RCPsych
INSIGHT

Well Huw, you join me back at the election that really matters!
First in Europe

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 Chinneze Ivenso, 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.

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 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 email, 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.

Find out more about efforts by the College to improve psychiatrists’ wellbeing at work on page 12.

Improving isles

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Ending 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.

C are 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 immense pressure and stress.

“People have got sicker or have attempted suicide while waiting for a hospital bed”

...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 2022/23 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. She says, “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. This crisis is 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

To send us your Insights email magazine@rcpsych.ac.uk or tweet using #RCPsychInsight
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 “learned 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 on, while a consultant at the Royal Free, she succeeded in getting medical student teaching time in child psychiatry. Black’s journey to becoming a leading authority on child bereavement, particularly in cases where one parent has killed the other, charts another moment of the future of psychiatry, both viewing advances in neuroscience and psychological treatments as “very important” to our understanding of mental illness and the development of treatments. It is thanks to efforts by them and others that psychiatry has already come so far.

“Doctor knows best” doesn’t wash now,” he says. “People rightly question much more.” He celebrates the fact that the profession is “much, much more open today.”

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In 1956, at the age of 24 and newly graduated, Dr Dora Black found herself in charge of 500 chronic patients in Napsbury Hospital on the edge of London. Despite the daunting challenge of daily rounds, she describes life at the mental health facility as “very comfortable”. We had a fine time, she recalls. “We lived in a communal house with staff and were very well looked after. We even had a croquet lawn.” For the many, mainly sedated patients, she adds, the institution was home where some would spend time tending the gardens. “They weren’t unhappy,” she says, “but treatment was very limited.”

“The old mental hospitals did offer real asylum for many very vulnerable people,” agrees Dr John Bradley, who was medical director of Friern Hospital, another of outer London’s institutions. Dr Bradley recounts the limitations of the treatments and practices that he was exposed to in his early career. “When I qualified in 1953, padded cells were still in use,” he says. He remembers too the ‘camisole de force’, or straight-jacket, from a brief spell working in Paris. As a young psychiatrist in the RAF, he was also put in charge of a deep insulin unit “the theoretical basis of which has always remained a mystery to me,” he quips.

Both agree that the arrival of neuroleptic drugs in the mid-1950s was a transformative moment in psychiatry. Dr Bradley’s 60-year career as a psychiatrist has taken him to Zurich – where he heard an 82-year-old Carl Jung present a paper on schizophrenia – to Paris and New York, where he worked alongside a pioneer in the use of antidepressants. Back in London, he worked for a period under Dr William Sargant and “learnt a great deal about various forms of physical treatment, many of which I later rejected as a consultant”.

His interest in medical negligence led to a long association with the Medical Protection Society, including as chairman of council. “ ‘Doctor knows best’ doesn’t wash now,” he says. “People rightly question much more.” He celebrates the fact that the profession is “much, much more open today.”

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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 to have 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.”

So, what does this look like in practice? One area of the UK that has blazed a trail in working with schools to improve mental health provision for children is Oxfordshire. Consultant child and adolescent psychiatrist 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 lead on schools, professor Tamsin Ford welcomes the new support teams. “We know that only one in four of the children with clinically impairing difficulties are seen by the current mental health provision,” she says, “and for each of these children there are probably several others who are struggling, if not so severely affected. This makes the provision of additional staff to work closely with schools to support these children, as well as the teaching staff who are working with them, unquestionably essential.”

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.

Children taking part in the Mentally Healthy Schools pilot study in Greater Manchester

Dr Mina Fazel

Professor Sandeep Ranote

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Class 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.

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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.

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 in 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”.

“Interviewing some of the parents and interviewing the service users, and people from BAME communities… seeing their experience and how their experience was different from those who are white,” she says. “I am wary of people who engage with the services and they are coming from a certain perspective.”

Research matters
Research by Black academics is playing a crucial role in this shift to services that are more responsive to BAME communities. Leading the way are projects like the Colour of Madness (CoM) 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. Research by Black academics is playing a crucial role in this shift to services that are more responsive to BAME communities.

Keisha York, a recent graduate of King’s College London in Organisational Psychology, agrees. Last year she founded BAME in Psychiatry & Psychology, a network of individuals of diverse ethnic background to pursue research interests. Keisha York, a recent graduate of King’s College London in Organisational Psychology, agrees. Last year she founded BAME in Psychiatry & Psychology, a network of individuals of diverse ethnic background to pursue research interests.

No more deaths.

Breaking barriers

Based on Eurocentric ideas and philosophies,” she adds, “not African, Caribbean, Asian or other minority ethnic insights or ideas. And what can we get to recovery when you are not dealing with our issues?” she adds. 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 dialogues 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.”

