowski, the College's other Associate Registrar for Sustainability. The Committee is currently working to produce RCPsych's response to the

climate and ecological emergencies, which is due to be published this autumn. It is designed to clarify what the College thinks about these issues and the direction in which it should be heading. To reach the position, the Committee recently convened seven roundtable discussions involving academics, experts and activists working across the areas of environment, public health and mental health.

As well as examining the impact of the climate and ecological emergency on mental health and specific patient groups, the group's discussions also focused on the significant spiritual and psychological aspects of the planetary emergency we face. "There are existential aspects to this work," says Dr Page, "because if we're not able to address this issue, we are potentially looking at something very, very serious with profound consequences for humanity."

Dr Krzanowski agrees that meeting the challenges requires emotional engagement. "It's a form of denial, otherwise," he says, adding that psychiatrists working with others, such as psychologists, are well placed to lead this work. "Before we can take action, we need a change in attitude, to one of active hope," he says. But while the scale of the challenge is unprecedented, the Committee's approach isn't new. "The growing alarm

of the climate emergency reminds us that we are nothing more than a product of our environment. We need to allow ourselves to imagine further and to think in longer time frames and then take a more public health approach to tackling this."

While these discussions could sound remote from the day-to-day world of psychiatry, there are clear connections between, for example, the ecological crisis, the inability to access and appreciate nature, and mental health. One practical measure the Committee is looking at is how to encourage more nature-based care to treat stress, anxiety and PTSD. "Services have to be safe," says Dr Page, "but why do we have to see people in a clinical setting? Is it just for our own convenience?"

To credibly lead on issues of sustainability, RCPsych recognises it first needs to get its own house in order. In February, the College took an important first step by removing fossil fuels from its £12m investment portfolio

– action in part driven by members. More than this, the College is now choosing to only invest in responsible companies that meet UN Sustainable Development Goals. Not only does this better reflect RCPsych's values and responsibilities, but given recent falls in the market, it is estimated that the College would be £1.5–2m worse off were it to have stuck with its previous investment policy.

With new RCPsych President Dr Adrian James making sustainability a priority of his presidency – and the passion and energy of the Sustainability Committee behind him – Drs Page and Krzanowski believe RCPsych will be well-placed to speak out on how mental health will be affected, including in its interactions with government.

"Many members are very concerned about the climate and ecological emergency," says Dr Page. "There's a groundswell of opinion that this as an area of debate that the College has a need and right to be articulate on."



Increased flooding is one of the problems caused by climate change (Photo: PA Images)

## "It's healthy to be frightened in a crisis"

Young people are taking to the streets and social media in ever greater numbers to protest against the inaction on the part of leaders to tackle the climate emergency. The emotions they feel – from anxiety and anger to grief and even guilt – are a natural response to the existential threat facing humanity and "a sign of understanding and care", says Dr Catriona Mellor, a specialty doctor in child and adolescent psychiatry and a member of the College's sustainability committee.

In response, Dr Mellor has led a team of CAMHS psychiatrists to produce two factsheets, one for young people, the other for parents and carers, on understanding eco-distress. It aims to raise awareness of what eco-distress is and, crucially, what it isn't, as well as providing guidance on how young people can work through their emotions to feel better.

"Eco-distress isn't an illness or disorder," says Dr Mellor. "It's healthy to be frightened in a crisis and much better than being indifferent. With support to understand these strong emotions, young people can feel better and also motivated to take action. Individuals must not be made to feel responsible for this global crisis. However, making meaningful changes can improve wellbeing, increase self-efficacy and build resilience."

Psychiatrists need to understand the context that young people are coming from and the wider public discussion around the climate crisis, she adds, even though the concept of eco-distress is new for many. "We are going to be asked to comment on it more and more," she suggests.

