RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

FOR MEDICAL STUDENTS & FOUNDATION DOCTORS

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VOLUNTEERING & ELECTIVES

PERINATAL MENTAL HEALTH

THE NEED FOR DIAGNOSTIC LABELS

Future Psych

RC PSYCH
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FROM THE EDITORS

Welcome to the Summer edition of FuturePsych, a magazine written to inspire medical students and foundation doctors wishing to pursue a career in psychiatry.

The articles in this edition approach psychiatry from many different angles, but all display the authors' curiosity about what it means to practice in mental health. They describe first encounters with psychiatric practice, from volunteering experiences and electives abroad to reflections on forensic and perinatal psychiatry placements. They also explore the structural inequalities that shape mental health and psychiatric practice, and examine the potential harm of diagnostic labels and the therapeutic potential of board games such as Dungeons and Dragons in psychistric practice.

We hope this edition invites you to explore deeper into the world of psychiatry and open your eyes to some of the experiences the speciality has to offer.

Ollie & Hollie

Oliver Porteous

FOUNDATION DOCTOR REPRESENTATIVE

Oliver Porteous is a Foundation Year Two Doctor based in the West Midlands. He studied at Imperial College London, and is the Foundation Doctor representative on the RCPSych's Psychiatric Resident Doctors' Committeee.

Hollie Meyers

MEDICAL STUDENT REPRESENTATIVE

Hollie Meyers is a final-year medical student at Imperial College London. She aspires to train as a psychiatrist after her foundation years and is in her second year as the Medical Student Representative for the PRDC, where she represents medical students on college committees.


becoming
curious

Volunteering with Festival Samaritans

Isobel Cammish, Medical Student at the University of Oxford

The music is loud by the stage, but its quieter here. I'm sitting by the Samaritans tent talking about grief and loss and pain, struggles no-one would normally tell a stranger. Around me, the other volunteers on shift are all doing the same. A couple of Samaritans are engaging a group of teenagers, who initially seem sceptical but start talking more freely once they are convinced we're not a religious group. It's a strange privilege to be able to listen and to hold stories being told for the first time. I always think about who I want to be as a doctor, when I have these conversations. Samaritans has a different role than psychiatrists in mental health, but a lot of the skills still carry over.

This summer is my first season with Festival Samaritans, and I've been training for it since January. Even though we would role-play these situations, it's still a shock the first time someone sits next to me and tells me they feel suicidal. Before I joined Samaritans, I volunteered with Oxford Nightline, a student listening and support service run by and for students in Oxford. Nightline taught me a lot - I have taken a lot of calls in over 100 shifts, and supported other call-takers as Coordinator through difficult topics of suicide and safeguarding - but I wanted something different. Amazingly, I found out once I joined the Festival branch of Samaritans that it had actually been set up by Nightline volunteers in 1973, and many current Samaritans had once volunteered at their own university.

The main lesson was to be comfortable with uncertainty, and be able to hold severe distress without flinching, or offering reassurance or promises. I had to confront how difficult silence can feel, but also how important it is in active listening, and I learnt to explore suicidal thoughts with curiosity instead of fear, and to ask about suicide without stigma. A key value of Samaritans is human contact: that giving people time, attention and empathy can reduce distress and despair. Getting to practise that care and compassion in the festival tent, and I could practise containment, offering calm when someone's world is chaotic, even in the middle of a busy festival. I also learnt how to maintain my own boundaries in what I disclose about myself to stay safe, and how to not take home the stories and pain I heard.

Festival Samaritans was set up to support people who might be less likely to reach out for help over the phone, by going to them in person. As it is increasingly having to fundraise to stay open, preserving spaces dedicated to listening without judgement feels more important than ever. Festival Samaritans has improved my clinical skills in so many ways, shaped the sort of doctor I want to be, and helped me to see patients as a whole person shaped by their environment and social context. It has also changed how I see psychiatry: it starts with being present, and making patients feel heard.

Taking Curiosity Seriously: Reflections from a Psych Star

Shahnoor Adil, Medical Student at Aston Medical School

Psych Star Scheme

One-year scheme open to UK medical students with an interest in psychiatry seeking mentoring and financial support for activities intended to increase awareness and knowledge of Psychiatry.

Before becoming a Psych Star, I already knew I wanted to pursue psychiatry. Through volunteering with young people and witnessing mental health stigma within my own community, I became interested in how culture, identity, faith, and lived experience shape mental health and help-seeking.

Yet despite knowing psychiatry was where my interests lay, I was unsure how to develop them further. Like many medical students, I assumed meaningful engagement with the specialty required publications, research, or a strong portfolio. I knew what interested me, but I was less certain whether those interests were enough.

During my interview, I spoke about The Pearl That Broke Its Shell by Nadia Hashimi and how it had led me to learn more about the practice of Bacha Posh in Afghanistan. I spoke about identity, culture, and the questions the novel raised about the lives people lead within particular social expectations. Afterwards, I remember wondering whether I should have spoken about something more scientific. I had not discussed landmark papers or recent research.

Looking back, that thought reflected how narrowly I understood what counted as a legitimate interest in psychiatry. I assumed engagement with the specialty had to look academic from the outset. What I did not yet appreciate was that many of the questions that draw people to psychiatry begins long before they become research projects, posters, or publications.