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Research by Black academics is playing a crucial role in this shift to services that are more responsive to BAME communities. Leading the way are projects like the Colour of Madness (CoM) 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. Research by Black academics is playing a crucial role in this shift to services that are more responsive to BAME communities.

Keisha York, a recent graduate of King’s College London in Organisational Psychology, agrees. Last year she founded BAME in Psychiatry & Psychology, a network of individuals of diverse ethnic background to pursue research interests. Keisha York, a recent graduate of King’s College London in Organisational Psychology, agrees. Last year she founded BAME in Psychiatry & Psychology, a network of individuals of diverse ethnic background to pursue research interests.
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.

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<th>The College recognises it needs to do more on a practical level</th>
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Change happens on the ground.

“**The College recognises it needs to do more on a practical level**”

Dr. Mihaela Bucur, associate registrar for wellbeing and retention

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

**Navigating change**

**Dr. Mihaela Bucur**

The College has created a wellbeing strategy to make sure that practical, meaningful changes are happening on the ground. Responsibility for the work lies with the 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 rcpsych.ac.uk, with useful tips and links for psychiatrists. To contact the PSS, call 020 72245 0412 or email pss@rcpsych.ac.uk

**The College recognises it needs to do more on a practical level**

Heavy caseloads and endless paperwork; a manager who’s unsupportive or worse; less and less time for contact with peers or career development. These are the most common scenarios described by psychiatrists struggling to cope with ever-increasing challenges. The result can be exhaustion, low morale, feeling undervalued, and ultimately compassion fatigue and burnout. Beyond the personal cost, the implications for the profession are significant. This is why RCPsych recently renewed its commitment to workforce wellbeing. Alongside its crucial work to influence policy and improve working conditions, the College has created a wellbeing strategy to make sure that practical, meaningful changes happen on the ground.

**The College recognises it needs to do more on a practical level**

**How are you, doctor?**

Dr. Mihaela Bucur, associate registrar for wellbeing and retention

**College Feature**

RCPsych Insight

**Navigating change**

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

**The Emerald research programme**

In every country around the world, people with mental disorders are failing to get the treatment they need. Governments and others, driven to improve mental health systems, need strong evidence about how to provide effective treatments, and how to deliver these treatments within robust health systems. The Emerald research programme – standing for ‘emerging mental health systems in low- and middle-income countries’ – has contributed enormously to how this can best be achieved. The academic project, which has produced some 35 papers to date, has supported doctoral students in three continents and developed teaching resources to build capacity. It has explored how best to finance mental health systems, how to integrate mental health into mainstream services, and the use of indicators to measure performance. The papers can be read at https://www.cambridge.org/core/journals/bjpsych-open/emerald-series

**The Emerald research programme**

**How are you, doctor?**

Dr. Mihaela Bucur, associate registrar for wellbeing and retention

**College Feature**

RCPsych Insight
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 RCPsych’s 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 – can be highly effective for older people, she says. Fewer than one in five people aged over 60 have received counselling following a death even though NHS guidance states that “older people, especially those with depression, are as likely to benefit from talking therapies as everyone else”. In fact, recovery rates for those who have been through the Improving Access to Psychological Therapies (IAPT) programme are often better for people aged 65 and over than those who are younger. “It is essential that we ensure that ageism does not prevent older people from accessing the services they need,” says Dr Thompsell. Social prescribing is another important strategy for tackling loneliness. But not all provision is suitable for older people, and appropriate consideration must be made of an older person’s mobility or ability to handle large group-based activities, in addition to their personal preferences and demographic. Anecdotally, programmes that promote the feeling of making a difference to others seem to have the most impact. The Downshall intergenerational project in Ilford, for example, sees older people visiting a primary school and helping the children with their reading and other activities.

Increased prioritisation of loneliness is included in the NHS Long-Term Plan, which Dr Thompsell welcomes, but she and the Old Age Faculty are concerned about the provision and continuity of services. The Plan aims to put 1,000 social prescribing link workers in place by the end of 2020/21. But many social prescribing and befriending schemes are in the hands of small local charities. “Sometimes, these services close after only a matter of months,” says Dr Thompsell. “By the time you’ve printed out the leaflets, they’re already out of date.” Continuity of services and the ability to plan are fundamental. “Psychiatrists have a role in advocating for these wherever they can and explaining to local commissioning groups that short-termism for loneliness services simply isn’t helpful,” says Dr Thompsell. Psychiatrists can also play a part in prevention by promoting awareness of the needs of older people who are experiencing, or are at risk of, mental and physical health problems. Although the impact of loneliness on mental and physical health is gaining increased political and media attention, it is yet to be embedded in many everyday healthcare considerations, and more broadly in the culture. Psychiatrists can help just by having a conversation with their multidisciplinary and multispeciality colleagues, as well as with medical students and trainees.