The *Understanding eco-distress and taking positive action* factsheets for young people and parents and carers will be published shortly on [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)





Balthasar Bekker and Christian Scriver sieve diseases from devils. (Wellcome Collection)

# Combatting conspiracies

When Dr Reena Panchal and Dr Alexander Jack discovered COVID-19 conspiracy theories circulating in the medium secure unit at which they work, they knew action was needed to reduce potential harm.

“I think we’re all interested in conspiracy theories,” muses Dr Alexander Jack. “Whenever I hear them, certainly my ears prick up.” And earlier this year, as he walked through the medium-secure mental health clinic at which he is senior forensic psychologist, he realised his ears had more cause than usual to be on high alert. Against the backdrop of a nationwide lockdown, coronavirus had naturally become a central topic of conversation at Birmingham’s Reaside Clinic – a facility caring for men with severe mental illness and a history of criminal offences or seriously aggressive behaviour. During a team meeting, Dr Jack mentioned he’d heard clinic staff discussing less mainstream explanations for the pandemic. It made his colleague Dr Reena Panchal immediately reflect on her own experience.

“I said that over that weekend I’d seen cases in the community where some patients had developed really serious delusions with a COVID conspiracy theory,” says Dr Panchal, an ST5 in forensic psychiatry.



Dr Reena Panchal



Dr Alexander Jack

This conversation clarified that such theories can potentially cause harm, and that they were circulating in Reaside Clinic. If you review the characteristics of those known to be most susceptible to conspiracy thinking, this becomes understandable.

“The clinic population is almost a total match to the demographics prone to taking on these beliefs,” explains Dr Panchal. “So, isolated individuals who’ve had trouble with authority or may have been oppressed in the past, and who use their own narrative to come up with explanations to protect themselves from the reality of what’s going on.”

It was clear to Dr Jack and Dr Panchal that there was a need to take action before such thinking caused more widespread problems. But quite how to do so wasn’t necessarily clear.

“There’s no model to deal with conspiracy theories and there’s even less so a model to deal with conspiracy theories about a viral pandemic in a secure unit,” says Dr Jack with a wry laugh. So, they drew on what the literature says about the causes of conspiracy thinking and devised a public health-type approach.

Education and transparency were deemed key – among both ward staff and patients. Conversations about what was and wasn’t known about the virus, and why procedures were changing, were held frequently by senior hospital management.

Patients in an acute phase of their condition, meanwhile, were identified as at particular risk from COVID conspiracy thinking and so were earmarked for extra support.

“Dr Panchal’s phrase was ‘pandemic-informed care,’” recalls Dr Jack. “The clinic really tried to address uncertainty by using a lot of acceptance and commitment therapy principles and increasing focus on sensory needs – so finding ways of helping to calm arousal.”

While the situation now feels different from that in March, Dr Panchal suggests the risk presented by COVID conspiracy thinking has not gone away. “There’s this ‘new normal’ of wearing masks, the two-metre rule, and using relatively new terms like ‘social distancing’. Then you have other changes that seem to be introduced almost weekly. So, I don’t think we’re out of the woods yet in terms of conspiracy theories about this.”

In any case, says Dr Jack, in some form such theories will always be present. “It’s almost like a bomb has gone off in society, and it could have been COVID, it could have been nuclear war – it’s something big that has happened.

“But I think what we’ve learnt about COVID conspiracy thinking is informative for the next conspiracy theory and all the ones that have come before and which still persist.”



# The international outlook

In June, RCPsych published its first-ever international strategy. We talk to the College’s presidential lead for international affairs and to a volunteer working with mental health services in Ghana.



Professor Mohammed Al-Uzri

**T**he College is a truly international organisation. Almost a fifth of its members are based overseas and twice that number qualified outside the UK. The Volunteering and International Psychiatry Special Interest Group (VIPSIG) is one of RCPsych’s largest SIGs. And in June, RCPsych published its first-ever international strategy, which is spearheaded by the newly appointed presidential lead for international affairs, consultant psychiatrist Professor Mohammed Al-Uzri.

