Well, hu? You join me back at the election that really matters!
First in Europe

The College beat strong competition to be crowned Charity of the Year at the European Diversity Awards in November. The award recognises RCPsych’s outstanding work in the field of equality, diversity and inclusion. Ever since the launch in 2018 of its values – Courage, Innovation, Respect, Collaboration, Learning and Excellence – the College has sought to ensure that they underpin everything it does. ‘Respect’ means taking decisive action to ensure diversity and inclusion across its membership, staff and wider mental health services. Action taken includes nearly tripling the number of new fellowships for ethnic minority psychiatrists to 49% of the total awarded. The judges also noted RCPsych’s position at the forefront of promoting equality on gender, race and sexuality in healthcare.

Improving isles

Diagnostic rates for dementia vary significantly across the four nations, with the rate in Northern Ireland being the highest at 73%, while in Wales it sits at just over 50%. Things are about to change, however, thanks to an innovative way of diagnosing some types of the disease. A PET scanner at the University Hospital of Wales, currently used to detect cancers and carry out research, has now been made available for patients with suspected dementia or Alzheimer’s. Extra funding from the Welsh government was secured for the programme by RCPsych in Wales, Aneurin Bevan University Health Board and Cardiff University. Dr Chinee Ivevso, chair of the Old Age Faculty in Wales, described how the country has “lagged behind for quite some time” without access to PET scanning for dementia. “It is very important we now have a way of making a quicker diagnosis in complex cases, so patients and families get the support they need faster.”

There is good news too for older people in Northern Ireland. In October, Belfast Health and Social Care Trust became the first in the country to be accredited by the College for its dementia care. Its Older People’s Dementia and Mental Health Service was awarded for completing the Memory Services National Accreditation Programme (MSNAP), an achievement described as “fantastic news” by Dr Gerry Lynch, chair of RCPsych in Northern Ireland. “After 18 months of hard work, the staff commitment and achievements for people accessing this service have been fully recognised. Well done to all involved.”

Election time

With the general election behind us, voting has now opened to decide who will be RCPsych’s next president. There are three candidates: Professor Kam Bhui, Dr Adrian James and Professor Parmela Taylor. Members, Fellows and Specialist Associates are all eligible to vote and will have received an email with a link to the voting site. Voting closes on Wednesday 8 January 2020. For the first time, RCPsych held a hustings event in October, where members had the chance to quiz the candidates, and a video of the event is available on the website for those unable to attend.

A written and short video statement from each candidate can be viewed by searching ‘meet the candidates’ at www.rcpsych.ac.uk. If you are eligible to vote but have not received the video, please contact elections@rcpsych.ac.uk.

Cannabis concerns

A new RCPsych Position Statement sets out the College’s view on cannabis-based medicinal products. It details the lack of high-quality evidence for their use in the treatment of mental illness and calls for more research in all health settings. Search ‘Position Statements’ at www.rcpsych.ac.uk to read the full text.
End the beds shortage

New independent research commissioned by the College has found that in-patient adult mental health services across England are struggling to cope with demand. With consequent harm to patients, and staff put under intolerable pressure, RCPsych is calling for immediate and longer-term action to help end the crisis.

Care in the community has been the stated aim of government since the 1980s. As a consequence, in the past 30 years, the number of adult in-patient mental health hospital beds in England has fallen by an astonishing 73%, from 67,100 to 18,400. But, in the same period, there has not been a corresponding increase in community care services. The upshot is that bed occupancy now exceeds 90%, reaching 100% in some parts of the country. Many people in crisis are waiting far too long for a bed to be free; others are sent ‘out-of-area’, far from home. And caught in the middle, under intense pressure and often struggling to cope, are members of RCPsych and their fellow mental healthcare professionals.

What’s particularly unsettling is that the problem has been known about for years. In 2015, RCPsych set up the Independent Commission on Acute Adult Psychiatric Care in England. The commission published its report in 2016, recommending urgent action. But in the intervening years, very little has changed despite intensive efforts nationally and locally. The NHS Long-Term Plan, published in January, does include a firm commitment to end out-of-area placements by 2020/21 and to greatly increase community care services by 2023/24, but action is also needed now.

Professor Wendy Burn, RCPsych’s president, knows only too well how the present crisis is affecting acutely ill people. “I’ve heard some horrible stories about what’s happened to patients while they’ve been waiting to go into hospital,” she says. “People who’ve got sicker, people who have attempted suicide while waiting for a hospital bed. There are around 750 patients at the end of each month who find themselves miles away from where they live, so they can’t be easily visited by their loved ones or their community teams, which we know can really set back patients’ recoveries. On top of this, we’re wasting money: we’ve cut the beds in people’s own local hospitals and then we’re spending money, often in the private sector, miles away from home.”

