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The Magazine of the General Adult Faculty

From Fragmentation to Neighbourhood
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Prevention of Health Harms: Old Ideas Need New Resources
Dr Peter Byrne

Prevention First: The Left Shift in Mental Health

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EDITORIAL

Editor's note

DR SOPHIA SENTHIL AND DR HIMANSHU GARG - CO-EDITORS, IMIND

Given the NHS 10 Year Health Plan, neighbourhood mental health and community mental health transformation are contemporary topics, so we decided to theme this issue on prevention within mental health - something that often remains just out of reach in day-to-day practice. Prevention is often framed as a future ambition; however, as Dr Jon van Niekerk highlights in Views from the Chair, it is already at the heart of what we do: preventing relapse, preventing suicide, preventing escalation, and preventing people from falling through gaps in our systems.

Across the contributions in this issue, a shared tension emerges. Despite the centrality of prevention, many of our services continue to function reactively. Dr Neeraj Berry, reflecting on the GIRFT programme, reminds us that many admissions occur not because patients are unknown to services, but because opportunities for timely, coordinated intervention are missed. Similarly, Dr Álvaro Barrera's perspective from inpatient psychiatry reinforces how often individuals reach crisis after delays in accessing community care. Together, these perspectives challenge us to reconsider whether our systems are truly designed to prevent deterioration, or simply to respond once it has occurred.

At the same time, we are encouraged by the direction of travel. The neighbourhood mental health model, explored through conversations with Professor Tim Kendall and Alison Buckley, offers a compelling shift away from fragmentation; towards integrated, place-based care. By bringing together services within communities and reducing barriers to access, these models hold real promise for earlier intervention and continuity of care. The early indications with improved patient flow and reduced reliance on inpatient care suggest that when systems are redesigned around people rather than pathways, prevention becomes more achievable.

As Dr Helen Crimlisk highlights, transformation is complex. It requires not only structural change but cultural change—moving from siloed working and rigid thresholds towards openness, collaboration, and trust. Chris Morton's contribution further challenges us to reflect on whether many of our existing services have been built around crisis rather than prevention, and what it truly means to design care that is relational, responsive, and co-produced.

> *"Prevention is not a single intervention or initiative. It is a way of thinking about care."*

We have also been reminded throughout this issue that prevention extends well beyond clinical services. Dr Ed Beveridge draws attention to the profound impact of social determinants such as poverty, housing, and inequality, while Natalie Cook and Katie Blissard-Barnes expand this further by linking prevention with sustainability and environmental determinants of mental health. These perspectives highlight that prevention is not confined to the clinic; it is shaped by the

environments in which people live and the systems that support or fail them.

At a policy level, Dr Peter Byrne's reflections are a timely reminder that prevention is not a new concept, but one that requires renewed commitment, investment, and evidence-based action. The challenge, as this issue illustrates, is not in defining prevention but in embedding it within complex and resource-pressured systems.

Although the shift towards prevention is gaining momentum, it remains fragile and contingent on sustained leadership, system alignment, and cultural change. We hold a cautious optimism: the foundations are emerging, but embedding them into consistent practice will demand time, perseverance, and collective commitment.

What becomes clear to us, as we reflect in this issue, is that prevention is not a single intervention or initiative. It is a way of thinking about care. It is found in continuity, in relationships, in formulation, and in the ability to act early and meaningfully. It requires integration across services, genuine collaboration with communities, and recognition of the unique role psychiatrists play in bringing together biological, psychological, and social understanding.

Ultimately, prevention should not be considered separate from treatment, but embedded within it. And as reflected throughout this issue, investing in prevention today creates healthier, more resilient communities tomorrow.

Through this edition, our aim is to inspire and motivate readers to engage with the evolving landscape of mental health care. At the same time, we encourage readers to approach the content with a constructive and critical perspective, and where appropriate, to share valuable feedback. We warmly invite colleagues to engage further by writing to the authors with any follow-up queries or unresolved questions.

A special thanks and acknowledgement go to Dr Roseline Ataria and Dr Flavian Naclad. Without their exceptional design expertise and IT skills, this issue would not have been possible. They are truly integral to our editorial team.

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VIEWS FROM THE CHAIR

Views From The Chair

DR JON VAN NIEKERK - CHAIR, GENERAL ADULT FACULTY

Prevention is often spoken about in healthcare as though it belongs primarily to public health, screening programmes, or physical medicine. Yet prevention sits at the very heart of good psychiatry. Every day, general adult psychiatrists work in spaces where prevention matters profoundly: preventing relapse, preventing suicide, preventing trauma from deepening, preventing admissions where possible, and preventing people from falling through the gaps between services, systems and society.

But increasingly, many clinicians will recognise a difficult reality: much of modern psychiatric practice risks becoming dominated by responding to crises after they have already escalated. Across the country, general adult teams are operating under immense pressure. Community services are stretched, inpatient beds remain under sustained demand, and clinicians often find themselves managing risk within systems that have limited capacity to intervene early. When services are overwhelmed, prevention becomes harder. We can inadvertently drift toward a model that reacts to deterioration rather than creating the conditions that help people remain well. This is one reason why the theme of prevention feels particularly timely for the General Adult Faculty.

Over recent months, the Faculty has been engaging in national discussions around the future of adult mental health services, including early conversations linked to NHS England's emerging Modern Service Framework. In these discussions, we have consistently highlighted that prevention in mental health cannot be reduced simply to brief interventions or risk prediction tools. Prevention requires relationships, continuity, formulation, housing, social connection, meaningful activity, and timely access to care. It also requires psychiatrists. Psychiatrists bring something distinctive to prevention: the ability to integrate biological, psychological and social understanding into coherent clinical care. In complex systems under pressure, this integrative role becomes even more important.

This is particularly relevant in suicide prevention. Recent discussions following the publication of NHS England's Staying Safe from Suicide guidance have rightly challenged the limitations of traditional risk stratification approaches. But moving away from simplistic prediction models does not mean stepping

away from psychiatric expertise. Quite the opposite. Prevention depends on deep clinical understanding: careful assessment, formulation, diagnosis, treatment, therapeutic relationships, and collaborative safety planning. At its best, prevention in psychiatry is relational. Often the most important preventative intervention is not a checklist or protocol, but a clinician who is able to understand a patient's story, recognise deterioration early, maintain hope, and help someone feel psychologically held during periods of distress.

This is one reason the Faculty has continued to support work around biopsychosocial formulation. Alongside colleagues from the Faculty of Medical Psychotherapy, we have been developing educational resources aimed at strengthening formulation as a core psychiatric skill. Good formulation helps us move beyond asking only "What is the risk?" toward understanding "What has happened to this person?", "What keeps this difficulty going?", and crucially, "What might help?".

> *"Prevention in psychiatry is relational. Often the most important preventative intervention is not a checklist or protocol, but a clinician who is able to understand a patient's story."*

Prevention also extends beyond the clinic room. Increasingly, we see how social determinants shape mental health outcomes long before individuals present to services. Housing insecurity, loneliness, poverty, trauma, digital harms, substance misuse and fragmented social support all contribute to mental distress and relapse. In hospitals across the country, psychiatrists continue to see patients who are clinically ready for discharge but unable to leave because there is nowhere suitable or stable for them to go. Others are discharged into environments that undermine recovery, perpetuating the damaging revolving-door cycle that many clinicians know too well.

If we are serious about prevention, mental health policy must treat housing, social care and community infrastructure as part of mental healthcare itself. At the same time, prevention must include preventing harm within our workforce. Many psychiatrists describe growing moral injury from working in systems where demand consistently exceeds capacity. Retaining experienced clinicians, supporting reflective practice, and creating environments where teams can think as well as act are all preventative interventions for the profession itself.

There is no single solution to the pressures facing mental health services. But prevention offers an important lens through which to think differently about the future of care. For psychiatry, prevention is not separate from treatment. It is embedded within the therapeutic relationship, within continuity of care, within thoughtful formulation, and within systems that intervene before despair hardens into crisis. General adult psychiatry remains central to that mission.

As a Faculty, we will continue advocating for services that allow psychiatrists and multidisciplinary teams not only to respond to crises, but to prevent them wherever possible. Because ultimately, some of the most important work we do in psychiatry is the crisis that never happens.

INTERVIEW

From fragmentation to Neighbourhood

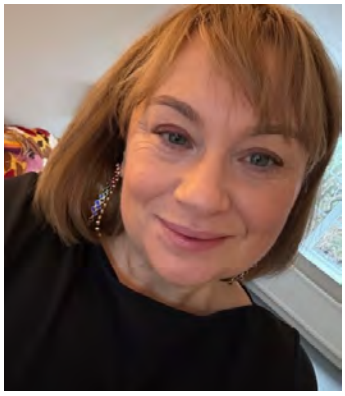
Interview with Prof Tim Kendall and Alison Buckley

INTERVIEW CONDUCTED AND TRANSCRIBED BY DR HIMANSHU GARG, CO-EDITOR, IMIND

The NHS is embracing neighbourhood-based mental health care, reshaping services around access, prevention, and community connection. This article draws on an in-depth conversation with Professor Tim Kendall, National Clinical Lead for New Models of Mental Health Care at NHS England, and Alison (Alee) Buckley, Senior Lived Experience Practitioner, to explore how this model works in practice and why it matters.