“Arming ourselves with the facts on loneliness, keeping up to date with what services are available locally, and building and maintaining strong relationships with providers is some of the best ways we can contribute,” says Dr Thompsell. “Of course, not everyone who is lonely needs 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.”

RCPsych’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.
Life after truth

Do we live in a post-truth world, where beliefs matter more than facts? And what does that mean for our mental health?

In 2016, the year of the Brexit referendum and Donald Trump’s election as US president, Oxford Dictionaries declared that its word of the year was ‘post-truth’, defining it as “relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to promotion and personal belief”.

In September, the RCPsych Philosophy Special Interest Group’s biennial conference discussed the impact on mental health of ‘post-truth’ and its comrades-in-arms, ‘fake news’ and ‘alternative facts’, with presentations from comrades-in-arms, ‘fake news’ and mental health of ‘post-truth’ and its Special Interest Group’s biennial in September, the RCPsych Philosophy in shaping public opinion than appeals to emotion and personal belief”.

Professor Bolton characterises the ‘post-truth’ world as one where social consensus is breaking down. “There’s a problem with defining truth merely as correspondence with the facts,” he says, “because the facts can be as contested as the truth. They stand and fall together.” Truth requires agreement, he argues; there has to be some kind of shared understanding if truth is to hold. But such understandings and truths that we once may have held in common are fracturing. Bolton points to a multitude of causes, including the decline in respect for authority, the rise of populism, growing economic inequality across classes and generations, the destabilising effects of globalisation and worries about the impact of climate change. And any resultant anxieties are, he says, “amplified by social media and the internet, where everybody has an opinion and some people very quickly get thousands or millions of followers, and off we go.”

“There’s a loss of coherence as to what might be considered real, what might be considered true,” says Dr Shepherd. “I would argue that a large portion of what might be called healthy psychological function is devoted to maintaining a positive sense of who we are in the world. But the symbols that we use to represent that identity are becoming diffuse, shifting in their meaning. Does a Facebook friend, for example, hold the same psychic significance to you as a friend that you meet on a weekly basis?

“As the things that we’ve always believed seem to be falling down, there is a growing uncertainty around that construct of who we are. And that opens up anxiety, which then leads to complications in terms of mental health.”

How bad have things become, then?

“There’s no doubt whatsoever that there’s been a big increase in demand for child and adolescent mental health services,” says Professor Bolton. However, allowing for factors such as earlier and better diagnosis, the underlying increase in the prevalence of mental illness may prove to be relatively modest. In any case, he says, “these may be anxious times but they’re not the worst of times. ‘I don’t have any view of a golden age nor that this trouble and strife is, in some way, new or worse.” Ask anyone who has lived through a war or under a totalitarian regime about ‘post-truth’, he says, and you’d get a very different perspective.

For more information on the Philosophy Special Interest Group and its events, search ‘Philosophy’ on www.rcpsych.ac.uk.

An existential crisis

Dr Katherine Kennet, a member of the College’s Sustainability Committee, talks about the role psychiatrists can play in creating a fairer, greener world.

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, upped the ante, calling on health professionals to “engage with 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 we can 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 “systematically”. 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 lobbied 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 anecdotal 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.
When mum or dad is mentally ill

Dr Roswitha Dharampal urges adult psychiatrists to ‘think family’

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 parent’s treatment plan,” she says.

Such isolation can mean 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.

Youth carers are at an increased risk of having emotional and mental health needs, which could be mitigated by professionals recognising the young carer’s role and including them in their parent’s treatment plan,” she says.

Dr Dharampal is one of a growing number of voices urging adult psychiatrists to ‘think family’ when treating a parent who is unwell.

“These children need the recognition of adult psychiatrists,” says Dr Dharampal, whose study is due to be published in BJ Psych Bulletin.

“A child of a parent with mental illness is often going to be involved in their care, helping with medication, looking after the home and possibly other siblings. Not only can this impact their academic achievement for which they may lack parental support, but their school may not even be aware. This all places a great toll on the child. It can also lead to attachment and relationship problems as well as substance misuse, if their parent is misusing substances.”

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. 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 rarely present in mental health policy and practice for children and young people.

“These children don’t necessarily need to be referred to CAMHS,” says Dr Dharampal. “But they do need the recognition of the adult psychiatrists treating their parent who should be making sure they are included in contact and future plans.

“If the parent is admitted, their psychiatrist should be making direct contact with the child and explaining their parent’s condition, as well as alerting the child’s school.”

“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.”

Because of the pressures on time and resources in psychiatry, often in the initial assessment, there is only interest in the patient, says Dr Dharampal.

“The first thing to do is to establish if a child 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 kids 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.

“Wit 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.”
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.”