People who do get a bed don’t always get the care they need. In wards running at full capacity, there may be barely enough staff to go around. And then, patients may be discharged early, leading to a relapse and the need for readmission. Professor Burn talks about people who have gone to A&E, where they’re assessed as needing a bed, “but there isn’t one, and they’ll live in A&E. They don’t have proper access to food. They don’t have washing facilities,” she says. “It’s just awful. I also know of a patient who was waiting in A&E and eventually got so frustrated he attacked a security guard, injuring them quite severely. RCPsych is calling for immediate action to help tackle the crisis. It commissioned a report, published in November, which sets out a three-point plan that seeks to improve capacity across the system. Exploring Mental Health Inpatient Capacity is based on in-depth research and interviews with members of RCPsych. It identifies those parts of the country where the problems are most acute, with persistently high numbers of out-of-area placements and high bed occupancy. The report proposes an immediate increase in beds, concentrated on these priority areas, to provide a ‘breathing space’.

“In five years’ time, when the community services have been enhanced and all the money is flowing, there will be less pressure on, and need for, additional in-patient beds,” says Professor Burn. “But in the short term, we certainly do need them. An immediate increase in bed numbers where they are needed most will help but won’t end the crisis. More beds need more staff and that requires current and projected staff shortages to be addressed. At the same time, the commission’s report found a wide variation in admission and discharge criteria, admission rates and average length of stay. In the next two years, RCPsych is calling for more focus on ensuring that all time spent in hospital by patients adds therapeutic value, and for local areas to better understand how well their services can meet demand. And over the next two to five years, the focus needs to be on investment to increase the capacity and capability of community mental health services, in line with the NHS Long-Term Plan.

The crisis in acute care for adult psychiatric patients is a complex problem that requires action on several fronts. RCPsych has set out how it can be done. But now, politicians and national and local health services need to take action as a matter of urgency. We are in a race against time, with much competing for their attention and focus, we need to make sure our voice is heard loud and clear – it’s time for action.

What the data tells us

- Since 1987/88 the number of mental health beds in England has fallen by 73%.
- Seven Sustainability and Transformation Partnerships (STPs) report particularly high levels of inappropriate out-of-area placements (after adjustment for population size and needs): Bristol, North Somerset and South Gloucestershire; Devon; Lincolnshire; Norfolk and Waveney; Nottinghamshire; Lancashire and South Cumbria; and Hampshire and the Isle of Wight.
- In just one year, patients were sent approximately 555,000 miles to get treatment that should have been available locally. That’s the equivalent of going around the world 22 times.

The full independent report, and RCPsych’s response to it, are available from: www.rcpsych.ac.uk/servicecapacity

Dr Sidra Chaudhry CT3 Yorkshire and Humber

A report on Congress’ cannabis debate (Congress Conversations, Autumn 2019 issue of Insight) correctly reported a majority against legalisation after the debate. Not mentioned, however, was that a majority were in favour of decriminalising the recreational use of cannabis. Also, the use of mobile phones to vote turned out to be highly unsatisfactory.

Professor Philip Graham FRCPsych (Hon)

You are right that the audience voted for decriminalising recreational use and it was misleading not to have reported this. This was an issue of space and not policy. RCPsych has reviewed its stance on recreational cannabis use and will publish a forthcoming Position Statement. We acknowledge that the technology piloted at Congress meant that only some votes were captured. This will be resolved for Congress 2020.

It is dangerous to encourage sufferers to quit smoking (Time to Quit, Autumn 2019 issue of Insight), or to advise nurses to encourage it, without reminding them that stopping smoking immediately is a risk to medication serum levels, and to relapse.

Dr David Yates FRCPsych

We did fail to stress that tobacco smoke stimulates the production of the CYP1A2 enzyme, speeding up the metabolism of some medications, which may decrease plasma levels. Smokers using these medications should be advised that changes to their usual smoking routine will require careful monitoring of plasma levels to inform required changes.
In October, RCPsych invited some of its most senior members to recount and record their memories of the profession and its practices. Here, retired consultant psychiatrists Dr Dora Black and Dr John Bradley share their thoughts on the changes they witnessed and helped to shape.

“I remember when they were first introduced,” says Black. “Patients who had been in an almost zombie-like state for years suddenly woke up.”

Besides the advent of effective drugs, Bradley also points to the huge impact that various pieces of legislation – not just mental health laws, but parliamentary acts on suicide, abortion and homosexuality – had in “liberalising and humanising treatments of the mentally ill.”