"the starting point was curiosity"

One of the greatest gifts of the scheme was helping me realise this. My mentor, Dr Nicole Fung, fundamentally changed how I thought about professional development. In medicine, there can be an unspoken pressure to transform every interest into an outcome. A clinic becomes a project. An idea becomes a poster. A question becomes a publication.

Dr Fung's approach was different. Whenever I mentioned something that interested me-a patient group, a clinic, or an idea-she never asked what it would become. Instead, she encouraged me to explore it further. Through conversations, introductions, and opportunities to shadow across a range of psychiatric services in the West Midlands, she helped me realise that curiosity does not need to justify itself before it is worth pursuing.

That was the lesson I had been missing after my interview. The fact that I spoke about culture, identity, and a novel rather than a research paper was not evidence that my interests were lacking; it was evidence of what had drawn me to psychiatry in the first place.

The scheme's funding opened further opportunities. At the Welcome Evening, I met fellow Psych Stars who became friends and conference companions, and I was particularly inspired by Dr Suhana Ahmed's reflections on her own journey into psychiatry. Throughout the year, I was struck by how welcoming and supportive the psychiatry community was, whether through local opportunities such as the Clinical Teaching Fellow Away Day or through the encouragement of doctors across the West Midlands.

Another important influence was Dr Anis Ahmed. After learning about my interest in psychiatry, he encouraged me to become involved in medical education. Through this support, I delivered my first oral presentation at the RCPsych Medical Education Conference and joined a panel discussion on artificial intelligence in medical education. I also presented two posters at the RCPsych International Congress and later had an abstract accepted to the World Congress of Psychiatry. Although I was honoured by the opportunity, I chose not to attend. I hope my first experience of the World Congress will come later in my career, when I can engage with it as a clinician as well as a learner.

When I reflect on my time as a Psych Star, it is easy to point to the conferences, presentations, posters, funding, shadowing opportunities, and professional connections. Yet these were never the starting point, the starting point was curiosity.

Psych Star gave that curiosity somewhere to go. More importantly, it introduced me to people who took it seriously. The opportunities that shaped my year came from mentors who encouraged me and a programme that recognised the value of curiosity before I fully recognised it myself.

For any student considering applying, do not wait until you feel ready. You do not need a perfect portfolio, a publication list, or a detailed career plan. Bring your interests, your questions, and your curiosity. In my experience, some of the most meaningful opportunities begin when someone helps you realise that those things are already enough.

encounters in psychiatric practice

Through the Locked Doors: A Third-Year at Rampton Hospital

Nana Obeng Asare Owusu-Sampah, Medical Student at The University of Nottingham

The first time I walked through the airlock at Rampton Hospital, the door behind me had to close before the door in front would open. I stood for a few seconds in that small space between, listening to the magnets, and realised where I was. Two more doors after that, two more sets of staff escorting me, and I was on the ward.

I am a third-year medical student. Rampton, one of the three high-secure hospitals in England, is not somewhere third-years usually go. I got there by emailing a forensic psychiatrist at my university and asking, repeatedly, whether he knew anyone who would let me visit. He did. I am grateful to him and to the consultant who hosted me on the ward.

The thing nobody had quite prepared me for was how quickly a patient can oscillate. I sat in on a ward round where a patient who had been floridly psychotic the previous evening was lucid, polite, and able to tell the team exactly what had happened. An hour later, on a different ward, a patient I had been told was stable for months became disorganised mid-sentence. The clinical signs I had revised for in textbooks were not always there. The change was sometimes only visible in the eyes, or in a small shift in the way someone arranged their hands. Consultations themselves had a conversational quality I had not expected. The patients knew the consultants well; the questions were specific and unhurried.

This is where the long-term antipsychotic question becomes real. The medication is what holds many of these patients out of the cycle that landed them in high-secure care. It is also what gives them the weight, the metabolic syndrome, and the sedation visible on every ward[1]. I watched the team weigh, in a single morning, whether to reduce a dose for someone whose physical health was deteriorating, knowing that relapse could mean a victim. I had read about side-effect profiles in pharmacology lectures. Watching a consultant hold both sides of that calculus for one named person was different.

What surprised me most was how little the clinical decisions belonged to a single doctor. The forensic multidisciplinary team, including social workers, occupational therapists, and nursing staff who knew the patients far better than any visitor could, weighed in on every plan. Decisions about leave, ward moves, and tribunal applications were made collectively. Several patients asked to be transferred back to prison, or out into the community, and the team treated those requests with the same seriousness they treated everything else.

The forensic psychiatrists I spoke with were unusually deliberate about their hobbies and coping strategies, in a way that started to make obvious sense by the end of the week.

I had asked for the placement because I thought I wanted to do forensic psychiatry. I left certain.

Questioning the Need for the Diagnostic Label

Anoushka Baluja, Medical Student at the University of Manchester

During the preclinical years of medical school, I completed a research project exploring stigma towards mental health conditions and the influence of various cultural structures on these attitudes. During this project, I learnt about the varying perceptions of mental health and the range of reasons attributed to the cause of an individual's mental health problem across cultures. This ranged from psychological disturbance to possession by evil spirits, a divine punishment, or personal failings. An 'East-West' divide has been identified, with higher levels of stigma reported in 'Eastern' countries compared to the 'Western' counterparts.

