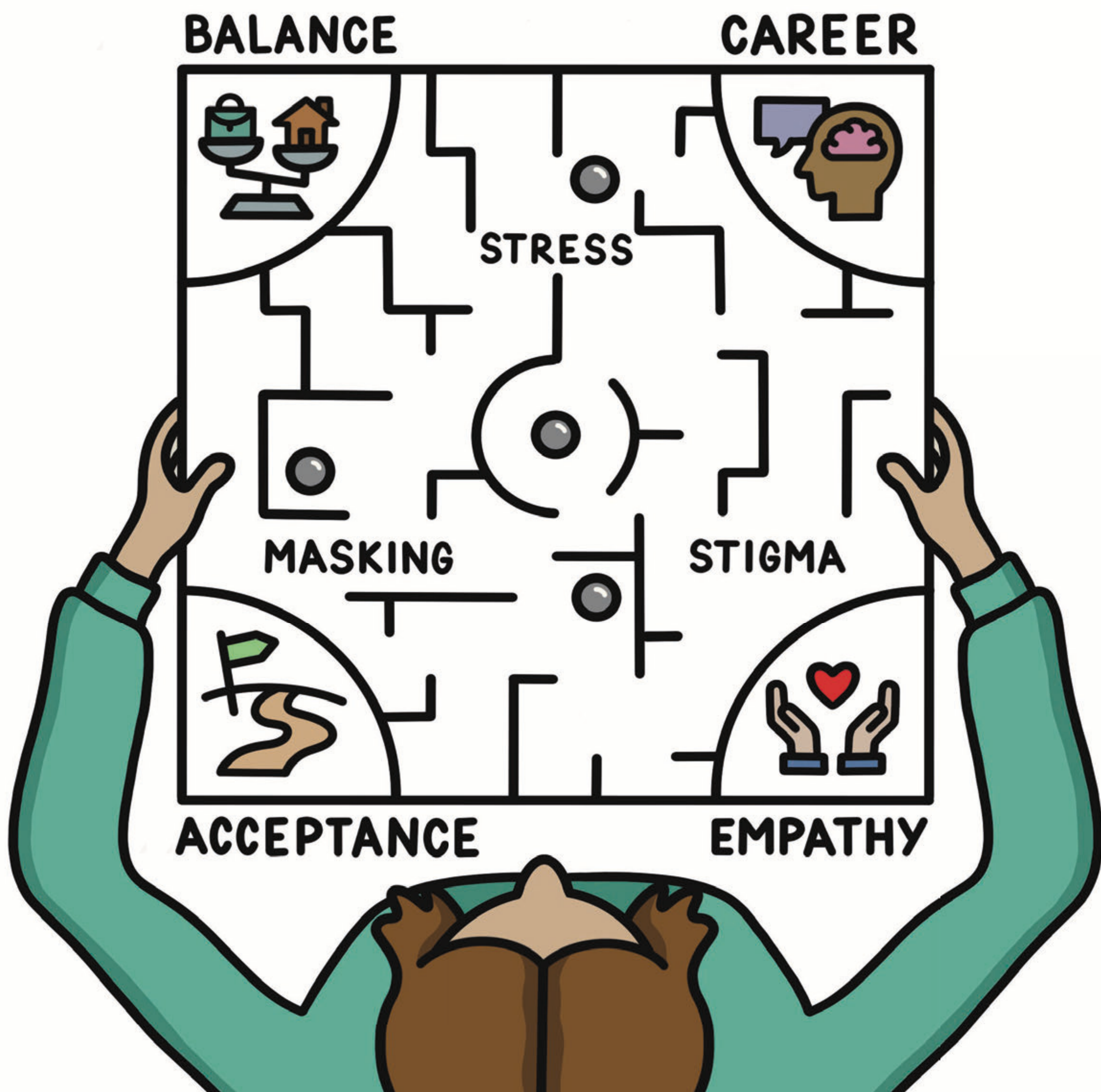
Issue 20 | Summer 2022

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT

Navigating neurodivergence



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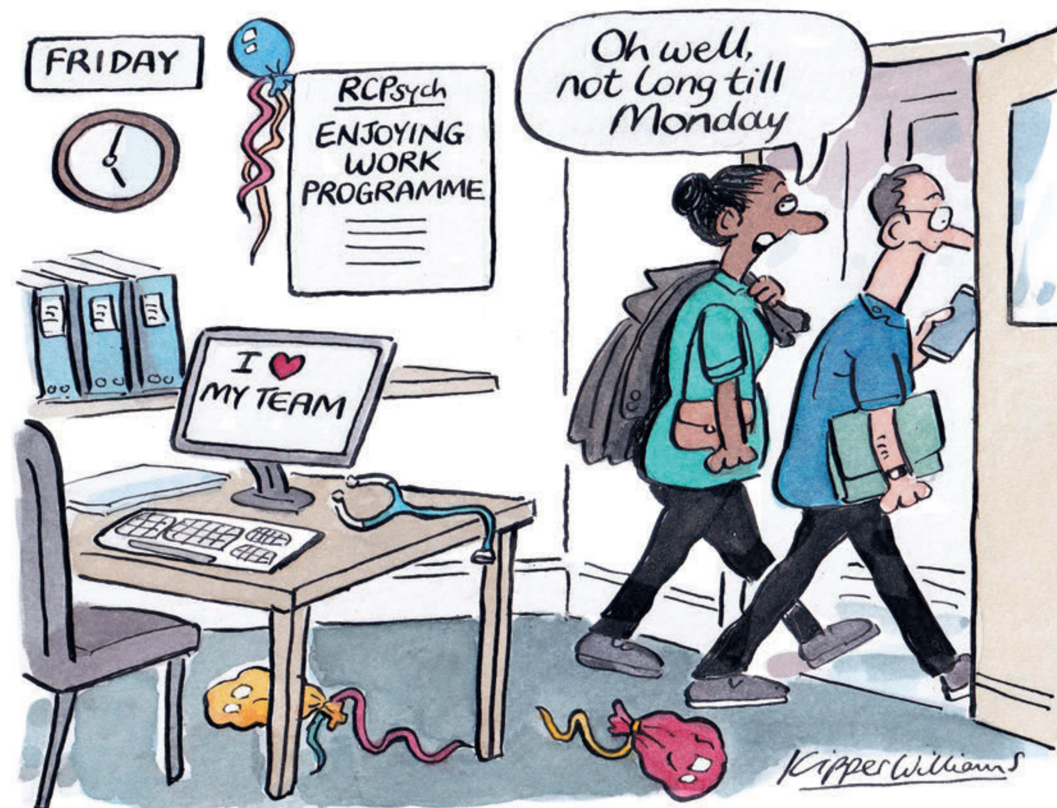
COLLEGE NEWS IN BRIEF

New eating disorders guidance

The College has launched new 'Medical Emergencies in Eating Disorders' guidance for frontline medical staff, so that people with eating disorders needing urgent care can be identified and treated earlier. Signs that someone with an eating disorder is dangerously ill can often be missed by healthcare professionals due to lack of knowledge and training.