The shift of services away from mental institutions to general hospitals was another positive development Black witnessed. It meant, in purely practical terms, that other doctors “learnt that I could be useful to them” (a shift in thinking that she attributes, in part, to eating with them in the common room). “Change happens through people,” she says. “You have to be in a certain place at a certain time.”

Her capacity to see – and seize – these moments meant that later in her career she became involved in a local group for widows run by the Watford branch of the charity Cruse. Once a month they provided group counselling, she explains, through which she “learnt a lot about bereaved children”.

At the time, family therapy was in its infancy in the UK, so Black decided to conduct some research. “I wrote to GPs and asked them to send me their bereaved children,” half of whom she then provided with family therapy. “It was a very important piece of work,” she says. Black went on to chair the Institute of Family Therapy and was founder-director of the Traumatic Stress Clinic in central London for psychologically traumatised children.

In October, Dr John Bradley and Dr Dora Black were among a number of speakers at a ‘witness seminar’ on psychiatric hospitals in the UK in the 1960s. A transcript of the discussion will soon be published on www.rcpsych.ac.uk
Classes acts

Schools can play a vital role in improving the mental health of children and young people. Innovative work in Oxford and Greater Manchester shows how it can be done.

The mental health of children and young people has long been a major concern. The scale of the problem was laid bare in a government survey of children in England published in 2018. It found that 12.5% of five- to 19-year-olds and 5.5% of two- to four-year-olds had at least one mental disorder when assessed. The study also reported an overall increase in the prevalence of mental illness among five- to 15-year-olds in the past 20 years.

The response to these figures has been a widespread call for better access to Child and Adolescent Mental Health Services (CAMHS) and, in particular, for schools and schools to provide a role in providing such access. Schools are seen as well placed not just to promote good mental health, but also to prevent problems later in life.

A central recommendation of the 2016 report by the Values-Based Child and Adolescent Mental Health System Commission, of which RCPsych is a member, was that schools should teach their pupils about mental health “in the same way they teach them about literacy or numeracy.”

“Schools should teach their pupils mental health in the same way they teach them about literacy or numeracy”

Dr Mina Fazel explains how it began 15 years ago through working with refugee children. “It came about by chance,” she says, “because a third-sector organisation approached us, interested in developing ways to improve access to mental health services. They asked us to provide a mental health service within schools.” Dr Fazel and her colleagues set about trying to find the best ways of supporting the refugee children and their families, holding regular meetings in schools with staff, initially without the formal involvement of mental health services, but making referrals to CAMHS where necessary. “We had a complete shift in our understanding of working in schools,” says Dr Fazel. “At the end of our meetings, the staff would say: ‘Thank you very much; that was really helpful. But now can I talk to you about the 20 other children in school that I’m worried about?’ So, we approached our mental health services and then the commissioners and said: ‘Actually, we need to provide a service for all kids, not just refugee kids.’”

“Now, through our School In-Reach programme, all secondary schools in Oxfordshire get specific CAMHS time. From a really small project with a select group of vulnerable children and families, we’ve been able to think a lot more about the needs of all vulnerable kids, no matter where they’re from, and about the role that schools could potentially play in enabling us to better help these young people.”

This way of thinking is fast spreading throughout the rest of the country. In 2016, RCPsych joined forces with NAHT Cymru, the school leaders’ union in Wales, to explore collaborative ways of working, understand each other’s challenges and share best practice. Their first joint conference was held in December last year in Cardiff. RCPsych has also developed a mental health pack for schools, a collection of 14 factsheets that cover a wide range of disorders, explaining how to recognise them and what can be done to help. They are much in demand, with Hertfordshire Council, for example, supplying them to every school in the county.

The government is also pressing ahead with its plans to fund new Mental Health Support Teams in schools. Led by NHS children and young people’s mental health staff, these are designed to provide extra capacity for earlier intervention and ongoing help.

From this year, the support teams will start work in 25 areas across England, the largest of which is Greater Manchester. Leading on the project for the Greater Manchester Health and Social Care Partnership is consultant child and adolescent psychiatrist Professor Sandeep Ranote. The work of her mental health support teams, already in training, is being informed by a four-month pilot undertaken in 2018. ‘Mentally Healthy Schools’ involved 31 primary and secondary schools across the conurbation. In collaboration with the NHS, it saw four local third-sector organisations deliver on-site training of staff and pupils. That was the best use of resources, says Professor Ranote. “We don’t have sufficient staff in CAMHS to send to the schools; we need to be here, providing our service. If you had a child that had self-harmed or you were worried that they had an eating disorder, you’d want to get access to specialist CAMHS teams, including a child psychiatrist, really quickly. So, we need to work better as a system in partnership to support our schools and use our workforce more wisely.”