One theory about why this difference exists explores the structure of society in these respective countries, looking at whether they are collectivist or individualist in nature. Collectivist cultures are ones that often prioritise the needs and goals of the community over the individual's independence or desires, and are predominantly seen in Asia, Africa, and Latin America. This contrasts individualist countries, such as the UK, USA, and Australia, where the individual and their immediate families' self-interest is promoted, with personal independence, autonomy and the individual's initiative taking priority. Due to a higher reliance on other members of the community in collectivist cultures, deviance away from social norms and values is generally less accepted and consequently, a mental health diagnosis can be seen as a 'threat' to the community and may contribute to some of the higher levels of stigma seen.

One paper I read during my research really interested me. A comparative analysis exploring the conversation around pathologized deviance within India, published by A. Hyne-Sutherland, 2015, reported a series of interviews with various health practitioners. Within it, one practitioner talks about choosing to omit terms such as 'schizophrenia', 'depression' or 'anxiety' when managing his patients, primarily due to the worry that the label may result in the individual being isolated from their surrounding community, due to the associated stigma.

The doctor describes one specific case of a patient with schizophrenia. Their condition was well controlled with medication and strong family support, and he believed the patient would not receive this familial support with the label of a schizophrenia diagnosis. While the doctor still explained the symptoms, treatment, and relevant aspects of the patient's care to them, less focus was placed on pathophysiology, with it simply explained as 'an illness of thinking'.

This method of practice highly contrasts the norm of practice in the UK, with not providing the name of a diagnosis to the patient would be considered poor practice and providing the patient with inadequate detail about their condition, undermining their own ability to understand the condition. The benefit of this in India, a country with a collectivist nature and one where stigma and its role in society operates differently, this can be understood and is shown by the worries of social isolation reported by the doctor.

As I continued to think about this further, I began to question the strict need for diagnostic labels, suggesting that a patient's full comprehension may be more valuable than technical terminology, especially if it may negatively impact the patient's life. I believe it is important to fully consider all the consequences of the language used around explaining conditions, and this example raises interesting questions about the need for a diagnostic label in every patient scenario. In current day practice, there is continually increasing cultural diversity within patient populations, and this is something we may need to consider using within practice in the UK as well, as a patient may still exist within a cultural community that follows a more collectivist structure while residing in the UK.

perinatal mental health

The Silent Crisis After Birth: Why Postpartum Mental Health Must Be Central to Psychiatry

Dr Aneesa Arshad, Foundation Doctor at Warrington Hospital

Becoming a mother is supposed to be one of the happiest times of a woman's life. That's the narrative, anyway. The reality for many women is something far darker, and the healthcare system is still not doing enough about it.

Perinatal mental illness affects up to one in five women. Postnatal depression alone impacts 10–15% of new mothers[1]. Perhaps most shockingly, maternal suicide remains a leading cause of death in the year following childbirth in the UK[2]. These aren't rare edge cases. This is happening on our wards, in our communities, to our patients, and too often it goes unrecognised.

The postpartum period can bring anything from transient "baby blues" to severe depression, anxiety disorders, and postpartum psychosis – a psychiatric emergency that requires immediate intervention. The problem isn't just that these conditions exist; it's that we keep missing them. Opportunities for early identification are lost across primary care, obstetrics, and emergency settings, largely because psychiatric training in these contexts remains inadequate[3].

Part of the issue is structural. Perinatal mental health straddles general practice, obstetrics, health visiting, and psychiatry, and that fragmentation means responsibility often falls through the cracks. Specialist services and Mother and Baby Units have made a real difference where they exist, but access is patchy and inequalities run deep. Women from ethnic minority backgrounds and those in more deprived areas face greater risk and greater barriers to care simultaneously[4].

In my own research comparing mental health outcomes in the UK and Pakistan, I was struck by how consistently maternal mental illness is overlooked, regardless of the healthcare system or the resources available[5]. Stigma, cultural expectations of motherhood, and systemic gaps seem to transcend borders. Better medication and better services matter, but they only go so far if the underlying attitudes don't change.

So should perinatal mental health be core knowledge for every doctor, not just psychiatrists? I'd argue yes, without hesitation. We are all likely to encounter these women in A&E, in GP surgeries, on postnatal wards. Knowing what to look for, and feeling confident enough to ask, could genuinely save lives.

This isn't a niche subspecialty interest. It's one of the most common and most consequential gaps in modern medicine, and as future doctors, it's ours to close.

Two Patients, One Decision: Reflections from Perinatal Psychiatry

Ellen Angel, Medical Student at the University of Liverpool

A woman at 32 weeks pregnant, stable on an antipsychotic she has taken for years. Do you continue it? Reduce it? Switch? The answer is never simple when the risks of relapse and the risks of foetal exposure must be weighed against each other in real time. This is perinatal psychiatry and my six weeks there proved to be the most thought-provoking experience of my medical training.

Perinatal psychiatry sits at a unique intersection between maternal and infant health. I was struck by the privilege of being involved in women's lives during such a vulnerable and transformative period. The emotional intensity of pregnancy and early motherhood was often compounded by significant mental illness, yet the resilience demonstrated by the women I met was remarkable.

One aspect of the placement that I had not anticipated was the number of women seeking asylum within perinatal services. Many had fled environments shaped by conflict, persecution, or violence, often carrying significant psychological trauma. I was struck not only by the burden they carried, but by their extraordinary resilience. These women were navigating pregnancy and early motherhood alongside the long-term effects of displacement, uncertainty, and loss. This experience deepened my understanding of how profoundly social and political contexts shape mental health, particularly in the perinatal period.