Neighbourhood mental health centres represent a shift away from fragmented pathways toward integrated, person-centred support located within local communities. These centres operate long hours—typically 8am to 8pm or later—ensuring that people experiencing difficulties have a consistent, visible place to seek help. Their core promise is simple: they do not turn people away.

This allows earlier intervention when needs escalate, reducing the likelihood of crises and unnecessary hospital admissions. Professor Kendall emphasises that current mental health systems often create a "pinball experience," where individuals are bounced between multiple teams, often facing rejection or reassessment at each point. Neighbourhood models aim to merge the key functions of primary care mental health teams, community mental health teams, crisis and home treatment services, early intervention teams, and older adult services into one coordinated workforce. In some areas, this can bring together more than 60 staff to support a population of around 40,000.



A central benefit of neighbourhood centres is their capacity to support prevention. By being physically present within communities, clinicians and lived experience practitioners can engage proactively with local residents.

Such integration preserves specialist expertise while ensuring that no referral is lost or redirected unnecessarily. Instead of rigid thresholds, neighbourhood teams offer a unified front door, with staff empowered to assess, plan, and deliver care in continuity with the person's needs.

Implementing this approach requires significant cultural change. Many specialist teams take pride in their identity and ways of working. Some have grown comfortable managing demand by narrowing eligibility thresholds. Both Prof Kendall and Alee acknowledge that staff may feel apprehensive about open access models, fearing additional workload or unpredictability.

Yet the benefits become clear when services begin to operate differently. With strong leadership and clear principles, neighbourhood teams can maintain clinical standards while reorienting services toward inclusion rather than exclusion.

Lived experience plays a pivotal role in shaping these centres. Alee describes the unique impact of having peer support workers and lived experience practitioners at the heart of the service. Their role begins at the door: greeting people, offering authentic connection, and helping them feel safe at moments of distress. This authenticity, she notes, has a "magical" quality that helps people feel understood and reduces barriers to help-seeking. Lived experience roles sit alongside clinical expertise, not in place of it. Their contribution complements assessments, enhances therapeutic engagement, and ensures that recovery is defined not only by symptom reduction but also by the principles of CHIME—Connection, Hope, Identity, Meaning, and Empowerment.

> *"Neighbourhood centres rely heavily on partnership with third-sector organisations... Many residents are unaware of the wealth of non-statutory support available, and neighbourhood centres help bridge this gap."*

Both Prof Kendall and Alee highlighted that neighbourhood centres rely heavily on partnership with third-sector organisations. In Sheffield, this includes groups such as Sheffield Flourish, Heeley Trust, community libraries, women's groups, and English-language support organisations. Many residents are unaware of the wealth of non-statutory support available, and neighbourhood centres help bridge this gap.

Digital inclusion is another enabling factor. While clinical digital systems face interoperability challenges, there is tremendous potential in AI-enabled documentation, online wellbeing toolkits, and shared digital care plans that empower service users to take ownership of their recovery.

Early evaluation results are encouraging. East London's 24/7 neighbourhood model has reported a 45% reduction in bed days—a striking marker of improved access and crisis prevention. With inpatient beds costing between £200,000 and £1 million per year depending on level of acuity, even moderate reductions in admissions and length of stay translate into significant financial and clinical benefits.

Neighbourhood centres also form part of a broader urgent care system. Most centres will not open to the public overnight for safety reasons. Instead, mental health A&Es or decision units will provide overnight support before handing over to neighbourhood teams each morning. Over time, centres may facilitate step-down from inpatient wards, supporting people on Section 17 leave before discharge.

Sustainability is supported through substantial investment. NHS England is allocating £316 million in capital funding over four years to develop around 150 neighbourhood centres across the country. Each Integrated Care Board will receive funding to establish at least one centre per place, with larger urban areas receiving more. Guidance will offer a framework for integrating existing clinical teams into cohesive neighbourhood units.

Alee notes that while funding is essential, much of the real value comes from reorganising existing resources in smarter ways. Staff time currently consumed by referral meetings and threshold decisions can be redirected to direct clinical care when teams work as one.

Equity is intentionally built into the model. Co-production ensures that services respond to the cultural, linguistic, and social context of each neighbourhood. In areas with high minority ethnic populations, centres may be co-located with faith spaces or community hubs. In more rural or mixed areas, partnerships with voluntary agencies ensure that support reflects local realities.

Ultimately, neighbourhood mental health centres represent a return to relationships—consistent, human, and accessible. They restore psychological safety, continuity, and trust. For clinicians, lived experience practitioners, and communities alike, the shift becomes not only a structural reform but a cultural renewal.

Professor Kendall encourages the Royal College faculty to champion this work: to embrace the principles, lead integration efforts, and model the collaborative approach required to make neighbourhood-based care sustainable.

Alee's closing message is equally powerful. Lived experience is not a threat to clinical identity; it is a partner in creating the best possible care. Her insights remind us that mental health support works best when it brings together professional expertise and the wisdom of those with lived knowledge.

Neighbourhood centres offer a pathway toward a more compassionate, prevention-focused, community-rooted mental health system. They are not an optional enhancement—they are the future of accessible and equitable care.

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Senior Lived Experience Practitioner

Interview conducted and transcribed by Dr Himanshu Garg, Co-editor, iMind

PUBLIC MENTAL HEALTH

Prevention of Old Harms: Old Ideas Need New Resources

PETER BYRNE, CONSULTANT LIAISON PSYCHIATRIST, ROYAL LONDON HOSPITAL AND STRATEGIC DIRECTOR, RCPSYCH PUBLIC MENTAL HEALTH IMPLEMENTATION CENTRE

Presentations to health services are rising, our NHS workforce cannot keep up with demand, so we must do something about prevention. So said then Prime Minister Gordon Brown in 2008, but nothing came of it. Now Wes Streeting is talking about prevention again, crystallised as Chapter 4 of the NHS 10 Year Health Plan. Its introduction sets out the challenges of rising inequalities that generate poorer health and economic inactivity. Four aspirations, and it is interesting to note the order of presentation, are to improve health, boost the labour market, narrow inequality and reduce NHS costs. Smoking is the first target, citing ¼ million UK households living in tobacco poverty. This is a continuation of seven decades of public health actions to reduce tobacco consumption, now 10.4% of adults in England.

The commitment to follow up on the previous Government's legislation to ban cigarette sales to the next generations is welcome. We need to consider too the statistic they quote of doubling of the rates of vaping in 11 to 14 year olds over the past five years. Here are two more stats that might have focused efforts more: one million people in the UK now vape who never smoked regularly before, and up to 40% of people with psychosis smoke. Higher still in people with psychosis who become homeless or have other addictions. Substance misuse is mentioned just once as an example of the range of services that local authorities are expected to provide, and no special provision is promised to tackle smoking in people with mental health conditions (MHCs).

Other than "Health Coach" (a website and a few Apps), there is nothing new coming to assist quitting smoking, but both the challenges and solutions to rising obesity carry more substance. Mostly these focus on legislation and regulation:

> • Ban junk food advertisements to children before the 9PM watershed
>
> • Ban on "energy drinks" targeted at children
>
> • Restoration of the Healthy Start programme: money for pregnant women and children under 4 from the poorest families
>
> • An uplift on the Soft Drinks Industry Levy that already drove 47% reductions in sugar content
>
> • Further expansion of free school meals programme
>
> • Enforce existing legislation where supermarket promotions (two-for-one, etc.) favoured the most unhealthy food options

So far so familiar, and some of this section's sentences echo more than two decades of failed UK Government Policy to reverse rising rates of weight gain: its failures have led to more than two thirds of UK adults being overweight. They tell us "wherever possible, we will prioritise smart regulation and give business the best chance to innovate to support the nation's health" and that (we are) "establishing pioneering relationships with industry" to identify weight loss treatment programmes. Not a single country that has slowed down its obesity rates has achieved this by cosying up to the Food Industry and its allied, powerful food retail corporations.

The whole point of the Soft Drinks Industry Levy was that a clear financial penalty led to incremental changes in the Industry's formulations. But for mass food production, uninformative and opaque food labelling has made "consumer choice" almost impossible for consumers. Right now it looks as if the corporations that facilitated unwanted weight gain across western populations and LMICs will be the same "pioneering" businesses that will sell us weight loss jabs and tablets to achieve a temporary slowing of our individual weight gain. The prevention challenges are harder in people with more inequalities and not because somehow they "chose a bad lifestyle". While the plan does reference physical activity, it does so with the same broad brush that it uses to aspire to healthier school meals. Our College has this month (February 2026) published a collaboration with Wales colleagues detailing the facilitators and obstacles to physical activity in people with MHCs: https://www.rcpsych.ac.uk (search: physical activity and mental health conditions, Wales collaboration, February 2026)

The plan treads even more softly in its Alcohol section. Problems are listed (e.g. the UK spends considerably more than the OECD average treating the health harms of alcohol) but limp solutions such as voluntary codes for better labelling or alcohol "education" are trailed here. Education is the weakest intervention to prevent alcohol misuse, and the same evidence reviews have all said the same thing. To reduce alcohol consumption, increase the price. The Westminster Government's failure to increase the minimum alcohol price, something that brings revenue rather than carries costs (other than political popularity), contrasts with the progress made by the other three devolved administrations. Our small unit in the College, PMHIC, advocates for prevention at every level, but only for interventions based on the evidence. As we move forward, we need to present this in ways that

engage with a public who have many sources of information that will contradict even the most rigorously proven interventions (screening, vaccines).