The pilot clearly worked well. A total of 690 pupils took part in ‘active workshops’ led by athlete mentors – good physical health being a key component of good mental health – and over 150 were trained as young mental health champions. In addition, 113 members of staff received mental health first aid training and, crucially, more than 60 senior leaders were taught how to respond to the mental health needs within their school.

RCPsych’s mental health factsheets for schools can be ordered via the College website. You can also email leaflets@rcpsych.ac.uk for more information.
The health service needs to undergo a “cultural transformation” to become more inclusive for staff from diverse backgrounds, the NHS’s lead on workforce race equality, Yvonne Coghill, recently told Nursing Times. Progress on culture change in the NHS had “flattened”, she said.

Coghill is director of the Workforce Race Equality Standard at NHS England and NHS Improvement, which was introduced in 2015 to expose and help close the gaps in workplace inequalities between Black, Asian and Minority Ethnic (BAME) and white staff in the NHS. It came on the back of a report that revealed discrimination in NHS governance and leadership and its potential impact on patient care.

The latest data backs Coghill up. While the proportion of BAME staff in very senior manager positions has increased slightly, it is still significantly lower than the proportion of BAME staff working in NHS trusts. Worse, the percentage of BAME staff reporting discrimination increased last year; fewer BAME staff believe that their trust provides equal opportunities for career progression and promotion; and BAME employees continue to be at a higher risk of disciplinary action than their white peers.

This, at a time when research shows disproportionate levels of mental ill health in BAME communities, particularly people from Black ethnic minority backgrounds, compared with the general population.

Race inequality in the NHS workforce is connected to mental health outcomes among BAME communities, says mental health equality adviser to NHS England, Jacqui Dyer.

“Wherever you’re located, you need to look at the demographics of the people entering mental health services and whether the workforce reflects that demographic makeup,” she says. “When it is representative, you have more of a chance of engaging with these communities and in a way that better addresses their needs.”

Dyer, who spoke at a recent RCPsych conference on combating discrimination, continues: “Our mental health experience is a symptom of wider decision-making – social, economic and political – that impacts, in particular, on African and Caribbean people in a deplorable way.”

Rates of involuntary detention among Black or Black British populations, for example, are over four times those of the white population. They also have poorer recovery rates following psychological therapies. The 2016 Five Year Forward View for Mental Health showed persistent inequalities in early intervention, crisis care and lengths of stay in secure services.

New thinking

To address these inequalities, however, requires new ways of thinking and working, Dyer says. “Psychiatry and psychology normally rely on theories based on Eurocentric ideas and philosophies,” she adds, “not African, Caribbean, Asian or other minority ethnic insights or ideologies. And how can we get to recovery when you are not dealing with our issues?” she asks.

Dyer, who is also chair of Black Thrive, which works to improve Black mental health and wellbeing through co-creation with affected communities, says the answer lies in much greater attention being given to the views of people from a BAME background – both mental health professionals and at a community level.

“I am wary of people who engage in these dialogue who don’t come from an experiential position,” she says. BAME staff “hold that differential experience to some degree in their own worlds and they should use that expertise to influence the services in which they work.”

On the need to co-create services, she adds: “Until the groups that are experiencing the worst outcomes are represented at leadership levels where they can articulate what the real challenges are – around racism and discrimination – we will not be able to create a response appropriate to the magnitude of the problem.”

The importance of co-creation is reflected in the Patient and Carers Race Equality Framework. Born of the Mental Health Act Review, this is a practical tool to help organisations understand the steps needed to achieve improvements for individuals of diverse ethnic background. These include national competencies, such as reducing the use of restraint, but also changes co-produced at a local level.

Dyer, who chairs the framework’s steering group, explains how – by working alongside service users, carers and communities, especially those from African and Caribbean backgrounds – a mental health service can become “more accountable to the population it serves”.

“It’s about improving the very negative experiences of Black people in mental health services,” she says, and “no more deaths.”

Research matters

Research by Black academics is playing a crucial role in this shift to services that are more representative to BAME communities.

Leading the way are projects like the Culturally adapted Family Intervention (CaFI) study, led by Professor Dawn Edge at the University of Manchester, which is testing new forms of talking treatments to meet the specific needs of people of Black African and Black Caribbean heritage with schizophrenia and their families.

More research of this nature is needed, however, and more needs to be done to ensure that students from BAME backgrounds can pursue their research interests.

“People like York,” a recent graduate of King’s College London in Organisational Psychiatry and Psychology, agrees.