The strategy sets out the values and principles that govern the College’s international work and outlines an ambitious plan of action for the next three years. “Our main focus,” says Professor Al-Uzri, “is to help make sure that the care provided for patients with mental health problems around the world is of the highest possible standard and delivered ethically.”

Training is key to achieving that ambition. RCPsych currently runs six overseas exam centres – in Ireland, Oman, Singapore, Malta, Hong Kong and India – where people can prepare for and take the MRCPsych exam to become members of the College. The international strategy proposes a significant expansion of the offer for trainees abroad, including the introduction of clinical skills training courses in China, India, parts of Africa and the Middle East and the setting up of a new exam centre that will increase access for a wider range of international trainees.

Beyond these formal structures, it is envisaged that volunteers will provide another key plank in the College’s international work. At present, only around five members a year sign up for international voluntary work. The strategy looks to increase that twentyfold.

Forensic psychiatrist Dr Stephen Attard has been a volunteer since 2018, when he had a chance meeting with a community psychiatric nurse who was involved with the Besstel Foundation, a charity that works with people with mental health problems in both the UK and Ghana. That led to a visit to the West African country, organised by the foundation, where Dr Attard helped deliver mental health awareness workshops, visited psychiatric hospitals and met politicians and other stakeholders.

A second visit last year took Dr Attard to the Komfo Anokye Teaching Hospital (KATH) in Kumasi, the country’s second city and capital of the Ashanti region, home to almost five million people. The hospital has just 11 psychiatric beds, one consultant psychiatrist and 16 or so other mental health specialists and trainees.

“I was incredibly impressed by the dynamism of the team,” says Dr Attard. “They’ve built up a really good service with incredibly limited resources. Most of their services are delivered by outpatient clinics and they’ve got a lot of initiatives under way, such as child and adolescent clinics, domestic violence clinics and drug and alcohol services, as well as schools’ outreach.”

Dr Attard had a third visit to Ghana lined up in June, as part of an RCPsych training initiative, but the pandemic put that on hold until next year. The College’s international work is similarly affected, though Professor Al-Uzri is undaunted. “We have moved quickly into delivering training online and the College has a series of webinars that are open to colleagues in the UK and abroad. And we are continuing to support our existing projects.”

In other words, the College needs international volunteers as much as ever. Dr Stephen Attard has no hesitation in urging fellow members to sign up. “It’s an incredible experience,” he says. “It’s mutually beneficial, seeing the innovative ways that services can be delivered when the resources are pretty scarce; being exposed to different approaches and learning from the teams over there. It’s a really, really valuable thing.”

To find out more, search ‘volunteering’ on [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)



Dr Stephen Attard (Photo: Besstel Foundation)

# A potentially lifesaving option

Electroconvulsive therapy has a complicated history and dubious reputation among the public but, when other treatments fail, it can be lifesaving.

**W**hen Karen Peckover thinks about the suspension of electroconvulsive therapy during the COVID-19 pandemic, she is concerned. The reason? “For me, ECT was a literal lifesaver.”

Electroconvulsive therapy (ECT) – which involves passing an electric current across the head to provoke a controlled fit – is used to treat some severe mental illnesses for which other treatments have not worked.

But as dealing with COVID-19 became an over-riding focus for the health service, access to ECT became limited. Research by RCPsych shows two thirds of people who would be having ECT have had their treatment affected in various ways by the pandemic, including not being able to access it at all. “Essentially, pretty much every ECT service in the country remains restricted,” reports Dr Rupert McShane, the College’s lead on ECT, although he emphasises work has been continuing to address that.

Concerns over access to ECT are pressing, however, because it is generally used when mental illness has become life-threatening.

For Karen, problems with her mental health didn’t arrive until her 40s. Her husband became seriously unwell with a heart condition. After a “very stressful” 18 months, he underwent a procedure and began to recover, but it was at this point that Karen’s health worsened.