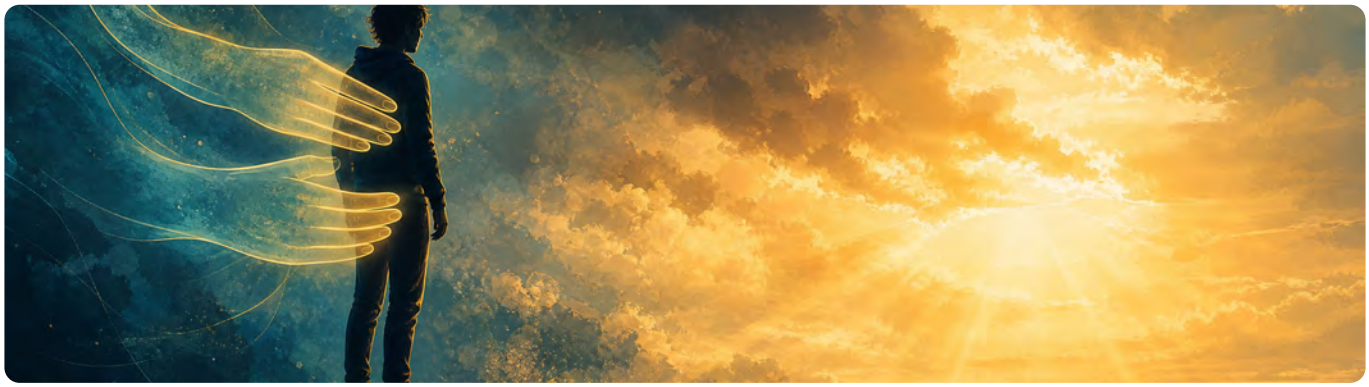
> *"Four key words are absent from Chapter Four, Prevention, of the NHS Plan: (the) commercial determinants of health."*

That said, other sections are welcome, not least an acknowledgement of our fragmented health services and the value of prevention. Highlights are air pollution, Get Britain Working White Paper, youth mental health, vaccines, screening programmes and emergent genomic research. We are not starting from ground zero. In workplace mental health, NHS talking therapies are established in every locality, and these are proven to increase people's chances of remaining in paid work. Existing programmes may be expanded: Individual Placement and Support (for people with severe mental illness), WorkWell, Employment Advisers in Talking Therapies and Connect to Work are all namechecked here. Although suicide is not covered in this chapter, its prevention is a solid example of the value of public health interventions.

Psychiatrists prevent suicide in individuals, and this work is paralleled by restrictions on paracetamol sales, reduced access to violent methods and suicide "hot spots" as well as coordinated interventions to highlight help for people in crisis and reduce (say) web / social media sources that increase suicidality. It can never be "either / or" as is "Treatment or Prevention" but both. Reducing smoking and alcohol misuse, knowing their combination magnifies the health harms of each, even more so in the poorest people, will of themselves reduce MHCs and their associated harms.

Psychiatrists should want to be part of this, and insist that interventions be adequately resourced and evaluated. A comprehensive Prevention Strategy could begin to reverse the toxic legacy of austerity, compounded by the pandemic and cost of living crisis. This isn't it, but we must try. Four key words are absent from Chapter Four, Prevention, of the NHS Plan: (the) commercial determinants of health.

Dr Peter Byrne
Consultant Liaison Psychiatrist, Royal London Hospital and Strategic Director, RCPsych Public Mental Health Implementation Centre



Q&A

Reimagining Community Psychiatry: Insights from the 24/7 Mental Health Team Pilot

Interview with Helen Crimlisk

CONDUCTED AND TRANSCRIBED BY DR SOPHIA SENTHIL

Community mental health services across England are undergoing significant transformation, with increasing emphasis on neighbourhood-based care, prevention, and integration across primary care, secondary care, and the voluntary sector. One of the most ambitious developments has been the NHS England-funded 24/7 Community Mental Health Team pilot, testing new ways of delivering care closer to home. In this interview, Dr Helen Crimlisk, Consultant Psychiatrist and Associate Medical Director for Research, Innovation and Development in Sheffield, reflects on the early learning from the pilot.

Helen, could you start by introducing yourself and outlining your current roles?

Helen Crimlisk: I'm a consultant psychiatrist working in community adult mental health at Sheffield Health and Social Care NHS Foundation Trust. Alongside my clinical work, I'm the Associate Medical Director for Research, Innovation and Development. Nationally, I am part of the NHS England 24/7 Neighbourhood Mental Health Centres Advisory Group. I'm also the Specialist Advisor for Workforce with the Royal College of Psychiatrists. I've previously held roles including Associate Registrar for Leadership and Management and positions within the General Adult Faculty. Those roles have really shaped how I think about service design, workforce, and system leadership.

You've been closely involved in the 24/7 Community Mental Health Team pilot. Can you explain what the pilot is aiming to achieve?

The 24/7 CMHT pilot is an NHS England initiative designed to test a different way of delivering community mental health care. At its heart, it's about co-production — with service users, communities, primary care, and the voluntary sector — and delivering appropriate help and care

closer to where people live. Rather than patients navigating a complex and fragmented system, the intention is to bring services together at a local, neighbourhood level, often aligned with a Primary Care Network footprint. The focus is on understanding the strengths and needs of a local population and designing services around that, rather than around organisational boundaries.

Prevention and timely access come through strongly in this model. How does this align with wider NHS priorities?

Very closely. There's a clear national emphasis on community-delivered care, and psychiatrists already have a lot of expertise here. However, over time, the way services have developed — particularly through highly specialised teams — has sometimes led to fragmentation of care. Specialist functions like early intervention, home treatment, and outreach services are recommended by NICE, evidence-based and essential. The difficulty is that when they operate as distinct or separate entities, patients can experience multiple handovers, internal waiting lists, and get caught up in discussions about thresholds or comorbidities. That's bad for continuity, experience, and outcomes. The pilot is an attempt to retain specialist expertise while reducing unnecessary handoffs and intervening earlier, ideally preventing escalation to crisis services or inpatient admission and deliver as much care as possible close to home, informed by the needs of communities and insights of people with lived experience.

One of the most interesting aspects is the use of alternatives to admission. Can you say more about that?

Yes, that's a really important component. The model includes non-CQC registered beds — not traditional beds on hospital wards — often supported by the voluntary sector in a way somewhat similar to crisis houses. They provide somewhere safe for people to stay during a period of acute difficulty, with support from community mental health teams, without the formality or disruption of an inpatient admission. It's about offering care that is proportionate, relational, and less restrictive, while still being clinically informed and safe.

What feedback have you had so far — from patients, staff, and the wider system?

It's still relatively early days, and the six pilot sites across England all look quite different because of the different local challenges, needs and context. That said, the overarching principles are consistent and there is a lot of enthusiasm from clinicians and patients for the approach. From a system perspective, there's strong support because the model aligns with strategic aims — care closer to home, reducing out-of-area placements, and better use of resources. Staff feedback has actually been more positive than some people expected. Change is always challenging, but many colleagues value working in a less "siloed" way, with a stronger focus on relationships, a well-functioning multidisciplinary team, and really strong and consistent input from voluntary sector organisations. Several have commented that it improves staff experience as well as patient care. As well as relational benefits, there's also an environmental benefit — instead of expecting patients to travel long distances, services are being embedded within communities and neighbourhoods.

What have been the main barriers to implementation?

Estates have been a major challenge, particularly in a financially constrained environment. Capital funding is limited, and identifying suitable community buildings isn't straightforward. In Sheffield, we worked with a voluntary sector partner, the Heeley Trust, that was running a local library which was

in need of renovation. By working with the organisation and investing in the building, we have created a shared community asset that benefits both local residents and communities and supports the delivery of mental health services. That kind of creative, "win-win" thinking is probably essential if the model is to be scaled up.

Cultural change seems central to this transformation. What needs to shift for this model to work?

The most important thing is having open and honest conversations with people involved and discussing the rationale for change. This is by definition time consuming and involves active listening especially as some communities carry the weight of previous offers which have not delivered the hoped-for changes. The other issue is keeping the focus firmly on the provision of better care for patients. Few people feel that the current system is delivering this. Relational continuity, fewer handovers, and care that makes sense to people all really matter. There's also a workforce dimension. When I became a consultant, we worked in what we used to call "sector psychiatry," with responsibility for a defined patch and close relationships with local GPs. With some of the mandated changes over the last 20 years, we've also lost some of that style of working and the system as a whole is not working well to deliver relational care, close to home especially for the many patients who are living with complex needs and comorbidities.