Last year she founded BAME in Psychiatry & Psychology, a network of BAME practitioners and students that organises events on issues around BAME representation and advancement in mental health professions.

York notes that it can be a struggle for students from a Black and minority ethnic background to pursue research that looks at issues of race and mental health. “Academics may feel unequipped to supervise research projects which address topics outside of their cultural and ethnic backgrounds,” she says. While York managed to find a supervisor with an interest in cultural diversity, she argues: “It’s important that individuals of all ethnic groups learn about and be exposed to ethnocentric models and therapies and begin to consider them as legitimate approaches.”

Representation is another important factor, says York. “I was elated when first taught by a Black identifying lecturer,” she says. “It was inspirational to see someone from my background working in my desired field.”

He later became York’s mentor.

Professor of Child and Adolescent Psychiatry at the University of Glasgow, Helen Minnis, says the lack of diversity in psychiatry research “matters hugely”.

“For me, it’s about the questions that get asked. Academia has been dominated by white men for centuries. Not to diminish the findings that they’ve produced, but inevitably they are coming from a certain perspective.”

Being a Black, female academic, and not in that group, has shaped the way that she thinks, Professor Minnis says. It has also brought benefits in terms of skills and ways of working: creativity, thinking laterally and “ending up with really well-evidenced work”.

Being overlooked for opportunities early on – the “invisibility cloak”, as she describes it – also meant that she “could get on with what I wanted to do.”

“We need lots more people like me,” Professor Minnis concludes. “When we’ve got genuinely diverse science – when psychiatry is genuinely diverse – we will ask the right questions.”

Junior doctor and co-editor of the Colour of Madness

Samara Linton explores how workforce barriers stand in the way of racial equality in mental health.

Breaking barriers

Keisha York, founder of BAME in Psychiatry & Psychology

#RCPsychInsight

Professor Helen Minnis of the University of Glasgow (Photograph: Herald and Times Group)

#RCPsychInsight
How are you, doctor?

Wellbeing is defined as “the state of being comfortable, healthy and happy”. Here’s how the College plans to deliver on its commitment to improve psychiatrists’ wellbeing at work.

change happens on the ground. Responsibility for the work lies with a dedicated Workforce Wellbeing Committee, which since January has been led by Dr Mihaela Bucur. “The first and most important thing is that the College recognises wellbeing as a key priority,” says Dr Bucur. “Our focus now is on implementing our plans.”

Look out for the new dedicated wellbeing page coming soon at rcp.ac.uk, with a dedicated email address for psychiatrists. To contact the PSS, call 020 72245 0412 or email pss@rcpsych.ac.uk.

“Navigating change”

The urgent need to improve mental health systems around the world requires a collaborative, equitable and above all practical approach to research.

Coordinating the work of an international team of colleagues is a challenging proposition at the best of times. But when you are based in a prosperous country and your collaborators are in low- or middle-income nations, there can be a whole extra degree of complexity. As principal investigator for the Emerald programme, this is a challenge with which Professor Sir Graham Thornicroft is well acquainted. The five-year EU-funded project began in 2012 and has centred on enhancing mental health outcomes in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda. Given the complexity of community psychiatry at King’s College London, says that meant confronting the loaded legacy of colonialism. “The history over many hundreds of years is of the northern countries exploiting the southern countries. So for me, these are the challenges for me in coordinating this project was to do as it was possible in a way that involves all the participants fairly and equally.”

Since the aim of Emerald was to strengthen the performance of health systems in each of the countries, capacity building – of healthcare professionals, policymakers, and service users and carers – was a huge focus. But it was an effort that also extended to the researchers. “What I enjoyed most was the constant learning process,” says Pauline Ade, who was Emerald’s programme manager before transferring to study for a PhD within the project. She describes the “incredible amount of capacity within the team” and its knowledge “both on mental health issues and scaling up and strengthening health systems”. “It was really amazing to see the capacity building being implemented in the countries”.

On the other hand, you can – with hundreds or thousands of other people around the world, contribute towards increasing the sum of human knowledge. “On the other hand, you can – with hundreds or thousands of other people around the world, contribute towards the urgent need to improve mental health systems around the world requires a collaborative, equitable and above all practical approach to research.
**Combatting loneliness**

Social isolation doesn’t have to lead to mental and physical illness in older people. Psychiatrists have a role in advocating for services to tackle and prevent loneliness.