Dr Dasha Nicholls, who chaired the development of the guidance, said: "We need to raise awareness of common eating disorders symptoms. Our guidance encourages healthcare professionals to spot when someone is dangerously ill, and dispel the myths surrounding them. They remain poorly understood with devastating consequences for thousands of patients and their families. If we are to stop the eating disorders epidemic in its tracks, it's vital that this guidance reaches healthcare professionals urgently and that government backs them with the necessary resources to implement them."

To help get the message across, the new College guidelines hit the headlines with broad national media coverage including the *Guardian*, the *Telegraph*, the *Mail*, ITV News, BBC News, Newsnight, and the Today Programme to name a few. In total there were over 278 pieces of coverage with a reach of 217 million.



Find out more about the Enjoying Work Quality Improvement Collaborative on page 9

Proposal for SAS votes narrowly defeated

Sixty-two per cent of members expressing a view at our AGM in June voted to support a change to our rules, proposed by President Dr Adrian James, which would have allowed Specialty and Associate Specialty (SAS) doctors and international associates to vote in College elections.

A break-down of the results shows that of the attendees in the room at the AGM, which was held during our International Congress in Edinburgh, 88% voted in favour of the proposal – which was supported by the rest of the College officers – compared with 52% of members who voted online to support the change.

Under our rules, a two thirds majority is needed to get changes to our Supplemental Charter approved, which means the proposal cannot go forward.

Ending out-of-area placements

RCPsych is calling for the NHS to adopt a 'zero tolerance' approach to inappropriate out-of-area placements (OAPs), as they can isolate patients, separate them from their homes and have a devastating impact on their mental health. They are also costly – last year, the NHS spent £102m on OAPs, which is the equivalent to the cost of the annual salary of over 900 consultant psychiatrists.

The NHS Long Term Plan aims to expand community services to help reduce the demand for inpatient admission and consequent OAPs.

However, the College insists more urgent action must be taken to put an end to this harmful practice including greater investment in community care, and government backing to address the workforce crisis in mental health.

World Maternal Mental Health Day

In mid-May, RCPsych co-hosted celebrations for World Maternal Mental Health Day alongside Sidra Medicine and Hamad Medical Corporation, two of the leading hospitals in Qatar.

The theme of the day was 'Stronger Together: Supporting Women Worldwide on our Journey through Maternal Mental Health Care' inspired by the disparities that came to light during the COVID-19 pandemic and the need for services to develop alongside complex and evolving patient needs.

The event, held in Doha, Qatar, on 11 May, was one of the College's largest overseas events, with over 500 people logging in and around 50 attending in person.

Could you be next?

RCPsych is embarking on its search for its next president to lead the College for three years starting in June 2023, when current President Dr Adrian James's term ends.

We are currently accepting nominations until midday on 5 August. The details of the nomination process can be found on the College website. Search 'presidential elections' at **www.rcpsych.ac.uk**

President's update

Many of you will be reading this having recently attended RCPsych's International Congress in Edinburgh. I was excited to have the opportunity to reflect on some of the fantastic achievements of the last year, as well as its challenges.

As outlined in this issue, the College continues to be front and centre of the transformation of community mental health services in England, through the College Engagement Network. It's wonderful to see the Community Mental Health Framework for Adults and Older Adults, produced by NCCMH, making a real difference.

It's also great that this issue celebrates and champions our neurodivergent workforce – something we should all value. Although we have so much more to do to ensure that autistic doctors, and those with other kinds of neurodivergence, can fulfil their potential, the College is truly leading on the issue, as the first medical royal college to publicly acknowledge neurodivergent doctors.

This issue also highlights the important work of physician associates – a growing and vital part of mental health services. I encourage all of you to read about the new Competence Framework for Physician Associates, which can be found on the College website.

As always, thanks to all of you for your fantastic work and dedication to your patients.

Dr Adrian James

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

Your comments on *Insight* issue 19:

"'Voyages of recovery' are part of the story here. Using writing for wellness and direct personal experience Linda Gask and Dr Tony Rao talk about this option - many crxeate Fellows value it a lot!"

cRxeate (creativity project for medical professionals)

"Very moving piece by Raka Maitra in the latest *RCPsych Insight* magazine."

Dr Derek Tracy

"Our own Dr Raka Maitra in *RCPsych Insight* magazine on doctor carers - value, challenges & accommodations.

GMC UK strategy supports us. It's time for national policy."

Women In Medicine Carers Network

"We are delighted to have two features from our exec members in the Spring issue of *RCPsych Insight*. Dr Beena Rajkumar and Dr Philippa Greenfield talk about the gender pay gap while Dr Raka Maitra talks about need for recruitment and retention initiatives for carers."

Women in Mind UK

Community **spirit**

The transformation of community mental health services in England is continuing apace. Find out how the College is involved and how your feedback can meaningfully contribute to the successful implementation of person-centred, community-based psychiatric care.

The NHS Long Term Plan promised that by 2023/24, England would have "new and integrated models of primary and community mental health care [to] support adults and older adults with severe mental illnesses". To achieve this, local areas would be "supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service".

These words don't quite capture the scale and significance of the task – this is a radical transformation which, if successful, will mean more people can spend time leading fulfilling lives in their community.

The transformation is already more than halfway through, but there is still a lot to be done. To guide the way, NHS England commissioned the College's National Collaborating Centre for Mental Health (NCCMH) to produce a Community Mental Health Framework (CMHF). Its implementation, however, is proving to be challenging.

"Unlike many other NHS programmes, this one is less explicit about exactly what needs to be done," says Dr Helen Crimlisk, RCPsych's Associate Registrar for Leadership and Management. "Instead, it says, go and learn about your local environments, talk to your local patients, service users, carers and voluntary groups. Think about where you're strong in your services and where you need help and devise something based on that.

"It's a great opportunity for people not to be told what to do, but to actually take some power into their own hands and think about how they want to do things. But, it's also enormously challenging for people who have been more familiar with being told what to do. So, it really needs a different sort of leadership."

To support psychiatrists involved in transformation work, the College Engagement Network (CEN) was set up for the sharing of information and advice. Psychiatrists are nominated by their trust's medical directors or RCPsych regions to be part of it. Dr Crimlisk and her colleague Professor Linda Gask, the Presidential Lead for Primary Care, facilitate monthly meetings of the network reps and support them to "think about the types of leadership that are likely to be helpful to thrive in this environment".

The CEN also acts as a conduit for RCPsych members to share their experiences of the implementation of the CMHF so that the College can consider how it can offer support. An example of this in action is the detailed guidance developed by the College on job descriptions of community psychiatrists – to be published shortly – which, while non-prescriptive, provides advice on meeting patient needs under an implemented Framework. The CEN, with its insight on a local level, was identified as best placed to deliver this.

Dr Crimlisk is keen for people to use the network to learn from others and show what, in their experience, works and what doesn't. The College, in turn, will feed back some of those experiences to the NHS, to highlight the challenges of implementing the Framework.

Dr Sri Kalidindi is the National Clinical Lead for Mental Health Rehabilitation for the Getting It Right First Time programme with NHS England and Improvement. In that capacity, she knows the importance of sharing good, evidence-based information. "Learning from one another, sharing challenges as well as good practice, is important," she says, "because sometimes we can be a bit isolated as clinicians."