This model asks us to rethink how specialist expertise is delivered, not to abandon it. That inevitably creates anxiety, so co-production with staff, patients, and communities is absolutely critical.

What role does the College have in supporting this kind of system change?

The College has long recognised the importance of system leadership. There has previously been work through the College Engagement Network, and ongoing discussions continue about workforce implications of community transformation. Importantly, College guidance on job planning for community consultants explicitly acknowledges non-patient-facing work — relationship-building, partnership working, and system leadership — as core to the role. These pilots really bring that to life.

Finally, is there anything you feel is particularly important not to overlook?

Yes — the role of lived experience workers. In Sheffield, we've been fortunate to have fabulous lived experience colleagues embedded in the programme from the beginning, and they've been absolutely instrumental in the project's success. They've helped articulate the purpose of the project to local communities, heard and addressed the understandable concerns, and built trust in a way that I, from a position of authority, simply can't always do. Their voices often carry more weight than mine in community settings, and that tells us something important about genuine co-production.

Interview based on a recorded conversation, 4 February 2026.

Dr Helen Crimlisk
Consultant Psychiatrist and Associate Medical Director for Research, Innovation and Development in Sheffield.

Q&A

Bridging the Mortality Gap: A Call to Action for Mental Health Services

Interview with Ed Beveridge

Conducted and transcribed by Dr Sophia Senthil

Ed Beveridge holds a national role with the Royal College of Psychiatrists as Presidential Lead for Physical Health. His work focuses on improving physical health outcomes for people with mental health conditions, addressing health inequalities, and closing the long-standing mortality gap between people with mental illness and the general population. Ed Beveridge is a General Adult Psychiatrist with over 15 years' experience working as a consultant across inpatient and community mental health services in London. He is currently Clinical Director at North London NHS Foundation Trust, where he oversees all inpatient services and psychiatric intensive care units. In 2026, he will take up a new role as Medical Director at another London NHS trust.

Ed, could you start by telling us a bit about yourself and what you do?

Of course. I'm Ed Beveridge, a General Adult Psychiatrist. I've been a consultant since 2008 and have worked across both inpatient and community mental health services in London. At the moment, I'm Clinical Director at North London NHS Foundation Trust, where I oversee all our inpatient wards and psychiatric intensive care units. I'll be moving into a Medical Director role at another London trust soon, which I'm really looking forward to. Alongside my NHS role, I also work nationally with the Royal College of Psychiatrists as Presidential Lead for Physical Health — a role that brings together many of my long-standing interests.

This issue focuses on prevention. What does prevention mean to you in mental health?

I tend to think about prevention through the lens of long-term illness — both mental and physical. That's because the underlying risk factors are often exactly the same. Things like deprivation, poverty, poor housing, and adverse childhood experiences sit at the root of both physical and mental health problems. So for me, prevention isn't something that mental health services can do in isolation — it has to be shared across systems and communities. At a practical level, prevention means picking up difficulties early and responding before people reach crisis point. That might be through earlier assessment, flexible thresholds for support, or using population health data more intelligently — for example, noticing when someone hasn't been in contact with services for a long time and reaching out proactively.

Do you feel the current service models support that kind of prevention?

There's definitely a clear vision emerging, particularly through neighbourhood-based models of care. In many areas, community mental health teams are now organised around neighbourhoods, with a focus on early intervention and supporting people closer to where they live. Alongside that, you have more specialist pathways — early intervention, rehabilitation, assertive outreach — often working at a broader 'place' or borough level. On paper, that makes a lot of sense. In reality, it's a

mixed picture. The structures are starting to align with the vision, but teams are under huge pressure, and prevention can feel like something extra rather than something built into everyday work.

What gets in the way most when it comes to prevention?

Resources are a big part of it. Many teams are stretched just managing existing demand and acute risk. When you're in that position, it's hard to create space for preventative work, even when you know how important it is. Another long-standing challenge is digital integration. There are still so many different systems across health, social care, and the voluntary sector that don't talk to each other. That makes coordinated, preventative care much harder than it needs to be. There has been progress — shared care records have genuinely improved access to information — but we're not yet at the point where digital systems really support joined-up, preventative working.

In your College role, what areas of physical health are you particularly focused on?

There are a few key strands. One has been developing a national protocol for safer clozapine prescribing. This isn't about neutropenia — it's about other serious risks like pneumonia or bowel obstruction. The aim is to improve safety and also increase confidence in prescribing, so more people who need clozapine can actually access it. We've also done a lot around smoking cessation, prevention of weight gain, and making sure there's a single, accessible place for good-quality resources. Education has been another focus — through podcasts, articles, and work on curricula. The biggest piece of work, though, is a forthcoming College position statement on physical health and the mortality gap. It looks beyond severe mental illness to everyone we care for, and takes a life-course approach — from primary prevention right through to learning from outcomes and early deaths.

That sounds like a huge piece of work. What are you hoping it will achieve?

We've known about the mortality gap for a long time, and we haven't done enough about it. What we're trying to do now is move from awareness to action. The position statement includes around 25 clear, tangible recommendations that are intended to drive real change — not just within mental health services, but across the wider system. We've also had really powerful input from experts by experience, which has shaped both the content and the tone of the work.

Finally, what gives you hope about the future of prevention in mental health?

Despite the pressures, I do feel hopeful. The direction of travel — towards neighbourhood-based care, integration, and earlier intervention — is the right one. If we can better align resources, improve digital integration, and genuinely treat prevention as core business rather than an add-on, there's a real opportunity to improve outcomes and reduce inequalities. That's what keeps me optimistic.

Dr Ed Beveridge
General Adult Psychiatrist
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FEATURE INTERVIEW

GIRFT Interview

An Interview with GIRFT Mental Health clinical lead, Dr Neeraj Berry

Conducted and transcribed by Dr Himanshu Garg

An in-depth conversation on prevention, variation, data and the future of mental health improvement.

As the NHS sharpens its focus on early intervention, population health and reducing avoidable crises, conversations about prevention in mental health have moved from the periphery to centre stage. Few people sit at the intersection of operational delivery, clinical variation and system learning as closely as Dr Neeraj Berry, the joint clinical lead for acute mental health for the NHS England programme Getting It Right First Time (GIRFT).

In this extended interview, Dr Berry reflects on how GIRFT's unique methodology can support the prevention agenda, what the data tells us about avoidable deterioration, and what systems must do to redesign care around proactive, timely and integrated responses.

Adapting GIRFT to a prevention-focused NHS

Asked how GIRFT's methodology can support the NHS Long Term Plan's emphasis on prevention, Dr Berry is clear: the approach is already well-designed for it. "GIRFT has always been data-driven, clinically led and operationally supported," he explains. "Our role is to identify unwarranted variation and understand why parts of the health system achieve better outcomes with similar resources."

Prevention in mental health is less about 'stopping' the onset of illness entirely and more about reducing the severity, duration and downstream consequences. Illicit substance use, stigma, losing a home/job/career/relationships, and involvement in criminal activities are common and serious complications of these disorders, alongside less common but very serious consequences such as suicide and homicide. This often means focusing on identifying place-based conditions that prevent illness from worsening or complications from developing. For example, GIRFT is closely studying Cambridgeshire and Peterborough, whose place-based approach appears to deliver strong outcomes in complex emotional disorders. "Understanding what they're doing differently – and how that can be replicated – is exactly what GIRFT is designed to do," he says.

Spotting preventable deterioration: What the data shows

One of the strongest patterns emerging from GIRFT's recent intelligence relates to the "declining patient in the community" pathway. "A large proportion of inpatient admissions are already known to services," Dr Berry notes. "The issue isn't about lack of contact – it is often a lack of timely, joined-up intervention before the situation became critical."

He references national serious incidents such as the Valdo Calocane review, which highlight how systemic fragmentation between community teams, crisis services and inpatient care can contribute to catastrophic outcomes. GIRFT has been working with the Nottinghamshire Healthcare NHS Foundation Trust to drive improvements to prevent incidents and increase resilience within day-to-day delivery.

Effective preventive practice often depends on: early identification of people whose mental state is deteriorating; timely intervention delivered before crisis; better linking of community and inpatient services; and proactive case management for high-risk cohorts. Dr Berry points to good practice examples such as well-structured depot management for SMI patients (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) and effective crisis services (Tees, Esk and Wear Valleys NHS Foundation Trust), including alternatives to admission. "Where people do need admission, the key is ensuring it's timely in and timely out."

GIRFT, in liaison with key stakeholders, is developing clinical operational standards for acute mental health intervention pathways covering community, crisis, emergency department, liaison and acute inpatients. These standards, along with national oversight framework measures, should allow systems a clear benchmark and improvement milestones that help prevention and reduce escalation. Examples of such milestones would be:

> • SMI case management indicators (e.g. depot compliance, CTO use)
>
> • Availability, use and performance of crisis lines, alternatives to ED, safe havens, crisis houses
>
> • Performance of crisis and liaison teams
>
> • Quality and consistency of 'gatekeeping' as well as 'early discharge to home'-based treatments
>
> • Balance of informal versus detained admissions
>
> • Admission sources – especially ED and Section 136
>
> • Readmission rates

"These indicators, when viewed together, tell us where deterioration is brewing long before a crisis emerges."