One of the most important insights I gained was the central role of the infant in all clinical decision making. Unlike other areas of psychiatry, there is a constant dual focus. Initially, I had assumed that pregnancy and breastfeeding would necessitate discontinuation of many psychiatric medications. However, this placement challenged that assumption. I observed that, when managed appropriately, there is rarely a need for women to sacrifice their mental health in favour of perceived foetal safety. Instead, perinatal psychiatry emphasises that a well mother, both mentally and physically, is the most important determinant of positive outcomes for her baby.

This perspective was reinforced through my involvement in a literature review exploring prazosin for post-traumatic stress disorder during pregnancy and lactation. I was struck by the lack of evidence surrounding not only prazosin, but pharmacological treatments in pregnancy more broadly.

Pregnant women have historically been excluded from clinical drug trials due to ethical concerns and methodological limitations in studying foetal outcomes[1]. Consequently, over 90% of approved medications lack pregnancy-specific pharmacokinetic data, leaving clinicians to rely on limited observational evidence and extrapolation from non-pregnant populations[2].

This gap has clear clinical implications. Referrals into the perinatal service highlighted hesitancy among some healthcare professionals when prescribing during pregnancy. While understandable, this caution can contribute to the undertreatment of maternal mental illness, which itself carries significant risks. Perinatal psychiatry therefore requires balancing incomplete evidence with clinical judgement, patient values, and shared decision-making.

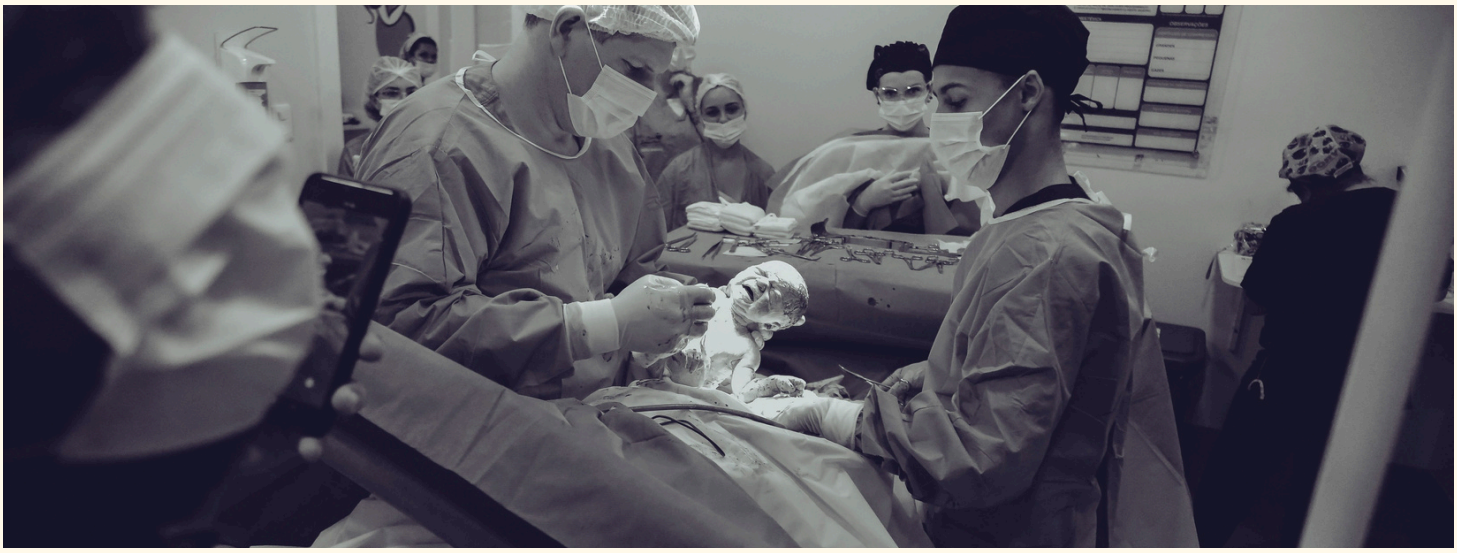
Emerging technologies such as placental organoids and placenta-on-chip models offer promising avenues to address these limitations[2]. However, they remain in early development and are not yet integrated into routine clinical or regulatory frameworks. Until then, clinicians must continue to make decisions in the context of uncertainty.

This placement has deepened my appreciation of the ethical complexity inherent in perinatal psychiatry. Above all, it has reinforced a principle I will carry forward into practice: that maternal wellbeing is the foundation of safe and effective care for both mother and baby.

More Than Baby Blues

Hania Arshad, Medical Student at the University of Aberdeen

We screen for postnatal depression. We counsel for baby blues. But for a condition that may affect 1 in 20 mothers in the UK[1], we have no routine pathway at all. Postpartum PTSD remains one of perinatal psychiatry's most underdiagnosed conditions - and for many women, it begins the moment their birth experience ends.



What is postpartum PTSD and why does it matter?