With her NHS hat on, Dr Kalidindi works closely with the College's Rehabilitation Faculty, and RCPsych President, Dr Adrian James, and Registrar, Dr Trudi Seneviratne, on the implementation of the Framework, "to ensure that we're aligned and that we're thinking about what's good for patients, what's good for carers and staff and the system, and thinking of solutions together, and then all getting behind that".

At the same time, as Chair of the Association of Mental Health Providers, she works closely with the voluntary sector. The new model for community care, set out in the Framework, sees a dissolving of boundaries between different elements of the health and social care system and between the statutory and voluntary sectors. The aim is to put people with severe mental illness more in control of their care and to ease their journey through the system. "When we all work together around the person," says Dr Kalidindi, "across health, social care, physical care, mental health care, and voluntary services, I think that gives people hope."

And hope is a very valuable commodity during a period of upheaval and change. The Community Mental Health Framework is backed by large investments of money that will amount to £1bn a year of additional funding by 2023/24. That holds out the prospect of tackling longstanding inequalities in the system, such as inappropriate out-of-area placements that can see patients sent hundreds of miles from where they live for in-patient care.

"The big change I've noticed since the implementation of the Framework got under way," says Dr Kalidindi, "is that there seems to be more hope among clinicians that we are at last getting the necessary investment to strengthen community services."

Find out more about the College Engagement Network and the Community Mental Health Framework for Adults and Older Adults at: **https://bit.ly/3zS2gSn**

Blended **model**

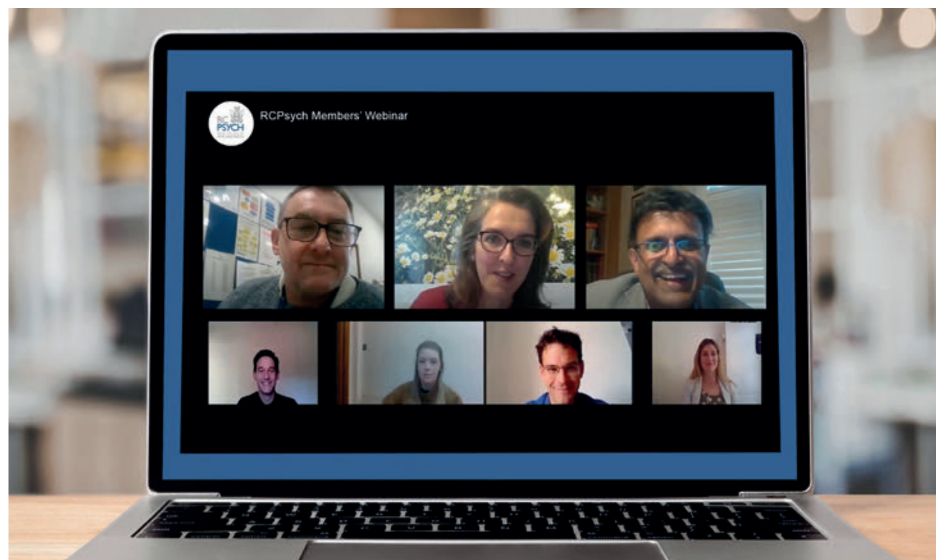
After two years of being a virtual organisation during the height of the pandemic, RCPsych is equipped to offer events and seminars in an improved and more flexible way to meet members' needs.

The New Members' Ceremony in March

Unrestricted numbers of friends and family tuned in live from 20 countries to watch the New Members' Ceremony in March. This marked the College's first ever 'hybrid' event – meaning it accommodated a mixture of in-person and online attendees. In previous years, being able to share the event with so many loved ones wasn't possible as seat numbers limited the number of guests to one or two per person. But, this year, even far-flung family members could celebrate this milestone in the careers of the new cohort of RCPsych members.

This is one example of how digital changes and innovations that needed to be made in order for the organisation to function online during the pandemic are now being used to enhance member experiences, as the College looks to the future of delivering events and ceremonies.

On 28 February, RCPsych formally launched a new, blended model for running the organisation – with College members returning for some in-person ceremonies and events, and staff returning to the office for part of the week. Re-establishing real-life meetings has happened at varying paces across different parts of the UK, with Northern Ireland being the last to lift its work-from-home guidance in early June.



A members' webinar

When the blended model was signed off last year by Trustees and Council, the delivery of events and ceremonies – as digital, face to face or hybrid – was ultimately intended to be led by member preference and the prevailing situation with COVID-19.

Four months into the roll-out of the new model, the College has delivered a number of large-scale, in-person and hybrid events. Two New Fellows' Ceremonies have followed the success of the first hybrid event – a New Members' Ceremony – while divisions, devolved nations, faculties and SIGs are holding increasing numbers of in-person events.

Many members had expressed a strong desire to get back to meeting in person to have the chance to network with each other face to face. However, thanks to our strong provision of digital activities and services, which has increased accessibility, many people are now used to engaging with a virtual organisation – with online events enabling people to take part from their homes or workplaces, with no need to travel, and the added bonus of lower carbon emissions as a result.

Ultimately, we are listening to what works for our members, and can be flexible in our delivery of events in line with what our members want and need. Having a blended model of service delivery means being versatile and responding to the challenges of the day in the best possible way – and RCPsych is well placed to react accordingly.

Keep up to date with all College events on offer at: www.rcpsych.ac.uk/events

You'll see increasing numbers of in-person conferences popping up for faculties, divisions, devolved nations and special interest groups, among other events.

Meanwhile, our online provision is still going strong, with plenty of virtual seminars and lectures. We also have the following fixtures:

- **Free members' webinars:** These lectures, which started during lockdown, are still being run on a range of different topics across psychiatry. These hour-long webinars can be watched live or on demand later, and are each eligible for 1 CPD point, subject to peer group approval. Past topics have included domestic abuse, caring for carers in psychiatric training and in the workforce and, in line with Pride, 'bringing your whole self to work – why it's essential for good mental health and better patient outcomes'.
- **The Dean's Grand Rounds:** This new series of webinars aims to help narrow the gap between education and practice. Each session will be the result of one faculty pairing up with a division or devolved nation to examine a question relevant to their area. The session will start with a problem/question/opportunity for change, followed by discussion of evidence and current practice.

A recent Fellowship Ceremony

Owen Bailey

Invaluable **insight**

The College recently redeveloped its gambling disorder resource using vital input from someone with lived experience of the condition.

Owen Baily knows more than most about the harm gambling can cause. For two decades, he struggled with a gambling addiction which, coupled with alcohol and drug misuse, regularly left him homeless and jobless.

It is this 'lived experience', and now his current role as a peer support worker with the NHS's National Problem Gambling Clinic (NPGC), that made Owen highly qualified to consult on the College's recent patient information on gambling disorder.

Covering everything from the disorder's causes to support and treatment, this comprehensive resource was written by assistant psychologist Zoe Delaney, family lead and systemic practitioner Jenny

> **"It's essential people with lived experience are involved in these projects"**

Cousins, and director and consultant psychiatrist at the NPGC Professor Henrietta Bowden-Jones OBE.

With patient involvement now core to the College's work, the authors sought feedback from someone with lived experience of gambling disorder, which is where Owen's insight came in.

Owen's story reflects the experiences of many. He knew that his habit was destroying his life but he could not stop. "Gambling was toxic for me. For years, it was the dominating force in my life, but no one seemed to understand," he says.