Which areas of care offer the highest preventive opportunity?

When asked which specialties show the greatest potential for prevention-focused redesign that would reduce acute demand, Dr Berry reframes the issue. "First, we need to clarify what we mean by acute demand," he says. "Crisis presentations increase when patients have extraordinary waiting times for planned interventions. Sometimes partners in the system see that leakage as the only way to get help. All this then requires repeated crisis management as well as planned interventions, reducing the overall capacity of the system."

"The biggest opportunity lies in strengthening the relationship between primary and secondary care and improving how place-based resources are knitted together." Effective system leadership, clinically integrated multidisciplinary pathways and a well-designed crisis pathway all substantially reduce escalation. In fact, these principles apply to all specialties.

Data is clear that mental health demand has significantly increased since Covid in several pathways. This need has been difficult to meet despite the increased staffing levels at all grades. While it could be framed as a productivity issue, in Dr Berry's view the availability of the right skills and experience to

assess and intervene at the first step, rather than demand recirculating through the system, is the only way to tackle this.

Prevention is not a single intervention; it's an ecosystem. "You need the right configuration of community services, crisis teams, out-of-hours support and inpatient flow. Each part either reduces or amplifies pressure on the others."

When GIRFT recommendations translate into early intervention

Although GIRFT is not a frontline service, its influence on system design has led to meaningful examples of earlier intervention and reduced reliance on high-cost, crisis-driven care. the former Mental Health Improvement Support Team (MHIST) – now a part of the GIRFT programme – has several case studies with such interventions.

'Listening services' at TEWV, supplementing NHS 111, support those patients who need regular validation and other psychological interventions, which prevents overwhelming of NHS 111 and/or presentation to crisis or ED.

> • A mental health crisis assessment centre (MHCAS) at Central and North West London NHS Foundation Trust has demonstrated evidence of reducing out of area admissions, as well as reduced time spent in acute hospital ED for patients with mental health presentations
>
> • Similar case studies of a psychiatric decision unit at Lincoln, the mental health ED at Hull and MHCAS in North London are all such examples where good practice pathway variations have been captured by GIRFT.

GIRFT's Further Faster programme, which focuses on MH urgent and emergency care (UEC) has identified 20 acute emergency department sites across the country where the flow and patient experience of mental health patients are being improved. GIRFT has carried out 'diagnostic visits' across all 20 sites in the past six months to triangulate the benchmarking data (as well as that from a MH core data pack) with actual dialogue and observation on the ground with the clinicians and senior operational teams across the acute and mental health provider. High impact interventions have been recommended.

"Too often, these services have adapted organically under operational pressures without strategic commissioning input," Dr Berry explains. "When commissioners join our visits, they frequently say: 'We didn't realise this is how it's actually working'."

Where GIRFT has helped systems review demand and capacity, fidelity to core crisis-team standards, intended outcomes versus actual practice, MDT skill-mix and gaps in leadership or commissioning, the results have been earlier identification of patient need, reduced bottlenecks and more efficient use of inpatient beds.

Dr Berry emphasises the importance of true outcomes, not just process metrics. "Systems often focus on activity data, but preventive practice requires defining what good looks like for the patient."

Unwarranted variation: Where systems fall short

One of GIRFT's aims is to illuminate unwarranted variation across trusts. The Further Faster programme has shown that the various contributing factors include: inconsistent configuration of

crisis pathways; variation in the use of structured case-management approaches; limited joint governance between community and inpatient teams; inconsistent engagement of commissioning bodies; and variable data quality, especially within MHSDS datasets.

"Data quality is a major barrier," Dr Berry stresses. "We brought together around 20 dashboards for GIRFT's Further Faster programme, and we repeatedly saw how poor data makes prevention harder." A national task-and-finish group is now working on improving Mental Health Services Dataset (MHSDS) quality.

Using GIRFT data to target at-risk cohorts

ICSs often ask how they can better use GIRFT intelligence to target preventive interventions. "High-quality data allows you to identify who is at risk early," says Dr Berry, "but the current MHSDS limitations mean we don't always get the granularity we need." Still, GIRFT has encouraged systems to focus on: people repeatedly accessing urgent care; pathways that produce high ED attendances; populations with high detention rates; and cohorts where community contact is high, but outcomes are poor.

One emerging tool is a Breach Analysis Tool, jointly developed with TEWV, which provides pathway-specific insights into A&E mental health breaches – a persistent blind spot in national data.

"Understanding where patients go after leaving ED is critical for prevention," says Dr Berry. "Without that, you're designing in the dark." The previously mentioned task-and-finish group is bringing several datasets from MHSDS together, allowing systems and providers access to benchmarking data to easily compare performance as well as the detail which helps improve it. GIRFT has worked with the National Oversight Framework (NOF) to make those measures more clinically meaningful and encourage improvement.

What boards should be watching

When asked which GIRFT metrics boards should pay closest attention to, Dr Berry suggests that boards may want to consider re-prioritisation. "Yes, performance measures matter, and NRLS and safety data are essential. But boards need sight of joint responsibilities too – A&E breaches, Section 117 aftercare, homelessness among mental health patients. Watching performance measures alone can have unintended consequences, such as transfer of cohorts of mental health patients from Emergency Department (ED) to acute medical short stay units. While it 'stops the clock' superficially, it also creates 'hidden waits' and poor patient experience."

He warns that many emerging risks are cultural, not always immediately captured in metrics. Complaints trends, the tone of patient feedback and triangulation of soft intelligence often reveal more than standard KPIs. "During the Further Faster programme we saw A&E departments where several mental health issues are particularly invisible at board level," he notes. "And yet, they're one of the biggest signals of system stress."

The financial case for prevention: Realistic but emerging

Some might expect GIRFT to quantify the financial return on preventive investment. Dr Berry is candid: "While it seems obvious, GIRFT doesn't yet have enough substantial evidence quantifying the cost-effective impact of various mental health prevention measures."

However, the programme has seen strong indications – particularly within complex emotional disorders and child and adolescent pathways – that place-based investment, combined with strong clinical

leadership, reduces escalation, improves patient experience and supports safer care. GIRFT is currently working closely with policy teams on national mental health urgent and emergency care redesign, which will likely generate stronger financial evidence over time.

GIRFT's future role: Shaping a preventive system

Looking ahead, Dr Berry believes GIRFT is uniquely placed to support the NHS shift from reactive to preventive care. In November 2025, NHS England's MHIST team was brought into the GIRFT programme, bringing their expertise in innovation, improvement, working with systems, and post serious-incident learning. The MENSAT tool, developed by the former MHIST, adds a new dimension to preventive insight.

"This team has seen the consequences of system fragmentation more closely than almost anyone," he notes. "Their findings help us understand why failures happen, which is the heart of prevention."

He says GIRFT's future contribution will lie in: strengthening data quality nationally; reducing unwarranted variation; improving system leadership and commissioning oversight; enhancing community–inpatient integration; clarifying what good looks like for prevention at pathway level; and supporting systems to redesign the urgent and emergency MH pathway.

"We're beginning to see themes emerge across the country," Dr Berry says. "Themes that move us toward what genuine prevention looks like – not as an aspiration, but as a system reality."

Conclusion: Prevention as shared purpose

Dr Berry's overarching message is simple: prevention is not a programme – it is a way of organising the entire system. It requires shared intelligence, multi-agency leadership, early identification of deterioration, robust community pathways and genuine accountability.

GIRFT's role, in his view, is to shine a light on where systems succeed and where they fall short; to support the NHS in designing safer, more proactive and more interconnected care. And above all, to ensure that preventable crises are truly prevented – not only for the benefit of services, but for the safety, dignity and wellbeing of the people they serve.