Postpartum or postnatal PTSD is when a mother experiences continuous anxiety and stress after a traumatic birth experience.[2] But what exactly is a traumatic birth? It's typically defined as a series of events surrounding childbirth that cause distress and subsequent health impacts for the mother.[3] In the UK, 4–6%[1] of women develop PTSD post-childbirth, and globally around 3–6%, with higher rates (16–19%) in high-risk groups.[4] The experience can be due to medically complex births or, more commonly, experiences where the mother feels unsupported and her feelings aren't considered; this disconnect and depersonalisation can lead women to feel as if the birthing is akin to rape.[2] The birth can be considered medically standard and yet lead to PTSD if the mother feels powerless and invisible to the medical staff - overall, feeling as if she is not in control and mistreated during a vulnerable time.[2]

Risk Factors

Risk factors span the perinatal journey. Antenatally, fear of childbirth and pre-existing depression carry the greatest risk.[4] During labour, subjective birth trauma and operative delivery are key predictors.[4] Postnatally, concurrent depression, lack of skin-to-skin contact, and absent social support compound vulnerability.[5] Previous sexual trauma, non-European ethnicity, and single-parent status further elevate risk.[5] Crucially, supportive care during labour is the strongest protective factor - greater in effect than many of the risk factors combined.[4,5]

Treatment

In the UK, psychological intervention is first-line for postpartum PTSD.[6] Trauma-focused CBT and EMDR are the main recommended treatments – a meta-analysis of 41 studies found trauma-focused therapies produced a large effect size (SMD −0.95), indicating a clinically meaningful reduction in symptoms.[7]

Pharmacologically, SSRIs - particularly sertraline, given its favourable safety profile in breastfeeding - and venlafaxine are first-line options.[8,9] However, pharmacological evidence is extrapolated from general anxiety disorders rather than perinatal populations, largely due to ethical constraints in recruiting pregnant and breastfeeding women into RCTs.[10] Psychological interventions, therefore, have a significantly stronger evidence base for this population.

Clinical conversation

Despite its prevalence, postpartum PTSD is rarely screened for routinely. Unlike postnatal depression, there is no standardised tool universally used in UK practice - the City Birth Trauma Scale[11] exists but is not yet embedded into routine care. For clinicians, this means the onus falls on asking; women are unlikely to volunteer that their birth felt traumatic, particularly when cultural narratives frame childbirth as a joyful event. A simple, non-judgemental question - "how did you find your birth experience?" - can open a conversation that a checklist never would. Early identification matters: untreated postpartum PTSD not only affects the mother but also the mother-infant bond and the wider family unit.[12]

Takeaway

Postpartum PTSD is common, underdiagnosed, and treatable - yet it remains absent from routine perinatal care pathways. As future and current clinicians, we have an opportunity to change this. You don't need a specialist referral to make a difference: asking one open question about a woman's birth experience costs nothing, and it could be the first step towards a diagnosis that changes her life. Birth trauma deserves the same clinical attention we give postnatal depression - and it starts with us.


beyond
diagnosis

Wizards And Wellbeing
An Overview of the Use of TTRPGs as a Therapeutic Tool

Dr Hannah Kingston, Foundation Doctor at Blackpool Victoria Teaching Hospital

Table top role play games (TTRPGs) are collaborative storytelling games where players create and inhabit fictional characters within an imagined world, navigating a shared narrative and making decisions and engaging with the setting as their characters, to influence the story[1]. They have existed in the public consciousness for several decades, with Dungeons and Dragons becoming the first commercially available game in this genre in 1974[2], though many others exist today. For many years seen as a countercultural pass-time, in large part due to the 'satanic panic' era of the 1980s[2], these games have seen a turning of the tides in recent years and are now undergoing a significant resurgence. Several television and film series such as Stranger Things and Dungeons and Dragons: Honour Among Thieves have given TTRPGs a firm place in popular culture, and Actual Play groups such as Critical Role or Dimension 20 have sold out stadium tours[3], performing these games live to thousands of fans.

With this resurgence of TTRPG popularity, many mental health professionals have been exploring its therapeutic applications for psychological and social wellbeing. Multiple studies have shown that use of TTRPGs promoted development of cognitive and psychological tools[4] and could provide some benefit as a complimentary aid in therapeutic interventions[5]. There have also been specific studies indicating benefits to social abilities, with evidence showing increased confidence and comfort with setting boundaries and coping with making mistakes in social settings[6]. This is particularly relevant when applied in the context of neurodivergence, where socially-led TTRPGs have been shown to support autistic youth with self-exploration, social connection and development of conflict resolution skills[7].

Alongside these more general applications in psychological and social wellbeing, there has also been demonstration of specific applications to marginalised youth, who may be more resistant to or less trusting in traditional mental health interventions, providing a more interest-driven approach and safe access to free play in a developmentally appropriate format[8]. There has also been significant benefit demonstrated regarding the impact of RPGs on gender identity exploration[9] with transgender and gender non-conforming youth, with specific reference to character customization as a noted and important aspect of this. TTRPGs have been generally reported as a safe space for deeper exploration of queer identity in an environment which is protective from the wider social environmental context[8].

As promising as a lot of the work in this field has been, the major obstacles for developing further applications for therapeutic use has been the limitations of the existing published evidence[4,5]. While further research is conducted and a firm evidence base is built, there are many charities and community initiatives throughout the UK offering TTRPGs and other Game-based approaches in a social and wellbeing context to a variety of demographics, including veterans, school children & working with homeless outreach teams.

From a personal standpoint, I have for the past 3 years been working with Game Therapy UK (GTUK), a British-based charity with several projects using TTRPGs, alongside other forms of games, as a therapeutic tool. I volunteer as the Research Ethics Lead for the academic branch of the charity, who hosted our first national conference in April 2026[10] and are currently working towards the development and publication of an academic journal, in an effort to aid in this development of a robust and rigorous evidence base for future endeavors in the field of therapeutic applications of gaming.