His journey to recovery has involved undertaking cognitive behavioural therapy (CBT), psychodynamic therapy and medication – Owen was one of the first to have his gambling addiction treated with naltrexone, a drug previously prescribed only for alcohol and drug addiction before gambling disorder was recognised as a health condition in 2014.

He describes "hitting rock bottom" four years ago as a turning point and he has led a life free of gambling ever since. "After years of being trapped in a relationship with gambling, finally breaking free and, eventually, qualifying as the NHS's first-ever gambling peer support worker, I was delighted to be invited to review the resource as a way of helping others," says Owen.

Owen is able to bring not only his own experiences to the table, but also those of the hundreds he has helped while working in gambling support over the past eight years. "Treatment for someone with gambling disorder can require a holistic approach, especially if there is some past trauma experience, as in my case. I have built up a very comprehensive overview of what professional help and self-help is out there and what skills and strategies work for individuals," he says.

A draft of the College's gambling disorder resource was sent to Owen to review and, over a period of two months, he and the authors worked together on the edit. "I read through it and thought 'what was missing?' offering suggestions and challenging the use of certain language to improve the leaflet's accessibility, especially any terms that are stigmatising, such as 'problem gambler'."

The College's Public Engagement Editorial Board is responsible for patient resources and is chaired by RCPsych past president Professor Wendy Burn. "We are working towards true co-production in the College as we make the creation of all patient and carer information a really collaborative process," she says. "Involvement of patients and carers, like Owen, is invaluable."

"Going forward, says Owen, "it's essential that people with lived experience are consulted and involved in these projects and see meaningful collaboration with professionals. Highly qualified professionals, like addictions psychiatrists, and people who use their services can learn so much from each other through genuine co-production."

Making time **for change**

A recent project to increase joy in work shows how even small changes can have real impact, but finding the time to implement ideas can be the biggest hurdle to success.

"**It's** much more of a balanced environment," says Tania Burnett, a peer support worker at the Isle of Wight Adult Community Mental Health Service, describing the difference she's seen in her workplace since it joined the 'Enjoying Work Collaborative'.

Led by the College's National Collaborating Centre for Mental Health (NCCMH), this year-long quality improvement (QI) programme ran until May of this year. Working with 44 mental health teams across England and Wales and two College staff teams, the programme sought to increase positivity and wellbeing in the workplace. With burnout among clinicians being well documented at record highs in recent years, this work is increasingly important.

The Enjoying Work Collaborative built on previous RCPsych QI projects and the Institute for Healthcare Improvement's 'Joy in Work' framework, which sets out how to apply evidence-based methods to enhance joy in work, and has already demonstrated success with some trusts in England.

Structured support was provided to participating teams in the form of pre-scheduled learning sessions and dedicated quality improvement coaches. However,

> **"It created a platform for conversations about employee experience"**

teams were also encouraged to create their own interventions.

"Teams have the freedom to pick anything they think will make a difference," says Dr Amar Shah, the College's National Improvement Lead. "In mental health particularly, we're seeing huge demand for care and services. This programme really allows teams to take more control over the factors that contribute to their experience at work."

Changes implemented ranged from creating formal reflective spaces to feel-good activities. Tania points to the highly popular appreciation box her team has introduced. "It's just been something really light in what otherwise is a heavy job," she says.

To empower teams to feel more in control of their work environment, they were encouraged to start with small changes that would have a tangible impact – but even with this modest approach, progress was not always easy. The demands on Tania's service, for example, not only demonstrated the need for greater employee wellbeing, but also made it incredibly difficult to make changes, however small.

It was only after a "massive learning curve" that Tania began to see results. She attributes her team's success to the validation the collaborative offered to focus on employee wellbeing: "It made it okay to be able to take that time," she says. "You have to prioritise the collaborative to make everything better for everyone. And then the patients will get a better service."

Dr Shah refers to the data collected throughout the project. Every week, teams were asked: "How much did you enjoy your work last week?", "How burnt out do you feel?" and "Would you recommend this team as a place to work?" These are "three questions that are pretty validated from the evidence base and the research," he says.

All three outcomes demonstrated improvement; responses to the first and second questions increased positively by 44% and 42% respectively. Additionally, a validated survey at the beginning and end of the project showed improvement in 19 out of 22 indicators, although Dr Shah cautions that further statistical analysis is still needed.

While the programme, along with its formal support provisions, officially ended in May, Tania's team will be continuing its work in light of how valuable the changes have been: "It created a platform for conversations about employee experience," she says.

Dr Shah also plans to make NCCMH's findings openly available for future improvement work. "We want to compile this learning and share it publicly, so anyone can take this work forward in their own team if they want to."

Navigating **neurodivergence**

Medicine's tendency to over-pathologise neurodivergent conditions has forced many autistic doctors to hide their diagnosis, but there is a growing awareness of the value of having a visibly neurodiverse workforce.

Dr Tahleel Javed

Dr Tahleel Javed was diagnosed with autism and ADHD in 2021 at the age of 27. Shocked by the diagnosis, she set out to gain a greater understanding of it by speaking to hundreds of autistic people. She soon discovered that there were many other neurodivergent doctors who felt compelled to mask their true selves because of the fear of stigma and judgement from colleagues and the negative effect on their careers.

Many neurodivergent traits centre on communication. Dr Javed explains that: "Autistic individuals speak a different language from their neurotypical counterparts. Some of us learnt to be 'neurotypical' better than others, but when faced with stressful situations, our instinct is to use our 'autistic mother tongue' which almost always gets us in trouble."

The pressure to conform and camouflage autistic traits in a world that is built for the neurotypical brain can cause overwhelming stress, mental health issues and burnout. "I have seen well-meaning psychiatrists trying to teach autistic doctors 'lessons' to adapt," says Dr Javed. "But the problem is we might be designed to swim, not fly. We would be great swimmers if you put us in water, but if you push us from mountains hoping we will fly, we will eventually fall."

Dr Javed created the Society for Tourette's, Autism and Neurodiversity (STAND) after a doctor in an online autism group died by suicide leaving a

"The social model accepts difference, celebrating the good bits"

heart-breaking message saying they were "done with judgements". STAND was formed to stand up for that doctor and others like them, to challenge assumptions and improve visibility of neurodivergent people.

In psychiatry, autism is defined as a disorder and the focus of this medical model is on 'fixing' people. Dr Javed favours the social model which refers to conditions rather than disorders. "The social model accepts difference, celebrating the good bits, and works around the difficult ones without the need to pathologise," she says.

Dr Conor Davidson, clinical lead for Leeds Autism Diagnostic Service, took up RCPsych's autism champion role a year ago and soon realised the need to focus not just on improvements for patients but also for neurodivergent members of the College.

He acknowledges that the debate about the social and medical model can be controversial but says the profession needs to find a balance. "Psychiatrists have to be guided by diagnostic classifications and use them to deal with problems, but we must also recognise the positives."

"For some people, autism is not a disorder. It can be disabling at certain times and in some environments, but at other times it is not. The main thing is to consider the individual profile of difficulties, strengths and needs."

There is a huge disconnect between the lived experience of neurodivergent people and the way it is presented in medical training. Dr Davidson says that a lot of the doctors in Autistic Doctors International – a peer support and advocacy group founded by Dr Mary Doherty in 2019 – have had late diagnoses partly because of this disconnect. "They don't recognise themselves and delay seeking a diagnosis thinking 'How can that possibly be me?'"