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INTERNATIONAL

From Trauma to Togetherness: Mental Health Implications of Cyclone Ditwah and the Power of Interfaith Support in Rural Sri Lanka

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Summary

Cyclone Ditwah caused severe flooding and landslide-related destruction in Rambuk-Ela Villanagama, a multi-ethnic rural village in the Alawathugoda–Ankumbura area of Sri Lanka. A psychiatric response team consisting of three consultant psychiatrists and two senior trainees provided Psychological First Aid (PFA) to displaced families amid difficult terrain. Early reports estimated around 400 displaced persons, 26 families experiencing death or missing members, and 15 whose homes were destroyed. Children exhibited mixed trauma responses, expressed through drawing activities, while many women presented with acute shock and distress. One survivor described being buried under soil for over 15 hours, losing her young daughter and witnessing severe injury to her son. Remarkably, the Buddhist monk, local mosque priest, and administrative officers collaborated to provide shelter, spiritual support, and a community-led coordination system. This interfaith solidarity served as a profound psychosocial buffer, highlighting the protective role of communal and religious cohesion in disaster recovery. [2,3]

~400	26	15
Displaced persons	Families with death/missing	Homes destroyed

Introduction

Natural disasters have consistently been associated with increased psychological morbidity, including post-traumatic stress disorder (PTSD), depression, anxiety, and complicated grief. Displacement, bereavement, and sudden loss of home amplify vulnerability, particularly in low- and middle-income settings. Children are especially vulnerable to disaster-related trauma, often displaying a spectrum of emotional and behavioural responses. [2,3]

Sri Lanka's rural communities are multi-ethnic and multi-religious, with Sinhalese, Tamil, Muslim, and Hindu populations often living in parallel cultural spaces. Yet religious and spiritual practices have

been shown to support coping, meaning-making, and community resilience after trauma. Cyclone Ditwah, which struck the Kandy district in late 2025, provided a poignant example of both psychological distress and interfaith solidarity. [2,3]

Methods and Approach

Following Cyclone Ditwah, a helpline was activated by the psychiatric team. One of the early callers reported approximately 400 displaced individuals, 26 families with at least one death or missing relative, and 15 families whose homes were destroyed. [2,3]

A field team consisting of three consultant psychiatrists and two senior trainees travelled to the site to deliver Psychological First Aid (PFA) and conduct rapid mental-health assessments. Access was severely impeded by fallen trees, eroded terrain, and layers of soil blocking roads, requiring the team to proceed partially on foot. [2,3]

Results and Observations

Trauma Exposure and Acute Psychological Distress

Many adults presented in states of acute shock, confusion, and emotional overwhelm. Women who were evacuated at short notice described intense fear as their homes were at risk of collapsing. Others had already lost their homes to flooding or landslide debris and spoke of persistent anxiety, uncertainty, and grief. [2,3]

A particularly severe case involved "X," a woman who was swept downhill by water and soil when her house collapsed. She was trapped under debris for more than 15 hours, buried except for a single hand she eventually managed to push through the soil—an act that led to her rescue. Her four-year-old daughter died instantly in the collapse, and her 16-year-old son sustained bilateral leg fractures.

Children's Mental Health Responses

There were 35 children aged 2–12 years among the displaced. Drawing activities with crayons and paper were provided as a therapeutic play intervention. Many children drew scenes depicting stability, home life, and resilience. However, several children produced drawings that were less colourful or depicted themes of loneliness and loss. [2,3]

Interfaith and Administrative Collaboration

In a striking show of solidarity, the chief Buddhist monk and the local mosque priest jointly organised shelter, food, and emotional support. The monk created a dedicated prayer space for Muslim residents and hung a Hindu deity image within the temple. Local administrative officers collaborated closely with religious leaders, and the monk developed handmade tokens for each family listing essential information for triage. [6,11]

> *"Interfaith solidarity served as a profound psychosocial buffer, highlighting the protective role of communal and religious cohesion in disaster recovery."*

Discussion

The early psychological effects observed mirror established evidence on disaster-related mental health: high rates of acute stress reactions, early symptoms of PTSD, and grief. Children's responses similarly reflected a continuum from resilience to emotional distress. What distinguished this setting was the extraordinary interfaith solidarity, which acted as a profound psychosocial buffer. [2,3]

Conclusion

Cyclone Ditwah brought devastating loss to the rural community of Rambuk-Ela Villanagama. Amid profound trauma, interfaith collaboration, community leadership, and culturally sensitive support emerged as powerful protective factors. These observations underscore the need for integrating community-driven, spiritually informed approaches with formal psychiatric care in disaster settings. [2,3]

Healthcare Continuity: Missed Clinic Visits and Medication Needs

In the immediate aftermath of the cyclone, many patients with chronic illnesses were unable to attend their routine clinic appointments. A coordinated mechanism was established through the Medical Officer of Health (MOH) and volunteers to dispense medications based on prescriptions issued at on-site health camps until regular services were restored.

Children's Emotional Impact Following the Loss of a Public Figure

Several children demonstrated heightened emotional reactions to the death of a well-loved schoolteacher. This highlighted the importance of community-based grief support and sensitive reintegration strategies.

Places of Worship as Safe Return Points

Although some families could return home, many continued to seek shelter at the temple or mosque, seeing these places as psychologically safe bases amidst ongoing threat of recurrence.

Community Resourcefulness in the Immediate Aftermath

According to the Buddhist monk, the community relied on internal resources such as a generator and stored water tanks until disaster-relief teams could reach them.

Post-Traumatic Growth (PTG)

Interfaith solidarity and collectivistic cultural values promoted PTG, helping survivors develop greater appreciation of life, deeper connections, renewed purpose, and strengthened spiritual beliefs.

Lessons for Practice

- Interfaith solidarity acts as a psychosocial buffer in disaster recovery
- Places of worship serve as psychologically safe bases
- Community-driven approaches complement formal psychiatric care
- Children's drawing activities reveal a spectrum from resilience to distress
- Healthcare continuity mechanisms are essential post-disaster

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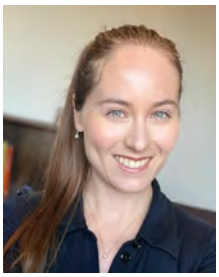
Integrating Public Mental Health and Sustainability Interventions for Psychiatrists

NATALIE COOK & KATIE BLISSARD-BARNES



As we argue in our recent BJPsych Bulletin (1) review, psychiatrists have a unique opportunity — and responsibility — to bridge public mental health and sustainability principles in both practice and advocacy. This article explores key overlaps between these domains and outlines actionable steps for mental health professionals.

> *"The discipline of psychiatry sits at the intersection of clinical care, public health, and sustainability."*

Public mental health adopts a population-based approach to improve mental well-being through evidence-based, preventive interventions delivered across sectors, including healthcare, education, workplaces, and communities. Sustainability, by contrast, emphasises environmental stewardship, social equity, and economic viability — aspects increasingly recognised as determinants of mental health outcomes.

Why the Overlap Matters

The case for integration is compelling. Sustainable healthcare seeks to minimise environmental impact while maximising social and economic value. In the UK, the National Health Service contributes approximately 4–5% of total national carbon emissions, underscoring the urgency for more sustainable models of care. At the same time, evidence highlights that environmental stressors — including heatwaves, food insecurity, air pollution, and limited access to green spaces — materially impact mental health at population levels. Moreover, climate change amplifies health inequalities by disproportionately affecting the most deprived communities, who often have greater exposure to environmental hazards and fewer resources to adapt or recover, thereby increasing mental health vulnerabilities.

In this sense, sustainability is not merely an environmental concern but a clinical and equity issue for psychiatry.

Three Domains of Action

1. Prevention of Mental Illness Public mental health's emphasis on preventive measures — such as parenting support, smoking cessation, physical activity promotion, workplace wellbeing initiatives, and early detection — aligns with sustainable health goals by reducing service demand and resource use. Preventive strategies can decrease caseloads and waiting lists while also lowering carbon intensity by shifting care upstream.

2. Healthy Environments The physical environment is both a determinant and an intervention point for mental health. Access to green and blue spaces is associated with reduced anxiety and depression and supports physical activity and social connection — all protective against mental ill-health. These

environments also mitigate urban heat effects and enhance climate adaptation, reinforcing their dual public health and sustainability value.

3. Reducing Inequalities Psychiatrists frequently encounter the mental health burden related to poverty, marginalisation, and social exclusion. These social determinants intersect with environmental disadvantage (e.g. poor housing, pollution exposure) to deepen inequities. Targeted action to improve access to culturally competent care, address barriers to services, and advocate for equitable policies is essential.

Practical Actions for Psychiatrists

At the individual level, clinicians can integrate environmental and social determinants into assessments and care plans, promote equitable access to supportive resources, and engage with community partners to enhance outreach. They could also consider integrating sustainability principles into quality improvement projects using the SusQI approach (2) and considering roles such as the RCPsych Sustainability scholar.

At the system level, psychiatrists can advocate for sustainable infrastructure (e.g. active travel, clean air zones), challenge commercial drivers of poor mental health, and support trust-wide sustainability initiatives.

Ultimately, aligning public mental health with sustainability enriches psychiatric practice by enhancing prevention, reducing disparities, and fostering environments that support psychological wellbeing — while contributing to a healthcare system fit for the future.

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Q&A

Interview chat with Dr Álvaro Barrera

CONDUCTED AND TRANSCRIBED BY DR SOPHIA SENTHIL

Dr Álvaro Barrera, Consultant Psychiatrist at Oxford Health NHS Foundation Trust and a lifetime achievement award winner, shares insights into inpatient psychiatry, the importance of strong community services, and his advice for the next generation of psychiatrists.

Introduction

Dr Sophia Senthil: Good afternoon, Dr Barrera. Thank you for agreeing to be interviewed for the iMind Faculty magazine. To begin with, could you introduce yourself and tell us about your role?

Dr Álvaro Barrera: Thank you for inviting me to have this conversation. I have been working as an inpatient psychiatrist for more than ten years. Before that, I worked in community services in Oxfordshire.