“As soon as the stress of my husband’s illness was removed, things

**“There’s a balance of risk and benefit. We’re dealing with life-threatening illnesses, and this is an important medical treatment”**

that had happened in the past came to the fore again,” she explains. “What I’d been able to store away in a box in my head and never go near resurfaced and I started to become very ill.”

She was diagnosed with depression, eventually severe enough that she was admitted to hospital. There she disclosed to a consultant what had happened when she was 14: she was raped by a man she did not know. It was the first time she’d told anybody about it.

“And everything exploded. Chaos. I was in a complete state. I was diagnosed with anxiety and post-traumatic stress disorder on top of everything else.”

Karen spent the next five years in and out of hospital, often detained under the Mental Health Act as a result of suicide attempts and self-harm. She was prescribed numerous medications over this period but none seemed to make a significant difference.

And while she received referrals for cognitive behavioural therapy and eye movement desensitisation and

reprocessing therapy, in retrospect she feels she wasn’t well enough to fully engage with either – which led to her condition worsening, and to reactive psychosis.

“It was just completely horrific. Like being in this black hole that I was completely stuck in, couldn’t get out of, didn’t know how to, didn’t want to, didn’t want my family to suffer – everything just got worse.”

She first had ECT in 2010, when in hospital. “At that point I wasn’t eating or communicating and was really depressed and suicidal. And because I’d already tried lots of different things, ECT was suggested to me.

“I was so desperate that I thought: ‘Well, I’ll try it.’”

The treatment wasn’t an entirely new concept to Karen. She had initially trained as a nurse and remembers seeing ECT patients coming round after the procedure. “But I only knew it from that and from films.”

The modern reality of ECT is very far removed from that portrayed in popular culture, however. A patient wears his or

her normal clothes and is given a muscle relaxant as well as a general anaesthetic. A mouthguard is only put in once the patient is asleep, and the actual procedure takes minutes – as does recovery from it.

“When ECT started, it would take eight hours for somebody to recover,” explains Dr Rupert McShane. “Now it takes 15 minutes. Things are very different now to how they were.”

That said, ECT is not without potential complications. There are side effects for some patients: in Karen’s case, she experienced bad headaches immediately following a treatment and had some problems with short-term memory loss and word finding.

For Dr McShane, who is consultant psychiatrist and ECT service lead at Oxford Health NHS Foundation Trust, an apt comparison is with a treatment for a serious physical illness. “I think the analogy with chemotherapy is a very important one. There’s a balance of risk and benefit. We’re dealing with life-threatening illnesses, and this is an important medical treatment.”

He says research shows that 50–70%

of people who have ECT see an improvement, with about half still well a year later. “Whilst that doesn’t sound great, it’s a lot better than the alternative treatments. In a sense, that shows why we continue to need to drive to find better therapies.”

While the evidence about long-term memory loss is controversial – about 17% of people complain of poor memory before ECT and about 23% after it – most concerning is that 2% of people complain of serious memory problems directly after the treatment.

“We need to focus our attention on preventing those more severe problems,” says Dr McShane. “But I haven’t worked in other branches of psychiatry where we get so many cards at Christmas. We’re treating people who are very sick and they get better.”

Certainly, Karen is in little doubt that she would no longer be around were it not for ECT. She had her last treatment in 2017, which was part of a ‘maintenance’ course she was given as an outpatient to help her through intensive therapy.

Today she takes a low dose of an antidepressant, has completed therapy, and shares her experience of ECT as a patient representative for the RCPsych Committee on ECT, the steering group for the ECT service that cared for her, and for the Electroconvulsive Therapy Accreditation Service (ECTAS). She is, she says, “living a normal life”.

“I’m looking after my family. I’m reading everything I can get my hands on. Doing a bit of writing. Going on holiday. I became a grandma in May – my daughter had a little boy and he’s absolutely gorgeous.

“I think whereas before I couldn’t see a future, now I can,” she says. “Life is good.”

The College has recently updated its patient information leaflet on ECT. You can download a copy from the ‘support, care and treatment section’ of [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk).