The irony is that the very qualities that define autism are traits that are ideal for working in medicine and psychiatry. Dr Doherty has said that "traits such as diligence, focus, perfectionism and honesty" mean that autistic doctors tend to be high performers. Dr Javed agrees, pointing to hyperfocus and an attention to certain details that may be missed by those with a neurotypical brain, as well as perseverance, problem-solving, and an internal sense of justice which makes for great advocacy skills.

Despite this suitability, "the way that doctors work and train can present inherent challenges," says Dr Davidson. Rotational placements create concurrent transitions with a new work environment to adjust to every six months, and frequent changes to NHS structure and a high staff turnover add to the uncertain environment, unsuited to those who crave predictability. In response to this, the College wants to ensure that clinical and educational supervisors have a better understanding of neurodivergence so they can better support trainees.

Having the lived experience of autism can only improve doctors' interactions with neurodivergent patients. And with as many as 5% of patients having autism, that's a lot of people who stand to benefit from this shared understanding. As an example, Dr Javed describes reducing a patient's reliance on anxiety medications by suggesting they listen to music as a stim (self-stimulating behaviour) in stressful situations, as she has found this useful herself.

The College is committed to championing its neurodivergent members and has stated three clear pathways it will pursue: supporting reasonable adjustments; making clear statements of support; and ensuring its own inclusivity. "Reasonable adjustments are crucial," says Dr Davidson, and trusts are not always good at providing them. "They don't necessarily need to be complicated – simple measures such as being more explicit about tasks or providing noise-cancelling headphones for hectic spaces can help people avoid feeling overwhelmed," he says.

RCPsych has been praised for being the first medical royal college to publicly acknowledge neurodivergent doctors. It has also been asked by the Academy of Medical Royal Colleges to provide recommendations for autism capabilities for other disciplines. It is in a perfect position to lead on this issue as it has a strong commitment to inclusion. It has updated its own guidance on recruitment for autistic employees and has made steps to raise the profile of neurodivergent doctors by publishing blogs such as *An Outsider's Inside Story* by Dr Javed. It has a strong Neurodevelopmental Special Interest Group and a cross-faculty autism group led by Dr Davidson. It is also about to embark on research surveying members' experiences of autism in collaboration with Autistic Doctors International.

"It's a work in progress," says Dr Davidson, but every step that enables autistic psychiatrists to fulfil their potential and avoid burnout is a step in the right direction.

Dr Javed believes things are improving but would like to see autistic mentors for trainees, interdisciplinary collaboration with psychologists and greater visibility of senior doctors with autism so that those still 'in hiding' can be encouraged to be their authentic selves.

Frances Leach

A framework for **the future**

A new College initiative aims to underpin the place of physician associates in mental health services.

Physician associates (PAs) are rapidly becoming an established part of mental health services. There are currently over 100 PAs working in mental health teams around the country, a fivefold increase since 2019, and that number is expected to more than double over the next two years. From the beginning, the College has supported this expansion and has now produced detailed guidance for the use of PAs in mental health.

"The Framework helps cement the idea that PAs have a place in psychiatry"

Two years ago, the College's National Collaborating Centre for Mental Health (NCCMH) was tasked with developing a Competence Framework for Physician Associates in Mental Health. The work was led by a project team and overseen by an expert reference group (ERG) whose members were chosen for their expertise in research, training and service delivery. The resulting Framework sets out the knowledge, skills, abilities, values and other attributes that PAs working in mental health should ideally acquire.

"However," says Dr Pranav Mahajan, a member of the Framework's project team, "we wanted to make sure that the competence framework wasn't just something that meant that if you don't meet all the competencies to begin with, you can't become a mental health PA. It is there to support people to become competent and to show what competence looks like."

And that matters because PAs are generalists by training. To qualify as a PA, you must have a degree in a health-related science subject, such as pharmacy or biomedical science. Then, you undergo an intense two-year training programme, of which mental health comprises only a small part.

"In the first year," says Frances Leach, a PA working in a crisis assessment team in south London and a member of the Framework's ERG, "you maybe get one day of lectures on mental health and then a three-week placement."

Some mental health trusts offer PAs an inceptorship programme, which is a year-long training course. But many PAs, like Frances, start working in mental health with only the day of lectures and the three-week of placement behind them. "It was a hugely steep learning curve and I was thrown in at the deep end," says Frances, "but the team I worked with was so welcoming and supportive; they never let me down."

Many of the medical skills that PAs have are immediately transferable to a mental health setting. They can take case histories, make physical health assessments, develop and deliver treatment and management plans, and much else besides. Once they start to specialise, however, they will have to acquire new skills – and that's where the Competence Framework comes in.

"Going into a new speciality is daunting," says Frances, "and it can be hard for a PA to know what they don't know. Quite often, we're thrown into jobs and we're not sure what we're meant to be asking for. The Framework provides a fantastic overview of what we could be learning, so now you can go to your supervisor and say this is where I'd like to develop my knowledge."

The Framework is also aimed at psychiatrists who are working with, or thinking of working with, PAs. "There's been a lack of knowledge amongst psychiatric colleagues about what physician associates can do," says Dr Phil Crockett, a consultant psychiatrist working in an outpatient adult eating disorders unit in Aberdeen and member of the Framework ERG. "There's a preconception that their place is in physical medicine. One important aspect of the Framework is that it helps cement the idea in people's minds that PAs have a place in psychiatry."

Dr Mahajan says he has also experienced "scepticism and pushback" when trying to persuade colleagues to consider taking on PAs. "One of the responses we often get is: 'Well, we want more doctors'. To that, I have to say: 'Well, there aren't any, so you will have to start thinking more creatively and PAs are one of the solutions to the workforce problem'. Ever since we've had physician associates in our trust, what we have found is that more and more teams have been coming forward and saying, 'we want one'."

"PAs will need training when they start in mental health and as their career progresses," says Dr Crockett, "but that's no different than it would be for a newly appointed doctor or a trainee doctor or a nurse practitioner: that training is still needed." And now that the Framework is available, he adds, "it can help guide the design of job descriptions for PAs and act as a guide for their ongoing training programme."

"Teams who have never had a PA can't quite understand how they would fit in," says Frances Leach. "But once they see the continuity that we provide to the team and our experience with physical health – which is more than mental health nurses generally have – then I think they start to understand it. Like many mental health PAs, my role is to support the patients with their physical health, as well as train up the nurses to be more confident in that aspect of their work. And alongside that we can also do mental health assessments, so we really do provide well-rounded support."

In Dr Crockett's experience, "PAs are a 100% highly motivated, professional group that just wants to make an impact. One of my PA colleagues, Waleed Elmsari, has been a stable presence in our team for four years now. He has become highly specialised in two sometimes overlooked areas, namely adult eating disorders and psychiatric rehabilitation. He's someone who's developed real skills and knowledge."

Next year, the General Medical Council (GMC) is planning to introduce full professional regulation of PAs. "Currently," says Dr Mahajan, "PAs are unregulated. They can join a voluntary register, which we encourage all employers to insist upon with their PAs, but there is no formal regulation."