*Imagine you like to run but find it difficult to stick to a schedule. One charity, GoodGym, has come up with a solution that also contributes to improving the quality of life of socially isolated older adults. Volunteer runners are matched with older people, or ‘coaches’ as they are referred to. Then, at a prearranged time, the volunteer runs to the older person’s home, pays them a social visit (and has a rest) and then runs home afterwards. In addition to making a rewarding personal connection, volunteers feel highly motivated to adhere to their running schedules and the coaches benefit from spending time in the volunteers’ company, that otherwise would have been spent alone. Half a million older people go at least five or six days a week without seeing or speaking to anyone, according to Age UK, and there are an estimated 1.2 million chronically lonely older people in the UK. While the subjective experience of loneliness is, of course, not in itself indicative of pathology – rather, a natural reaction to unmet social needs – it has very serious health consequences that should not be overlooked. “Far from being a trivial concern, loneliness is associated with an increase in mortality on a par with smoking and worse than obesity,” says Dr Amanda Thompsell, chair of the Old Age Faculty.

The College’s Old Age Faculty has produced a joint Position Statement with the British Geriatrics Society on loneliness and social isolation. Among their priorities is the need for increased identification and prevention. But reaching lonely individuals in the first place is one of the key challenges. Taking full advantage of people’s existing points of contact with healthcare services is a practical starting point. A 2018 study found that older patients who live on their own are heavy users of health services. “This means that we, as healthcare professionals, have opportunities to intervene and stop patients’ physical and mental health from deteriorating. But very often, no one is picking up on loneliness – yet it could be so easy,” says Dr Thompsell.

Bereavement – particularly of a spouse – is a key challenge. “It has been shown to be a risk factor for loneliness – yet it could be so easy,” says Dr Thompsell. “Of course, not everyone who is lonely is a patient. Psychiatrists need to see a psychiatrist. But if an older person has risk factors for loneliness, we can do more to offer support and encourage our healthcare colleagues to do the same. Asking simple questions such as: ‘Are you seeing people as much as you’d like? Do you feel lonely? Does that bother you?’ could open up a conversation that otherwise might not have happened.”

*Far from being a trivial concern, loneliness is associated with an increase in mortality on a par with smoking and worse than obesity* – Dr Amanda Thompsell, chair of the Old Age Faculty

“Far from being a trivial concern, loneliness is associated with an increase in mortality on a par with smoking and worse than obesity,” says Dr Amanda Thompsell, chair of the Old Age Faculty. Being lonely is also predictive of pathology – rather, a natural reaction to unmet social needs – it has been shown to be a risk factor for the progression of frailty. The College’s Old Age Faculty has produced a joint Position Statement with the British Geriatrics Society on loneliness and social isolation. Among their priorities is the need for increased identification and prevention. But reaching lonely individuals in the first place is one of the key challenges. Taking full advantage of people’s existing points of contact with healthcare services is a practical starting point. A 2018 study found that older patients who live on their own are heavy users of health services. “This means that we, as healthcare professionals, have opportunities to intervene and stop patients’ physical and mental health from deteriorating. But very often, no one is picking up on loneliness – yet it could be so easy,” says Dr Thompsell.

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RCPsy’s joint Position Statement with the British Geriatrics Society on loneliness and social isolation will be available from both www.rcpsych.ac.uk and www.bgs.org.uk.
In September, a group called ‘Doctors for Extinction Rebellion’ joined thousands of others in the capital to highlight government inaction on climate change. The following month, Richard Horton, editor-in-chief of The Lancet, upper the ante, calling on health professionals to “engage in all kinds of non-violent social protest. The climate emergency is the most important existential crisis facing the human species,” he said.

The message couldn’t be clearer, but what can we do as individuals, as a profession and as a College is still a work in progress. Fortunately, action is being taken at all levels to try and address the many environmental and social challenges we face. Leading the way for RCPsych is the College’s Sustainability Committee, which was established in 2016 and is led by associate registrar, Daniel Maughan. Meeting quarterly, it is a resource for interested members wanting to understand more or to share what they know. It also acts as a path into other campaigning health organisations.

Crucial to the committee’s work are the College’s sustainability scholars. These are advanced trainees who work on projects of their choosing relating to the committee’s four priorities of prevention, empowering individuals and communities, improving value, and considering carbon.

Dr Katherine Kennet, a higher trainee in child and adolescent psychiatry currently based at the Tavistock, has been involved with the committee from the start and has focused on social prescribing in mental health. “I have been interested in the social side of green issues – so fairness and social justice – for as long as I can remember,” she says. Her work with the committee, she says, “allows me to bring both of my interests together”.

The connections between individual and planetary ill health are clear, she says, citing evidence of the impact of pollution on mental health. “We can’t afford to think small,” she stresses, which is why the committee approaches challenges “systemically”. Through its membership of the influential UK Health Alliance on Climate Change, whose high-level advocacy is targeted and evidence based, the College has successfully lobbed on big policy issues, like air pollution.