From my time spent working with GTUK, attending conventions and working with teams who run these game projects and see their effect directly on the communities they work with, I personally believe in the significant therapeutic potential. They have anecdotally shared the benefits of social skills building, communication tools, among many others. All in a form that is generally approachable and enjoyable for participants, allowing them to be the hero in their story.

UK's First Drug Consumption Room Overcoming Barriers that Hinder Evidence-Based Medicine

Dr Melissa Chang, Foundation Doctor at University Hospitals Coventry and Warwickshire

Fantasies of a warm, sunny elective destination was my coping mechanism at medical school. When last-minute funding cuts ended my Sri Lanka dream, I followed my interest in drug policy and wrote to shadow the team at The Thistle—the UK's first official drug consumption room (DCR) in Glasgow. What felt like a compromise became one of the most intellectually challenging experiences of medical school.

DCRs are hygienic clinical spaces where people who inject drugs (PWIDs) take pre-obtained drugs under trained supervision, with sterile equipment and reversal agents available[1]. International evidence suggests that DCRs reduced HIV transmission and overdose deaths, while improving engagement with health and social services[2]. From a health economics perspective, preventing six to eight cases of HIV would offset the annual cost of operating the Thistle[1]. Yet the UK's first DCR only opened in 2025 as a three-year pilot study, nearly four decades after the world's first in Switzerland[1]. Throughout medical school, we are taught that research evidence informs guidelines, and guidelines inform care. If medicine is truly evidence-based, why has this evidence been so difficult to act on?

Evidence-based medicine (EBM) integrates scientific evidence, clinical expertise and patient values to guide decision-making[4]. DCRs satisfy all three pillars. However, one key barrier in the UK has been legal. The Misuse of Drugs Act criminalises possession of drugs making it impossible for DCR to exist[3]. Despite repeated calls from Glasgow Health and Social Care Partnership in response to Scotland's status as Europe's drug death capital, proposals were rejected for a decade before prosecutorial discretion enabled the Thistle to be established[3,5,6]. During the negotiation period between 2015 to 2024, Glasgow city alone saw 2,307 drug-related deaths[7].

Alongside legal constraints, The Thistle as a medical intervention was obscured by its entanglement with politics and social stigma. Harm reduction is the underlying philosophy of DCRs: a public health approach focused on reducing drug-related harms without requiring abstinence. This is contentious because it is often misinterpreted as condoning drug use, yet evidence suggests otherwise. The Thistle serves a persistently disadvantaged population for whom abstinence is unsustainable. They are often people with a low "recovery capital", referring to limited access to social, financial and psychological resources. Until wider societal issues like homelessness, chronic poverty, trauma and unemployment are addressed, an abstinence-for-all approach remains unfeasible and may never be fully realistic, and services like The Thistle become essential in preventing avoidable deaths[8].

Dr Saket Priyadarshi, Associate Medical Director of Glasgow's Alcohol and Drug Recovery Service, identified stigma as a major barrier: "I don't see why we shouldn't be spending money on a group with some of the highest mortality of any population in Scotland. If I was the clinical lead for an oncology service, I wouldn't be asked those questions"[9]. This comparison exposes the bias in how society values different patient groups, where moral judgements to do with drug use can hinder EBM.

The Thistle surpassed every expectation I had. One PWID told me he would never return to hospital after previous dehumanising experiences as well as feeling unable to cooperate with the hospital's zero-tolerance policy to drugs. The Thistle's unique position at the intersection between traditional hospital-based care and community services meant that this person was able receive vital medical care including redressing of wounds and receiving antibiotics.

I may not have returned from my elective as a better surfer, but I left Glasgow with a deeper understanding of the factors that shape service provision. The Thistle taught me the necessity to critically evaluate our service provision and how biases are embedded within our systems. When we allow ourselves to actively question and undo our biases, EBM will become a reality.

What Are We Really Hungry For?
Obesity, Addiction and the Empty Space Beneath Appetite

Dr Monika Mikalauskaite, Foundation Doctor at Aberdeen Royal Infirmary

Obesity is often discussed through the language of calories, BMI, risk and willpower. These frameworks can be useful, but they can also miss something deeply human. Obesity is a complex chronic condition shaped by biology, environment, social factors, medication, sleep, stress, metabolism and eating behaviour[1,2]. Yet as someone interested in both psychiatry and lifestyle medicine, I have become increasingly struck by the gap between knowing what is "healthy" and being able to live it.

For some people, eating does not feel like a simple choice. It can carry features we recognise from addiction: craving, loss of control, repeated attempts to stop, continuing despite harm, secrecy, shame and temporary relief. This does not mean that obesity is the same as addiction. Indeed, the concept of "food addiction" remains debated, and obesity should not be reduced to addictive-like eating[3]. However, for some patients, an addiction lens may offer not blame, but compassion.

An addiction-informed lens may also protect against stigma. Patients with obesity are often told, explicitly or implicitly, that their condition reflects poor discipline. Yet shame rarely produces durable change; more often it increases avoidance, secrecy and cycles of self-punishment. A psychiatric formulation asks what maintains the behaviour now, what losses may follow its removal, and what alternative sources of regulation can be built before the familiar coping strategy is taken away[2].