Regulation would allow PAs to re-validate their qualifications more easily. At the moment, they have to retake their final exams every six years. It would also allow them to prescribe medication and request procedures, such as X-rays, that involve ionising radiation – something they can't currently do.

"The College is very keen to make sure that they have an active seat at the table with the GMC when it comes to regulation," says Dr Mahajan. "And the Competence Framework will, no doubt, feed into the curriculum that the GMC will develop."

"We've set a review date for after GMC regulation – so, late 2023 – to sit back down and have a look at the Framework, because we want it to be a dynamic document, something that changes with time."

The *Competence Framework for Physician Associates* can be found on the College website, along with other dedicated pages for physician associates.

Rural roads in Karamoja, Uganda

Peer support workers for Red Cross Uganda engaging with refugees

A busy street in Kampala, Uganda

Global health **partnerships in action**

A long-standing collaboration between a London trust and Ugandan mental health services is creating positive changes in both countries.

Back in 2005, a partnership between health professionals at the Butabika National Referral Hospital in Kampala, Uganda, and East London NHS Foundation Trust (ELFT) began with the aim of improving mental health in both countries through mutual collaboration.

It followed a request from the Ministry of Health (MoH) in Uganda for support in developing its mental health services as it had identified high levels of unmet needs. "It had the foresight – and bravery," says Dr Nick Bass, Director of Global Health at ELFT, "to recognise mental health as a public health priority."

Uganda has a population of nearly 48.5 million and is one of the fastest growing populations in Africa. It has patchy mental healthcare provision with most specialists being based in urban areas. Poor infrastructure makes provision in rural areas difficult. It has been estimated that 90% of people in need of mental health treatment do not access mainstream services and instead are seen by traditional healers, with variable results. The collaboration with ELFT very much recognises the need to develop mainstream, government-backed services rather than having piecemeal projects that have a limited impact – especially post-COVID.

There are few psychiatrists in Uganda (although the number has more than doubled in the past 20 years) and the backbone of mental health provision is delivered by psychiatric clinical officers (PCOs) – qualified and experienced nurses who have had additional mental health training. They diagnose and treat mental health conditions and make referrals when necessary. This model of care delivery has recently been adapted for training some of the new physician associates in the UK through a pilot scheme – an example of so-called 'reverse innovation'.

Mental health services in Uganda have a much broader remit compared with the UK, covering serious mental health disorders, depression and anxiety, but also epilepsy, delirium and the aftermath of head injuries. Epilepsy accounts for as much as 50% of community workloads as there is a greater prevalence due to infections and disease in early childhood.

Mental health is integrated into primary care, but a big skills gap has been identified in frontline staff. The West Ugandan Mental Health Service Improvement Project aims to help address this, but it was almost scuppered by the fall-out of the COVID-19 pandemic when the UK overseas development budget was slashed and research and development projects promptly dropped. It was saved by a much smaller grant from the Department of Health and Social Care – an unexpected benefit of attempts to persuade it of the advantages global health partnerships can bring to the NHS. It was also supported by the Tropical Health Education Trust and RCPsych.

It was initially a 3- to 5-year project focusing on two areas of priority identified by the Ugandan MoH – Arua (West Nile region) and Mbarara (in the Southwest), with oversight from Kampala. These regions are areas with high need, with fewer than 10 medical doctors per 100,000 people. Resource pressures are compounded by high birth rates and growing numbers of refugees.

The initial remit included a focus on refugee settlements, but the reduced funding and logistical difficulties caused by COVID-19 restrictions meant it was adapted to maximise the potential benefits in a shortened length of time.

Starting in November 2021 and ending in June this year, the project now has two main elements: training using mhGAP – the World Health Organization's general package of mental health training for non-specialist staff – and training peer support workers.

Dr Kenneth Kalani, psychiatrist and medical officer at the Ugandan MoH, coordinated the mhGAP sessions. He describes the structure of the training which allows learning to cascade from the 15 facilitators – the "master trainers" – who ensured the 70 trainers of trainers – mainly PCOs, psychiatrists and registered mental health nurses – were equipped to train the non-specialist frontline primary care staff who were chosen to take part by the MoH. About 250 general staff received the training, and now, says Dr Kalani, "the Ministry has a bank of trainers that we can call upon."

The initial training was delivered by clinicians in Uganda and volunteers from ELFT and RCPsych. It is mainly online and a low-bandwidth version was developed for places with scant Wi-Fi. There was also face-to-face training at village level. Initially planned as a hybrid project, Dr Bass says that a positive side-effect of the pandemic was a willingness to adopt online platforms, cutting the need for carbon-wasting travel.

While it is too soon to evaluate the effects of the training, pre-and post-training tests and service evaluations will feed into a report on its impact. The focus now is following up the training with a support supervision plan with trainers visiting facilities to help establish or strengthen mental health services. "We need to see how the training is being translated in practice. In some ways the training is the easy part – putting it into practice is more difficult," says Dr Kalani.

By upskilling frontline workers to confidently conduct mental health assessments and provide basic care, the project will ease the strain on the referral system. At present, many psychiatric patients are misdiagnosed and end up on non-psychiatric wards, or people are referred directly to Butabika without a mental health assessment or being offered basic care. This puts immense pressure on Butabika and it is hoped that the project's cascaded approach will catch these problems at more than one level.

"It is not about parachuting in with a fistful of money for 6 months. It is a long-standing, open-ended global health partnership network that can continue regardless of funding with the goodwill of those in the UK and Uganda," says Dr Bass.

Plans for the College's continued involvement include the creation of a CPD programme to be co-delivered with Ugandan colleagues. It could also include one-to-one sessions, group support, supervision and mentoring, says Dr Bass. "Resources are more than just money. They are our people, our communities."

Dr Bass is proud of the long-standing relationship with colleagues in Uganda. "Despite the funding difficulties, we have demonstrated that long-term partnership is feasible and works wonders. It benefits everyone."

Anyone interested in getting involved is encouraged to contact the Volunteering and International Psychiatry Special Interest Group: **https://bit.ly/3O8tmsQ**

The Board's first in-person, post-pandemic meeting in May

Demystifying the **Board of Trustees**

We take a look at the function of our Board of Trustees and speak to Lay Board Member Karen Turner to find out about her role.

If you're keen to find out about the inner workings of RCPsych, a good place to start is the Board of Trustees – this is where decisions about anything from College strategy and finance through to employee issues are discussed and approved.

Alongside the RCPsych Council, the Board of Trustees is one of the two key committees in the whole organisation. Chaired by RCPsych President Dr Adrian James, it consists of 12 members and is responsible for the College's use of resources, employee matters, project management, governance, risk and disciplinary issues. The Trustees, who meet once a quarter, also ensure the College observes Charity Commission regulations.

There are eight RCPsych Council members on the Board, including the four College officers – Dr James, Registrar Dr Trudi Seneviratne, Dean Professor Subodh Dave, and Treasurer Professor John Crichton. There is one chair from a faculty, one chair from a division and one chair from a devolved council. These are currently Josanne Holloway of the Forensic Faculty, Rafey Faruqui of the South East Division, and Richard Wilson of the Northern Ireland Devolved Council. There is also one elected member, Professor John Gunn, a founder member of the College.