“But we also try to give people tangible things to do as well,” says Dr Kennet, pointing to the committee’s ‘Top ten tips for practising psychiatry sustainably’, which she strives to apply to her practice. “For me, medication is key as it brings the biggest carbon footprint through its production and shipping.” She is adamant that this doesn’t mean doctors shouldn’t prescribe. “It’s more about taking five minutes to talk to patients about taking their medication correctly. It’s about cutting waste where possible and cutting out problems where we can by empowering patients.”

Like the doctors who glued themselves to a government building in September, Dr Kennet thinks psychiatrists ‘have a role and responsibility’ when it comes to climate change. “We don’t yet have the data on climate anxiety but anecdotaly I can see it, particularly among adolescents. There is a feeling that there is this impending threat. She encourages anyone with ideas, or who wants to know more, to get in touch with the committee. “We are always happy to hear from people. There’s a lot of work to do.”

The Sustainability Committee has produced a ‘Top ten tips for practising psychiatry sustainably’ guide, which is available from www.rcpsych.ac.uk/improving-care/working-sustainably.

To join the Sustainability Committee, please email Lesley Cawthra: lesley.cawthra@rcpsych.ac.uk

Dr Katherine Kennet, sustainability scholar

An existential crisis

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When mum or dad is mentally ill

How adult psychiatrists can do more to help the ‘hidden’ children caring for a parent with mental health issues.

They are hidden in plain sight - the children living with, and often caring for, a parent with mental illness. And there are as many as 3.8 million of them in the UK, according to the Children’s Commissioner.

Many struggle in isolation, tasked with household chores and parenting themselves and their siblings, often socialising at school as a child of a patient, who may be newly diagnosed with a mental illness, or a mum or dad with a mental illness whose symptoms they don’t comprehend.

But in the absence of proper mental health provision or practice, these youngsters aged five to 17 receive little or no support. Yet without intervention, they are at high risk of developing mental illnesses themselves in later life.

So what measures are being taken to help these young people and stop the intergenerational cycle of poor mental health in families? And more importantly, what more can be done by the psychiatry profession?

RCPsych Fellow Dr Roswitha Dharampal recently carried out a literature review into parental mental illness and its impact on their young carers. What she found was that these children are being overlooked by professionals due to a lack of awareness, resources and time.

“Parents and young carers are often separated from each other, and may be seen as being at high risk of developing mental health problems due to the stigma still surrounding mental health. Some parents and young carers are worried about their child’s future plans. There is evidence that he or she will have the greatest impact on a young person’s physical and mental health, it is necessary to have an understanding of the presenting problems of the child and their family. It is necessary to have knowledge about their parent’s condition and also help to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported.”

Because of the pressures on time and resources in psychiatry, often in the initial assessment, there is only interest in the child’s condition. The child needs to be empowered with knowledge about their parent’s condition and also helped to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported.”

“Children of parents with a mental illness, or COPMIs as this group is referred to in Norway and Australia where they receive government support, aren’t just at risk of mental illness. A recently published review of evidence relating to low- to middle-income countries found that children of parents with a mental disorder also have physical health disadvantages. A UK survey further suggests that a higher proportion of young carers have special educational needs or a disability; are from Black, Asian or minority ethnic communities; and do not speak English as their first language.”

Primary mental illness is acknowledged as one of the ten adverse childhood experiences considered to have the greatest impact on a young person’s physical and mental health, it is necessary to have an understanding of the presenting problems of the child and their family. It is necessary to have knowledge about their parent’s condition and also help to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported.”

While parental mental illness is acknowledged as one of the ten adverse childhood experiences considered to have the greatest impact on a young person’s physical and mental health, it is necessary to have an understanding of the presenting problems of the child and their family. It is necessary to have knowledge about their parent’s condition and also help to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported.”

Some parents and young carers are worried that they may be separated from each other, and some parents may hide the fact they have children due to the stigma still surrounding mental health. Naturally, there are safeguarding concerns for patients with postnatal depression or psychosis. But for less serious, more common conditions such as depression, children may still need professional contact without being at serious risk themselves.”

One charity, Our Time, is helping COPMIs with its pioneering parent-child workshop and school welfare programmes. It is currently supporting 250 children and young people and around 180 families at its Kids Time workshops where families can meet once a month in a safe space to share their experiences and learn how to communicate about mental illness through art and drama.