Receiving the Faculty Prize

Dr Sophia Senthil: Congratulations on receiving the faculty prize last year. Could you tell us what that recognition means to you?

Dr Álvaro Barrera: I was very surprised and extremely grateful to the faculty. What made it particularly meaningful was that former residents came together to nominate me for the award. That was a very kind gesture. Inpatient psychiatry is not always widely recognised as a role, so it felt positive not only for me but also for all the colleagues who work in inpatient settings.

Working in Acute Inpatient Psychiatry

Dr Sophia Senthil: Can you tell us more about your work in inpatient services?

Dr Álvaro Barrera: I work in an acute general adult inpatient unit at Warneford Hospital in Oxford, which is one of the oldest mental health hospitals in the UK. In our unit we care for people with severe mental illness who are in crisis. These include individuals with schizophrenia, bipolar disorder, and severe depression with psychotic symptoms. Many patients admitted to our ward are

detained under the Mental Health Act, reflecting the increasing threshold for hospital admission. I am fortunate to work with a great team of resident doctors including foundation doctors, core trainees, specialty doctors and higher trainees. I am also an Honorary Senior Clinical Lecturer with the Department of Psychiatry at the University of Oxford, which allows me to combine clinical work with academic and research activity.

Academic and Research Work

Dr Sophia Senthil: Could you tell us more about your academic and research work?

Dr Álvaro Barrera: I supervise and assess fifth-year medical students from the University of Oxford who undertake placements in our service. I also participate in multidisciplinary assessments involving nursing students from Oxford Brookes University, which involve simulated scenarios where students work together as a team, reflecting the collaborative nature of clinical practice. My research broadly focuses on two areas, first, psychopathology of severe mental illness, including hallucinations and formal thought disorder and second, trying to improve inpatient care. For example, we conducted the first pilot randomised controlled trial investigating cognitive behavioural therapy for insomnia within an inpatient psychiatric unit. The results were promising and may lead to wider implementation. Another recent study explored patients' preferences regarding digital monitoring of their physical and mental health. Interestingly, patients with severe mental illness showed similar attitudes toward digital health monitoring as individuals with physical health conditions.

Feedback from Patients and Families

Dr Sophia Senthil: What feedback have you received about the impact of your inpatient work?

Dr Álvaro Barrera: One thing I try to do is involve families and carers during admissions and ensure that their concerns are heard. Despite the fact that many patients are detained under the Mental Health Act, the overall feedback from both patients and relatives is often, but not always, positive. A common theme among relatives is how difficult it was for them to access support in the community.

Inpatient Care and Prevention

Dr Sophia Senthil: The theme of this issue of the magazine is prevention. How do inpatient services contribute to prevention in mental health?

Dr Álvaro Barrera: Prevention can be understood in different ways. The first relates to broader social determinants of mental health such as poverty, inequality, discrimination, poor housing, and exposure to trauma or abuse. When we look retrospectively at the life stories of many patients with severe mental illness, we often see long histories of adversity. Earlier intervention in these social factors might reduce the severity or likelihood of subsequent mental illness. The second is timely intervention and treatment in the community. Sometimes patients remain untreated for months before they reach crisis point and need admission, which means they arrive at hospital extremely unwell.

Current Challenges in Mental Health Services

Dr Sophia Senthil: What do you see as the major barriers in the current system?

Dr Álvaro Barrera: One challenge is that secondary community services and primary care are often overwhelmed. As a result, some patients with severe mental illness may struggle to access timely care. Another issue is the dramatic reduction in inpatient beds over the past 30 years. According to

a 2019 report from the Royal College of Psychiatrists, the number of mental health beds in England has fallen from over 70,000 to fewer than 20,000. I think that this reduction has not been matched by a proportional increase in community services. As a result, the threshold for admission is now extremely high. Patients are often severely unwell and under the Mental Health Act. Additionally, sometimes patients are discharged earlier than ideal in order to maintain patient flow.

> *"Strengthening general adult community mental health teams could therefore improve prevention, continuity of care, and long-term outcomes."*

What Needs to Change?

Dr Sophia Senthil: How could these challenges be addressed moving forward?

Dr Álvaro Barrera: In my view, there needs to be significant investment in generic community mental health teams. Over recent years, there has been an emphasis on developing specialised services. While these are valuable, they sometimes divert resources away from general adult psychiatry teams that provide, in my view, the foundation of care. Tom Burns, Professor of Social Psychiatry in Oxford, often emphasised that strong generic community teams are essential. If individuals receive good generic general adult community care early, it may reduce escalation to severe crises requiring hospital admission or to forensic services. Strengthening general adult community mental health teams could therefore improve prevention, continuity of care, and long-term outcomes.

Advice for Trainees

Dr Sophia Senthil: Do you have any advice for trainees and resident doctors?

Dr Álvaro Barrera: Resident doctors are the future of the profession, and we need to look after them. Many now graduate with significant financial pressures and face demanding working environments and these factors must be acknowledged. It is important that training emphasises core clinical skills, including interview skills, mental state examination, descriptive psychopathology, psychopharmacology, comprehensive risk assessments, biopsychosocial formulation, and collaborative work within multidisciplinary teams and with external agencies. A strong grounding in general adult psychiatry will give trainees the confidence and competence to work effectively under pressure.

Closing Reflections

Dr Sophia Senthil: Thank you very much for sharing your insights.

Dr Álvaro Barrera: Thank you for the opportunity. I hope that this conversation is helpful.

Dr Álvaro Barrera
Consultant Psychiatrist
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LIVED EXPERIENCE

When Co-Creation Becomes Prevention: Lessons from Designing an Alternative to Admission

CHRIS MORTON, LIVED EXPERIENCE DIRECTOR, TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

The NHS Fit for the Future 10-year plan commits to one of the most significant shifts in health policy in a generation: moving the NHS from a sickness service to a prevention service. It is a commitment worth taking seriously. But if we are to genuinely realise it in mental health, we need to be honest about something uncomfortable. Many of our current services were not designed around prevention. The fact that we continue to invest most heavily in crisis and inpatient services is itself a sign that prevention has not worked to the real extent it needs to. These services exist to catch people who have fallen through every net before them.

I do not say this to diminish the people who work in these services, many of whom show extraordinary commitment under impossible conditions. I say it because naming it honestly is the starting point for doing something different.

At Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), we have been attempting to pull at the threads of this complex jumper, knowing that unknitting it will take time, and that pulling the wrong thread too hard risks unravelling something we still need. One thread we have pulled carefully is the development of an alternative to admission: a crisis house and safe haven model, built through a genuine co-design process involving Healthwatch, service users, carers, peer workers and clinical staff across three structured workshops.

What we built matters. But how we built it, and why the process itself embodies a preventive logic, is what I want to explore here.

Services Built Around Exclusion

If we look at the previous crisis house model in our area, inclusion and exclusion criteria had become increasingly rigid. The house had become clinically led, risk-averse and oriented toward certainty. Staff involved in the co-design told us the model had not worked as intended. What emerged from their accounts, and from the very different experiences shared by people who had accessed other models of crisis support, was a telling contrast.

When services try to respond to people who need flexible, personalised approaches in rigid ways, implementing strict checklist-type responses and treating risk as something that can be eradicated rather than navigated, they make people smaller. They produce the very chronicity and dependency that prevention is meant to interrupt.

A Different Kind of Prevention

A crisis house and safe haven is not, on the surface, a prevention service. It sits at the acute end of the spectrum. But the model we developed operates on a fundamentally preventive logic, one the 10-year plan's framing of prevention as lifestyle change and early detection largely misses.

Prevention in mental health is not only about catching illness earlier. It is about responding to distress through dialogue and relational care rather than through restriction and deprivation of liberty. The model we designed centres on the belief that people in crisis retain the capacity to negotiate their own support, that this capacity should be strengthened not bypassed. Access is broader: a safe haven providing daytime support for up to twenty people alongside four to six residential beds. The model is led by the voluntary and community sector, deliberately outside the institutional logics that had constrained its predecessor.

> *"Prevention in mental health is not only about catching illness earlier. It is about responding to distress through dialogue and relational care rather than through restriction and deprivation of liberty."*

This is prevention understood as a collective response to distress, embedded in community, founded on human connection and built on amplifying our greatest human asset: the capacity to relate to each other with compassion and care.

The Ongoing Friction

I would be misleading readers if I suggested the tension is resolved. It is not. The dominant logic of risk, of certainty, of wanting clear answers to complex human situations, does not disappear because a co-design process produced a better model. It reasserts itself in implementation, in governance, in every conversation about thresholds and eligibility.

There are two specific pressure points worth naming. The first is the relationship between VCSE providers and NHS commissioners. Once a voluntary organisation enters a contractual relationship with a trust, the gravitational pull of NHS governance expectations is significant. The creativity, relational artistry and tolerance of uncertainty that make this model work can quietly erode as organisations adapt to survive within a system built on different assumptions.