"Our role is to help the College get it right for members"

In addition, there are four Lay Members, who bring in expertise from fields outside the profession.

"The board contributes to the good governance of the College, making sure it adheres to its constitution and members' interests are well represented," says Karen Turner, one of the Lay Members. Ms Turner was NHS England Director of Mental Health from 2015 to 2018, when she established the Mental Health Taskforce and oversaw the development and new funds for the Five Year Forward View for Mental Health.

RCPsych CEO Paul Rees says: "Being able to draw on the skills, experience and knowledge of the Lay Trustees provides the College with a full range of insight and expertise to go alongside the expert member perspective."

The other three Lay Trustees are Cindy Leslie, a former partner and dispute resolution solicitor at a City law firm, Meera Nair, who has held senior HR roles in the NHS, and Sally Spensley, who brings a wealth of financial knowledge.

Given the College has 20,000 members and 380 staff, there is a lot to get through at Board meetings. There are regular items such as finance, staffing and reports from ongoing projects and in-depth discussions on what Ms Turner calls more "thorny topics" such as "supporting troubled doctors, improving the curricula or supporting the President in agitating for more money". Trustees can contribute to areas they have particular interest in – for example, Ms Turner is looking into support and training for psychiatrists that come to the UK from overseas. "We have time to think about these things in a way that busy doctors on the ground don't," she says.

In spring 2020, Board meetings were shifted to being held virtually and the Trustees' swift decision-making enabled services to be rapidly migrated online and the College exam to be digitised. It also seized the opportunity to ensure the main office, in central London, was refurbished.

Ms Turner says there are rarely big disagreements, but nor are things waved through. "We have to get to an endpoint; it doesn't stop you saying what you want, but you have to be able to give way as well."

Ms Turner is enthusiastic about her role: "It's a big privilege and hugely stimulating. Our role as Lay Trustees is helping the College get it right for members, so that they are equipped with the support they need, and we can get the right outcomes for patients. That is why I am there."

For more information, search 'Board of Trustees' at: **www.rcpsych.ac.uk**

Dr Natalia Pidkalyuk (centre) and her team

The power **of support**

Ukrainian psychiatrist Dr Natalia Pidkalyuk talks about her work with traumatised people in a time of war.

When Russia launched its full-scale invasion of Ukraine on 24 February, trauma specialist Dr Natalia Pidkalyuk went into shock and, for three days, was unable to respond to calls and messages from her patients. "I didn't believe this could be happening nowadays in the centre of Europe," she says. "I felt all the symptoms of acute stress disorder: fear, nightmares, 'freeze', anxiety." When she was able to talk to her patients again, she found that they weren't calling about themselves, but to see how she was and how they could help.

Then came a call from the College via an international network of psychiatrists. She was asked to translate the College's trauma resources into Ukrainian. This also led to her striking up an email correspondence with former RCPsych president, Professor Wendy Burn. "Translating the materials was both therapeutic and grounding," says Dr Pidkalyuk, "and the letters from Wendy Burn were very supportive. I began to feel okay enough to go back to my work."

Dr Pidkalyuk lives in Khmelnytskyi, a city of more than a quarter of a million people, some 200 miles to the west of the Ukrainian capital, Kyiv. She has worked in adult psychiatry in her region since 2004. Five years ago, she became interested in working with traumatised people.

"I started to work as volunteer with my colleague, psychologist Maryna Malinovska, with people in the military and their families," she says. "We decided to create space for them, but not in the psychiatric hospital because it was a stigmatised place. Our local government supported us, and we created our first small centre for stress disorders. We made about 2,500 consultations a year, ran a support group for citizens and started training sessions about stress disorders for psychologists. We came to see that a lot of people need professional support, not only people in the military."

"Sometimes, we can change nothing, but we can still be there"

But then came the war. Dr Pidkalyuk's home city is a long way from the fighting, although, in the early days, it was subject to Russian air strikes and rocket attacks. Even now, there are sporadic alarms when everyone has to rush to a shelter. But, comparatively speaking, Dr Pidkalyuk says her city is "peaceful and quiet", which makes it a common destination for refugees. Tens of thousands of displaced people have settled in the city; many more have passed through. Dr Pidkalyuk and her clinic have obtained funding from the NGO 'People In Need' to work with refugees. This is the only paid work done at the clinic – everything else is done on a voluntary basis – which means that Dr Pidkalyuk continues her private practice, when she can.

It's difficult to know when Dr Pidkalyuk and her colleagues manage to get any sleep. Her clinic offers phone consultations and Zoom sessions alongside face-to-face work. They work with traumatised children and adolescents, often remotely, via the internet, and they have a children's room in the clinic, kitted out as a playroom. Dr Pidkalyuk finds that the College resources she translated, as well as helping her to cope with trauma, have been of value to members of the military and their families with whom she still works closely.

The experiences of Dr Pidkalyuk and her compatriots are humbling. She talks of how the war has brought everyone together, of how former patients of hers have signed up to fight, of how valuable international support is, and of how she fears exhaustion is setting in. "But," she says, "we continue to fight."

Not long after the outbreak of the war, Dr Pidkalyuk worked as a volunteer on a telephone helpline. "When people from occupied territories called me to say that their relatives had psychosis, I thought, what can I do, how can I help?" she says. "They couldn't get any medicines, but still they continued to call. And what I began to understand was that the most important thing we can give is support. So, sometimes, we can change nothing, but we can still be there, even if it is only on the other end of a phoneline, or even if we are just keeping someone in our thoughts."

Many thanks to Lyuba Shevchuk, a volunteer and interpreter at Dr Pidkalyuk's clinic, who assisted with this interview.

Dr Pidkalyuk's Ukrainian translations of RCPsych's trauma resources, edited by Professor Irena Grygа, are available on the College website, along with the English language versions.

Aiming for precision

In research and data analysis lies the potential to precisely identify those most at risk of mental illness – and the specific treatments likely to help.

(Illustration: Andrea de Santis)

You're in your early 20s, about to begin your adult life in earnest, when a question arises: Do you want to know your risk of developing psychosis at some point in your lifetime? And if you are shown to be at risk, would you want to know how likely you are to respond to treatment? The extent to which it's likely to affect your life, and in what ways?

That sort of precise assessment of risk and likely response to treatment is what researchers in precision medicine and personalised healthcare in psychiatry hope might ultimately prove possible. They envisage being able to identify individuals at high risk of developing or worsening illness, and then intervening with medications and therapies shown to be reliable for a particular patient group.

Their path to doing so lies in data and, particularly, sophisticated analysis of it. Rachel Upthegrove – professor of psychiatry at the University of Birmingham and youth mental health consultant psychiatrist in the city's early intervention service for psychosis – admits different people in psychiatry use the terms 'precision medicine' and 'personalised healthcare' to mean different things.

"But the common thing across all of us," she says, "is using advanced data science to inform our research questions, and then get that into clinical practice."

"Neurobiological precision is only the first step. We then have to integrate that into patients' understanding"

It is a mission not unique to the specialty. Many will be aware that there are already cancer drugs that target the specific gene change involved in an individual's disease. In mental health, however, it is not just genetic data that is crucial in building treatment or risk models.