The question, therefore, is not simply: "How do we help people eat less?" It is also: "What did eating make possible for this person to survive?"

In psychiatry, we are trained to ask what a symptom does for a person. What does it protect them from? What does it express? What does it regulate? Food can become more than food. It can become comfort when there is no comfort, stimulation when life feels flat, sedation when the nervous system is overwhelmed, or companionship when loneliness is unbearable.

This is where the idea of different "hungers" can become helpful. There is physical hunger, but there may also be

hunger for safety, rest, pleasure, connection, emotional containment, meaning or a sense of being held in the world. Emotions can alter eating behaviour in different ways, including eating to regulate emotional states[4]. When these hungers are unnamed, the body may keep asking for food because it is the only language available.

This matters because removing the behaviour does not always resolve the need underneath it. In addiction psychiatry, substance use may sometimes be understood as an attempt to manage otherwise unbearable internal states, described in the self-medication hypothesis[5]. Stopping the substance is therefore only one part of recovery. If alcohol, drugs or gambling once gave structure, relief or identity, their removal can leave an empty space. The same may be true for some forms of compulsive eating. If food has been a patient's main method of self-regulation, then weight loss alone may expose grief, anxiety, anger or emptiness that had previously been numbed.

The question, therefore, is not simply: "How do we help people eat less?" It is also: "What did eating make possible for this person to survive?" A more compassionate approach to obesity would hold both truths together: the body matters, and so does the psyche. Metabolic health matters, and so does meaning. Behaviour change matters, but only if we also help people build new ways to regulate, connect, rest and feel alive.

Perhaps the most psychiatric question we can ask is not "Why can't this person stop?" but "What hunger has not yet been heard?"

bridging divides

Building Futures

Ali Zomorrodian, Medical Student at the University of Southampton

Sitting in the smallest piece of shade in Bambouti, Cameroon, I asked the children of the village a simple question: "What is your dream?" Every answer came with a beaming smile. A doctor. A teacher. An engineer. To simply go to school. The ambition was electric. What stayed with me was not the confidence with which they spoke but everything just beyond their words: school cut short, adult responsibility thrust onto young shoulders and structures that quietly foreclosed the futures they were describing.

This tension sits at the heart of global mental health prevention and it is one that psychiatry cannot ignore.

The WHO's 2022 World Mental Health Report places social and structural determinants at the centre of the global burden of mental ill health[1]. Yet the primary response continues to favour clinical treatment over upstream prevention, forming a prevention gap that is widest where need is greatest.

The link between adverse childhood experiences and mental ill health is well-established. Children exposed to the highest cumulative adversity are over four times more likely to develop a mental disorder in adulthood[2]. But adversity is not only neglect or abuse. There is a quieter harm: the progressive narrowing of what a child can imagine for themselves. Abbas Kiarostami's documentary Homework (1989) captures this unsettlingly well. Filming Iranian primary school children discussing their daily routines, what surfaces beneath the ordinary answers is fear, fatigue and domestic burden carried in silence, a reminder that developmental risk does not always announce itself.

Nowhere did this become more vivid to me than during a malaria prevention programme I led as part of a medical student project in Cameroon with Cameroon Catalyst. At a

The most important intervention often does not happen in a consulting room. It happens years earlier

workshop distributing insecticide-treated nets, one girl absorbed every word, explained the entire programme back to us and set up the nets with effortless confidence. By the end of the session, I realised she was cradling a baby. She was barely a teenager. Adolescent mothers in low- and middle-income countries are twice as likely to experience depression compared with adult mothers, with the vast majority going undiagnosed[3]. Her story was not one of individual failure but the product of a system in which gendered constraint and limited educational access had long converged, leaving early motherhood not as a choice but as a structural inevitability.

This is why psychiatric prevention must begin upstream. Poor educational attainment independently predicts depression and anxiety in adolescence, particularly for girls[4]. School retention, supported by fee provision, pastoral care and community engagement is one of the most powerful and underutilised mental health interventions available. Evidence from sub-Saharan Africa shows that multi-level programmes combining economic empowerment with community-based psychological support produce meaningful improvements in adolescent mental health outcomes, especially when co-designed with communities rather than delivered to them[5].

One in seven adolescents globally experiences a mental health condition, but most receive no support of any kind[6]. These figures reflect a structural reality in which the determinants of mental ill health, disrupted education, early gendered constraint and economic deprivation are treated as someone else's problem and so remain no one's responsibility.

For students entering psychiatry, this matters. The most important intervention often does not happen in a consulting room. It happens years earlier, in whether a child stays in school, whether a young mother is seen by a system not built for her, and whether those closest to the problem are trusted as the experts they are[1]. Global mental health prevention cannot wait for disorder to declare itself. By the time it does, the opportunity to intervene has already passed.

The Gender and Racial Gap
Why Bipolar Disorder Demands a Biopsychosocial Lens

Gauravi Kaushik, Medical Student at the University of Lancashire

When asked to analyze a chronic illness through the Biopsychosocial (BPS) model as part of my student-selected component (SSC) coursework, I was eager to explore how clinical practice affects patients differently based on their socio-cultural identities. As medical students, we are taught the clinical diagnostic and management criteria for Bipolar Disorder (BD), yet the depth of disparities in care is rarely indicated in core textbooks. My investigation into gender, racial, and socioeconomic inequalities in BD patients in the UK revealed significant research gaps concerning the social determinants and associations with BD incidence and presentations.