Our Time also runs “Who Cares?”, an informal intervention-based programme held in primary and secondary schools in which the average classroom has eight children with a parent experiencing mental illness. Teaching staff are given guidance to identify affected pupils and offer practical help, as well as to promote a culture shift to encourage greater sensitivity and understanding among all students.

The charity is calling for the children to be officially recognised as ‘at risk’ and the implementation of a national strategy with specialist teams to properly advise local authorities. They also want to see clinicians change the way they think, and move towards an approach which supports the whole family. This includes putting pressure on local authorities to get involved.

Our Time’s communications lead Christina Clarke explains: “At the moment, the children aren’t being picked up by adult psychiatrists. And while we offer the services we do, unless there is government policy to provide these children with support, nothing will change.”

“With intervention, their risk of developing mental illness is halved and the change we see in children using our workshops is phenomenal. It’s as simple as listening and talking.”

Clarke stresses the need for psychiatrists to think about the family as a whole and see that the child gets support, through CAMHS or other appropriate services.

“It’s about ensuring there is a clear and direct pathway to getting help. And when psychiatrists are asking those questions, they’re flagging to the local authorities that the provision to support these children doesn’t exist and they need to put a plan in place,” she says.

How professionals can work more closely together to support parents and children was one of the areas discussed at a major conference at the Royal Society of Medicine this December where speakers included RCPsych Hon Fellow Professor Sir Michael Marmot. Its main focus was the effects of parental mental illness on a child’s brain development, cognitive function, and emotional and relationship development.

“Charities and groups like Our Time play an invaluable role,” says Dr Dharampal. “But adult psychiatrists can do more to ‘think family’. We all want the best for our families and by getting the children involved we help prevent a generation from repeating the same unhelpful mental health patterns.”

“The child needs to be empowered with knowledge about their parent’s condition and also helped to become more resilient to cope. There is evidence that he or she could derive benefits from their caring role, when appropriately supported.”

“The first thing to do is to establish if a patient has kids and then initiate contact with the child or children involved.”

Some parents and young carers are worried that they may be separated from each other, and some parents may hide the fact they have children due to the stigma still surrounding mental health.
Dr Simon Bradstreet is well aware of the prevailing narratives about digital technology in mental healthcare. The lecturer in digital health interventions at the University of Glasgow says they tend to go one of two ways. Either they glorify digital mental health intervention, depicting it as a universal remedy, or they dismiss its value, claiming its suitability only applies to young, tech-savvy people with straightforward needs. Dr Bradstreet contends the reality lies somewhere in between, and it's an argument reinforced through the EMPOWER trial that he manages.

The trial has created an app enabling people with previous experience of psychosis to monitor their wellbeing. They answer a series of questions, with an algorithm identifying if those answers indicate a downturn and a possible risk of relapse, alerting healthcare professionals or peer support workers as appropriate. That algorithm was the first digital mental health intervention to be regulated as a medical device by the Medicines and Healthcare products Regulatory Agency (MHRA). In a trial, the app was used even more widely than anticipated, including by non-millennials with complex needs, contrary to predictions in focus groups run at the outset.

But perhaps what really sets the app apart is a dedication to developing a nuanced view of its impact. “When you scratch the surface, people have all sorts of reactions to self-monitoring and using digital interventions,” reports Dr Bradstreet. EMPOWER has its roots in a 2014 call from the UK’s National Institute for Health Research and Australia’s National Health and Medical Research Council. The bodies wanted to commission a study into detecting and responding to early warning signs of relapse in schizophrenia. That appeal immediately caught the eye of Andrew Gumley, professor of psychological therapy and Dr Bradstreet’s colleague at the University of Glasgow. He was particularly interested in creating an intervention for those with prior experience of psychosis, in which he says fear of relapse often prevents them from seeking help early. The notion of using a digital tool came early on. But, crucially, it was never seen as a solution in and of itself. “We wanted to design a system to enable not just the person to monitor their wellbeing but mental health staff to be able to respond in a timely way,” explains Professor Gumley, who is chief investigator for EMPOWER.

There was also a strong desire to understand when the system wasn’t working for someone. That – and the MHRA regulation – meant a robust approach to adverse events perhaps not typically characteristic of such work. “What we found was there was a reasonable number of adverse events once you looked for them,” explains Dr Bradstreet. Discovering, for instance, that a user felt an anxiety-provoking pressure to answer questions immediately led the researchers to adapt the intervention to fit individual need.

“That’s why I think monitoring adverse effects of digital interventions is a really useful thing for the wider field to be doing,” says Dr Bradstreet. “Because it’s improved our practices and it would improve a future intervention. Digital tools can have different effects for different people – not surprisingly.”