"Precision medicine in psychiatry would mean making medicine or treatment more relevant to the patient by identifying their genetic, molecular, neurobiological characteristics, but we also need to precisely understand life circumstances and behaviours," says Dr Lana Kambeitz-Ilankovic, research group leader at the University of Cologne's Department of Psychiatry and Psychotherapy and a practising psychotherapist.

"That does not mean we don't need to do the same in somatic medicine – we certainly do. But I think that in psychiatry, the neurobiological precision is only the first step. We then have to integrate that into patients' understanding of this world."

To do that would require a broad range of data – both biological and that related to environmental factors – and in large quantities, to allow analysis of common themes and the construction of models. And, for now, that availability of information is the major obstacle researchers are trying to overcome.

"The challenge, at the moment, is that a lot of models are based on research data," explains Professor Upthegrove, who (along with Dr Kambeitz-Ilankovic) recently guest edited a themed issue of *The British Journal of Psychiatry* looking at precision medicine and personalised healthcare.

"That [research data] might include detailed brain imaging that is not the type of brain imaging you would be able to order in-clinic; it may include lots of biomarker data; it may include a lot of really detailed clinical assessments that would be hard to do in a busy clinic."

That, in turn, causes two difficulties: firstly, getting any predictive models to work in a useful way and, secondly, creating models that can actually be used in a clinic with a patient and with the sort of data that tends to be available in that setting.

For Dr Kambeitz-Ilankovic, a possible solution would be for all treatment centres to collect a small amount of core data for research as part of day-to-day activity. "Let's say the level of functioning, or the Beck Depression Inventory: little things that I would say would not really jeopardise privacy if handled in line with all ethical guidelines."

Because therein lies another challenge in advancing precision medicine in psychiatry: which data would the general public be comfortable with being shared for research, how to ethically use what is shared, and how to appropriately communicate with patients about their risk.

"If an algorithm says you've got an 80% chance of developing treatment-resistant symptoms, would you want to know? At the end of the day, it's only a prediction, it's not the ordained truth," says Professor Upthegrove. "But if you are predicted a poor outcome, is it a self-fulfilling prophecy or an opportunity for early intervention that might ameliorate such risk?"

"I think it's really important that patients have the right to know, but they also have the right not to know," adds Dr Kambeitz-Ilankovic. "And this right not to know is something we need to focus on, especially if we will be screening the general population [for risk of mental illness].

"As our algorithms get better with time, we will have to be very detailed and transparent in our informed consenting."

Despite this challenge, she believes the benefits of being able to predict risk would outweigh the downsides. "I think that knowing the risk is often very beneficial, because I think that anxiety without purpose is much worse. Once we know, we may be able to change or adapt or make our lives nice and liveable despite certain risks."

It's an argument that touches on the potentially transformative nature of precision medicine and personalised healthcare in the treatment of mental illness. The scale of the potential impact – but also the reality that it will take time and an awful lot more research to get to the ultimate destination. Consequently, Professor Upthegrove suggests "all psychiatrists need to educate themselves on what's happening within this field and how close that is to clinic."

"Already in psychiatric genomics, companies are coming along and saying they have a test which will tell you whether your patient will respond to, say, lithium or clozapine. But, often, they're actually just testing how quickly somebody metabolises the medication, not whether they respond to it or not."

"We all need to be literate enough in this field to make sure we're not going down a rabbit warren of costly interventions or tests."

For Dr Kambeitz-Ilankovic, using a slightly different term than 'precision medicine' may also help. "For now, 'stratification' may be a fairer term," she says. "We can define certain subgroups with more or less likelihood to experience symptoms or have poor outcomes. But the ultimate goal is to make individual-level predictions and recommendations. We're not there yet."

The *BJPsych* themed issue in which Professor Upthegrove and Dr Kambeitz-Ilankovic were both guest editors is available online: **https://bit.ly/3NJdHzv**

Crystal Palace For Life Foundation's Advantage Mentoring programme (Photo: Gabriel Larmour)

Advantage **programme**

An exciting mentoring scheme is proactively filling gaps in mental health care for young people with mild to moderate need.

Among a sea of lengthy CAMHS waiting lists – which have only grown since the pandemic – a community project has been engaging with young people in a relatable way. 'Advantage' is a free, confidential, mental health and wellbeing mentoring programme for 14- to 21-year-olds, where the mentors look more like football coaches than clinicians.

Combining the community reach of local football clubs with the NHS's expertise in mental health care, the project, which started in 2020, offers mentoring via the community club organisations of Arsenal, Crystal Palace, Leyton Orient, Manchester City and West Ham United.

"With this project, we're accessing a group of people who are not interested in coming to CAMHS," says Dr Hannah Prytherch, clinical psychologist at Newham CAMHS. She describes often seeing CAMHS patients who are lacking connections to their community, adult support and role models. "For some young people, this project can be a more helpful intervention than talking therapy," she says.

Risk assessment is paramount, and only young people assessed as having mild to moderate mental health needs can be selected to take part. There is one CAMHS clinician in every project location whose role it is to screen referrals and conduct assessments before carefully matching mentees to mentors with shared interests.

Jack Fergusson, one of the mentors in Arsenal's community team, brings with him a wealth of experience in, and a genuine passion for, supporting young people. "The key thing I've learnt from this kind of mentoring," he says, "is the importance of giving the individual ownership of the actions that are coming out of the sessions and that sense of empowerment that they can tackle some of the challenges they're facing."

Sessions often take place in non-traditional spaces, mainly at the club's inspirational facilities or a local café. During the pandemic, a lot of sessions were online, but many have switched over to face-to-face sessions – a decision left up to the mentee in each case. "Every mentoring conversation is unique to that individual," says Jack, "and very much led by what they would like to get from it."

Before delivering any sessions, mentors have safeguarding training from their club and mentoring training with the dedicated NHS practitioner for their area, who continues to meet with the mentors regularly as a team to guide and support their on-going practice. "These supervison sessions are a good space to bounce ideas off each other and discuss how we're finding the mentoring sessions, all while respecting confidentiality," says Jack.

Referrals to Advantage can come directly from CAMHS or schools, colleges and the clubs themselves. In Newham, where Dr Prytherch is the dedicated practitioner for the project, there is now a 'multiagency collective', which brings together various organisations and services to allocate support to children and young people waiting for CAMHS treatment. "Someone from Advantage attends a weekly meeting," says Dr Prytherch. "If, for example, a young person is discussed who is dealing with bullying and low self-esteem, and is really into football, then someone from our team can say: 'They sound like a good fit for us'."

Some of these young people might be a year away from being seen by CAMHS, and the hope is they might need less intervention, or even none, by the time they reach the top of the list.

The programme is still small and has only been in operation for two years, but staff have seen tangible changes in the participants. On the four outcomes scales being used, "responses to every question on every measure have gone in the expected direction," says Dr Prytherch. Everyone who has taken part has said they would recommend it, many citing the quality of the mentoring as to why it was such a positive experience.

Konrad Deckers Dowber, Managing Director of Advantage Mentoring, says: "Our programme is about helping young people re-engage, find a sense of connection, develop a positive outlook and reignite passions that may have lapsed." What's also remarkable about the Advantage programme is "the uniqueness of the football clubs working together," says Jack. "We leave the rivalry on the pitch."

For more about the Advantage programme: **www.advantageprogramme.co.uk**