Insight into patient experiences of ECT can be found at [healthtalk.org](http://healthtalk.org) under ‘electroconvulsive treatment (ECT)’.



Karen Peckover, patient representative for the RCPsych Committee on ECT

**W**hen the Government announced the lockdown in March, it also pledged to get people who are homeless off the streets to protect them from the virus.

In just 48 hours, local authorities in England closed night shelters and hostels and in London alone 5,600 rough sleepers were placed in accommodation or hotels left empty as the nation was told to stay at home.

GP Dr Dana Beale is the joint clinical lead at the Great Chapel Street Medical Centre, a specialist NHS walk-in surgery for rough sleepers in Westminster. When footfall suddenly dropped off, the clinic was forced to shut its doors – switching from open-access walk-ins to total telephone triage.

With multiple agencies working together around the clock to set up in the hotels, Dr Beale's team went to work in a hotel in Wandsworth, south-west London, designated a 'Covid Protect' site for patients whose underlying conditions put them at greater risk.

Here they flipped their walk-in service on its head, turning it into one of the first, almost 100% 'in-reach'-based services working out of the hotels, setting up two medical rooms and doing ward rounds to patients in their rooms.

Aside from the logistical nightmare of 140 homeless patients with various co-morbidities suddenly under one roof, dealing with acute substance misuse presented another challenge.

Dr Beale says: "With London locked down, there was a complete disappearance of 'begging money' or sex work, a scarcity of class A drugs and dealers, and no way to buy alcohol.

"We were facing dozens of bewildered patients withdrawing from drugs and alcohol and needing support."

None of the GPs were opiate-substitution specialists and local drug services could not immediately adapt and cope with the sheer numbers.

Thankfully, help came in the form of Dr Emmert Roberts, an addiction psychiatrist at the South London and Maudsley NHS Trust who Dr Beale describes as "an absolute hero".

Dr Roberts joined the clinical leads group for the homeless health sector and immediately made himself available to Dr Beale's team at Wandsworth.

Practically overnight, he helped set up the Homeless Hotel Drug and Alcohol Service (HDAS-London) and wrote countless resources. These included three protocols for drug, alcohol and nicotine



Dr Emmert Roberts

## Room **service**

With homeless patients moved to hotels during the pandemic, an 'in-reach' service has kept them safe from COVID-19 and substance misuse.

**"It was chaos at the start, so we quickly needed a structure"**

withdrawal, which were then used across all London boroughs by GPs, homeless sector charities and health and care workers, some of whom hadn't worked with substance misuse before.

"It was chaos at the start, so we quickly had to set up a structure," says Dr Roberts.

For the first four months, he and his team were on call 24/7 providing telephone, email and face-to-face support for drug or clinical queries, even turning up at weekends to help out with a 'substance misuse ward round' in the hotel. He helped the on-site medics establish the residents' substance issues through questionnaires and drug tests. He then wrote each patient a support plan.

"We worked with the hotel to let us provide alcohol to the residents as sudden withdrawal can be fatal," he explains.

"And because residents couldn't smoke

in their rooms and we didn't want them all congregating to smoke outside without social distancing, I quickly wrote a nicotine replacement policy. "This way we provided nicotine therapy and donated e-cigarettes. It's been a real success, and some quit entirely."

The residents using drugs were provided with clean needles, syringes and naloxone, an antidote to heroin overdose, as well as locked boxes in their rooms in which to store their opiates and methadone. Thanks to Dr Roberts' specialist supervision, Dr Beale was able to safely prescribe methadone, which also helped many reduce class A drug use.

The rough sleepers were so well supported and protected during the pandemic, their overall health improved. In London the mortality rate – usually largely from alcohol and drug misuse – dropped 10 times to just six deaths in the first three months.

"The phones are still busy but with a network now established, things are calmer now," says Dr Roberts. "We hope HDAS will be extended beyond September, especially given the predicted rise in homelessness as people lose their jobs."