Current data sources[1,2] have reached a consensus that social deprivation—measured by the Townsend score[3] using factors such as unemployment, overcrowding, and lack of accommodation—positively correlates with higher rates of BD diagnosis. However, when focusing on gender, the evidence is more varied. Some academic literature suggests that bipolar women are frequently misdiagnosed with Major Depressive Disorder (MDD), exposing them to ineffective antidepressant therapy. This could risk triggering a mood switch into a hypo-manic state[4]. This study also indicates differences in symptom presentation; females often show higher rates of rapid-cycling, depressive, and suicidal characteristics compared to their male counterparts. Other sources highlight distinct comorbidity profiles, like higher rates of eating disorders and PTSD in women and alcohol-dependence in men[5]. Crucially, because much of this specific presentation data is over a decade old, it highlights a persistent gap in contemporary, gender-specific BD research.

Contrary to the distinct clinical profiles suggested by the aforementioned studies, official physician-facing resources such as the NICE Clinical Knowledge Summaries (CKS)[6] and the Adult Psychiatry Morbidity Survey[2] in England state that prevalence rates are similar across men and women. Clinicians may base opinions on these statistics, however a lack of evidence for distinct presentation or comorbidity profiles may cause us to diverge from the best care pathway for certain kinds of patients. To me, this discrepancy between NICE CKS and NHS surveys versus individual studies, highlights a classic research-to-policy gap where localized academic findings have not yet been replicated on a scale large enough to alter nationwide guidelines. As future clinicians, navigating these variations will require our critical analysis of different data sources and knowing our patients' needs.

A similar disconnect emerges when examining the intersectionality of gender and race in bipolar disorder. While a study[7] highlights severe health disparities such as Black Caribbean women with BD facing the lowest life expectancy at birth across all ethnic groups, these outcomes are often absent in broader demographic studies. This gap may suggest that differences in symptom expression, help-seeking behaviour, and systemic barriers to care deeply influence how marginalized demographics interact with and are served by mental health services[2].

Ultimately, the BPS model cannot remain a theoretical concept relegated to introductory modules. Recognizing where research and national guidelines diverge is a vital skill for medical students and Foundation doctors. It reminds us to look past the "neutral" presentation templates in our textbooks, ensuring we remain observant of the complex socio-cultural factors that shape our patients' real-world outcomes.

Are Doctors Allowed to Struggle? Reflections on Mental Health in Medicine

Alice Derbyshire, Medical Student at Kent and Medway Medical School

Medicine prides itself on compassion. As medical students, we are taught to recognise distress, explore risk sensitively, and openly address mental health concerns in our patients. Yet, somewhere along the way, many of us absorb a quieter, more troubling message: that this same compassion does not always extend to ourselves.

During my clinical placement, I have noticed how medicine implicitly rewards resilience, stoicism, and high achievement. From early on, we learn to function despite exhaustion, self-doubt, and emotional strain. While these traits may help us survive demanding environments, they can also foster a culture in which vulnerability is perceived as synonymous with failure. This is reflected in a national survey of UK doctors conducted by the BMA, which found that 80% were at high or very high risk of burnout, with junior doctors most affected[1]. Despite this, many continue to work without seeking support, a pattern also described in wider research on doctors' help-seeking behaviours[2].

There is a persistent societal stereotype that doctors are endlessly capable and remain composed under pressure. When doctors experience mental health difficulties, this expectation can collide with professional realities. Concerns about being perceived as less competent or unreliable are often tied to fears around fitness to practice and career progression. Within this framework, struggling becomes something to manage privately, rather than address openly.

What is perhaps more striking is how deeply this expectation can be internalised. Many medical students and doctors are high-achieving, self-critical individuals. When struggling, we may respond not with kindness, but with frustration or shame, leading us to question whether we are cut out for medicine at all. A BMJ report highlighted that many doctors continue working while struggling with their mental health, driven by a fear of appearing weak[2]. This shows how the language we use internally is often far harsher than anything we would ever direct at a patient.

This creates a paradox. We promote early intervention, openness, and support in mental health, while holding ourselves to different standards. We reassure patients that their difficulties do not define them, yet secretly fear that our own struggles might shape our professional identity.

Psychiatry, perhaps more than any other speciality, brings this contradiction into focus. It highlights that mental health is not a fixed state but exists on a spectrum and is shaped by context and circumstance. Exposure to this perspective raises an important question: if we accept this complexity in our patients, why do we deny it in ourselves?

Encouragingly, conversations around doctors' mental health are becoming more visible. Senior clinicians speaking openly, supportive occupational health services, and peer-led initiatives all represent meaningful steps forward. Importantly, professional guidance already recognises that doctors have a responsibility to look after their own health and to seek support when needed[3]. The challenge, therefore, is less about what professionalism requires, and more about how it is experienced in practice. Cultural norms within medicine can still make help-seeking feel at odds with being a "good doctor," despite clear guidance to the contrary.

Perhaps the better question, then, is not whether doctors are allowed to struggle, but why we ever believed they were not. Recognising doctors as human may make medicine not only more compassionate, but also more sustainable for those within it.

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Correction and Apology Notice: Winter 2026 Issue
In the last edition of FuturePsych, the name of Shashvat Swarup, author of the article "Why Is Men's Mental Health Such a Major Issue?", was misspelt. We apologise for this error.

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