The second pressure point is participation itself. Maintaining genuinely co-produced governance over time requires the sustained involvement of people who have accessed crisis services. These are often the people least resourced to attend formal committees, sustain involvement through institutional processes, and advocate within governance structures designed for professionals. If we do not actively address this, co-production becomes a founding story rather than a living practice.

The answer is not to win the argument for relational approaches once at the design stage. It is to build the governance structures that protect those approaches over time, holding the space for the creativity and uncertainty that effective prevention in mental health actually requires.

The NHS 10-year plan is right to shift its gaze toward prevention. But prevention in mental health will not be delivered by technology or earlier detection alone. It will be delivered by services that trust

people, that respond to distress with relationship rather than restriction, and that are built and continuously renewed by the people who need them most.

Chris Morton
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FEATURE

Prevention at the Centre: Community Mental Health Transformation across TEWV

Dr Ranjeet Shah and Dr Himanshu Garg

Dr Ranjeet Shah is Group Medical Director for Durham, Tees Valley and Forensic Care Group at Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). **Dr Himanshu Garg** is Group Medical Director for North Yorkshire and York Care Group at TEWV. Together, they are leading community mental health transformation across the trust, embedding prevention into everyday practice through place-based design and strong partnerships.

Across Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), community mental health services are undergoing a profound change. In place of systems shaped largely by crisis response, long waits and fragmented pathways, a new model is emerging. One that places prevention, early intervention, community-based support and partnership working at its core.

This shift is being delivered through community mental health transformation, guided by national policy but adapted to local need. While the overarching principles are consistent across the trust, their implementation looks different in different places to support different needs within neighbourhoods and communities. This article brings together two complementary stories of transformation within two care groups: Durham and Tees Valley, and North Yorkshire and York. Together, they demonstrate how prevention can be embedded into everyday practice through place-based design, strong partnerships and a purposeful shift towards earlier support.

Building Prevention into the System: Durham and Tees Valley

Durham and Tees Valley include some of the most deprived communities in England, alongside areas of significant rurality and industrial transition. The region has high levels of mental ill-health, stark health inequalities and suicide rates above the national average. Historically, this combination translated into high demand for specialist services, growing waiting lists and an over-reliance on secondary and crisis care.

Community mental health transformation in this geography has been explicitly framed as a preventive response. The aim has not simply been to redesign services, but to intervene earlier, reduce avoidable escalation and build resilience within communities.

Fragmented teams were brought together into integrated, place-based community mental health teams, aligned closely to Primary Care Networks, local authorities and voluntary sector partners. This included moving from multiple teams to single integrated teams in each locality, supported by co-located mental health hubs. These hubs act as the front door for support, providing earlier access, joined-up assessment and coordinated multi-agency responses. The organising principle has been flow and prevention: responding when difficulties first emerge, stabilising people quickly in their communities, and enabling step-down and recovery rather than progression into crisis pathways.

> *"The organising principle has been flow and prevention: responding when difficulties first emerge, stabilising people quickly in their communities, and enabling step-down and recovery rather than progression into crisis pathways."*

Durham and Tees Valley: Early Intervention at Scale

Multi-agency hubs have been established across all areas, bringing together colleagues, local authority services, VCSE partners and drug and alcohol teams in shared spaces. Weekly multi-agency huddles enable emerging risks to be identified early and addressed collaboratively.

Alongside this, a strengthened primary care mental health workforce has been developed through the Primary Care Network additional roles reimbursement scheme. New roles - including mental health and wellbeing practitioners, advanced nurse practitioners and care navigators - are embedded directly in general practice.

41,000+	<3%	94%
People supported in primary care MH services (1 year)	Needing referral to community MH teams	Patient experience rating (good/ excellent)

The preventive effect has been striking. In the last year over 41,000 people have been supported within primary care mental health services, with fewer than 3% needing referral on to community mental health teams. At the same time, waiting times for CMHT assessment have fallen from around six months to under one month, demonstrating how earlier intervention can both improve access and reduce pressure on specialist teams.

A critical shift has been moving triage into primary care, rather than secondary services. This enables faster advice, signposting and intervention, preventing unnecessary escalation and helping many people receive timely support without needing referral into community mental health teams.

Community teams employ structured clinical management as a psychologically informed approach to working with people with complex emotional needs. This has led to proactive safety planning, reduction in patterns of repeated admissions and an overall reduction in the number of admissions. There has been a sustained reduction in demand for female inpatient beds, which has enabled the service to consolidate provision.

In County Durham, prevention has been embedded through a distinctive gateway model, delivered in partnership with the Durham Wellbeing Alliance. This provides a single point of access across the

system, ensuring that people contacting services receive a response within 48 hours, with daily multi-agency decision-making. Over 54% of transformation investment in County Durham has been directed to the voluntary and community sector, reflecting its central role in prevention, early help and social connection.

Durham and Tees Valley: Measurable Impact

- 43% reduction in unique referrals into planned secondary care
- 62% reduction in people waiting for assessment in community MH services
- Gradual reduction in average caseloads following the post-pandemic surge
- Sustained high patient experience (94% good or excellent)
- Response within 48 hours through the Durham gateway model
- 54% of transformation investment directed to VCSE sector

Prevention at the Centre: North Yorkshire and York

North Yorkshire and York present a very different, but equally complex, context. Serving almost 655,000 people across two unitary authorities, this area spans dense urban neighbourhoods and some of the most rural areas in England. Alongside affluence, there are pockets of deep deprivation, rural isolation and variable access to services, all of which shape mental health need.

In this setting, community mental health transformation has been built around a clear premise: prevention must be local, flexible and community-rooted. A standardised model would not meet such diverse needs.

The model emphasises blending clinical and social approaches, addressing housing, debt, employment and isolation; treating people with lived experience as active partners; strengthening integration across primary care, secondary care, social care and the VCSE sector; and moving towards genuinely trans-disciplinary working, enabling flexible, needs-led responses.

Prevention in North Yorkshire and York is delivered through partnership with the VCSE sector, comprising more than 3,000 organisations. In York, VCSE coordination through York CVS has enabled the development of well-established community mental health hubs in partnership with the City of York Council, York Mind and the Carers Centre. In North Yorkshire, Community First Yorkshire supports a more distributed model, working with local community anchor organisations to reflect rural geography and local identity.

"Prevention must be local, flexible and community-rooted. A standardised model would not meet such diverse needs."

Mental Health Hubs: Prevention in Practice

York now has two fully operational mental health hubs - 30 Clarence Street and Acomb Garth - which are both delivered as genuine multi-agency partnerships. Acomb Garth operates as a 24/7 neighbourhood mental health resource centre and forms part of a national pilot.

Since opening in October 2025, a total of 387 individuals have accessed support from the centre. Notably, only three individuals have subsequently required referral to secondary care services, indicating effective early intervention and support within the hub. The hub plays a key preventive role by offering rapid access support, reducing pressure on crisis and emergency departments, and connecting people with community-based recovery resources.

A major driver of prevention in North Yorkshire and York has been the rollout of primary care first contact mental health practitioners. With 37 practitioners embedded directly in GP practices, support is available at the point where people most often seek help. Since implementation, first contact mental health practitioners have seen over 60,000 referrals per year, of which 80% are new to services.

387	37	60,000+
Individuals supported at Acomb Garth since Oct 2025	First contact MH practitioners in GP practices	Referrals per year to primary care MH practitioners

Prevention has also been embedded in specialist pathways. In adult eating disorders, additional psychiatric and nursing capacity has been secured, alongside widespread "See the Signs" training for hub staff and first contact mental health practitioners to support early identification. For people with complex emotional needs, investment in trauma-informed care and structured clinical management, delivered jointly with VCSE partners, aims to address need earlier and reduce cycles of crisis-driven care.

The hubs have transitioned from maintaining separate records to using a shared electronic patient record (EPR) accessible to all partner organisations. Notably, the Acomb centre was the first in the country to implement a fully shared EPR across partners.

Conclusion: One Trust, Two Stories, Shared Purpose

Across TEWV, the experiences from Durham and Tees Valley, and North Yorkshire and York, illustrate how prevention can be embedded into the fabric of community mental health services. While each area has developed solutions shaped by local context, the shared direction is clear: earlier help, stronger partnerships, integrated teams and support delivered closer to people's lives.

Together, these transformations show that prevention is not an abstract ambition, but a practical, deliverable approach. One that improves access, reduces pressure on specialist services and supports people to stay well in their communities.

Service Development Plans

- Third integrated mental health centre and mental health A&E in York
- Expansion of integrated centres in Harrogate and Scarborough (24/7 models)
- Review of rehabilitation pathways into community services
- Streamlining VCSE contracts and maintaining robust project management
- Strengthening early intervention and improving patient flow
- Enhancing data sharing through unified systems

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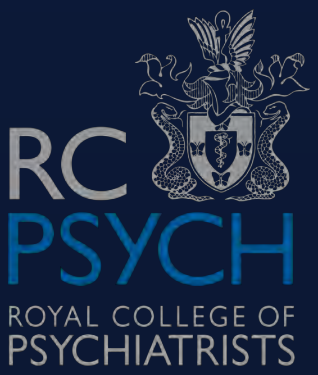

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