

Issue 11
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RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

RCPsych INSIGHT

INTERNATIONAL WOMEN'S DAY



THE SUMMER
A Long Climb Yet

Contents

4-5

New House

Amplifying the College's voice in Parliament

6-7

Female psych

Reflections on equality to mark International Women's Day

8-9

An end to 'us' and 'them'

The College's commitment to co-production

10

The importance of being audited

RCPsych's award-winning clinical audits

11

Wellcome investment

Funding our understanding of anxiety and depression in young people

12-13

Meet your next President

Dr Adrian James outlines his plans and why he feels optimistic

14-15

Lessons from America

How we can better prevent suicide among doctors

16

Mental health and #MeToo

Consequences of the movement against sexual harassment

17

Leading nations

The new College chairs for Wales and Northern Ireland anticipate what lies ahead

18-19

Sight unseen

The far-reaching psychological implications of vision loss

20

Family matters

A ground-breaking talking therapy programme

COLLEGE NEWS IN BRIEF

Registrar election



Dr Peter Aitken



Professor Al-Uzri



Dr Raj Mohan



Dr Gertrude Seneviratne

With Dr Adrian James elected to take over from Professor Wendy Burn as President of the College in July, the race is now on to appoint a successor to his current post of College Registrar. Four candidates are standing: Dr Peter Aitken, Professor Mohammed Al-Uzri, Dr Raj Mohan and Dr Gertrude Seneviratne OBE. The Registrar is responsible for the College's work on policy, campaigns and communications, as well as member engagement. As such, the post-holder is responsible for influencing politicians and giving many of the College's national media interviews. Written statements by the candidates outlining

their qualifications and vision for the post can be viewed on RCPsych's website (<http://bit.ly/RegistrarElection>). All members, fellows and specialist associates are eligible to vote and an email with a link to the ballot will be sent to your email registered with the College. Voting opens on 23 March and closes on 20 April 2020.

We asked Dr James if he had any advice for his successor (the full interview with him is on pages 12-13). "Enjoy it and get stuck in," he says. "Think every day what an amazing opportunity it is and how to really do something with the job."

Setting the agenda

Media coverage of mental health issues generated by the College broke all records in January. RCPsych's call for social media companies to hand over their data to researchers – to allow a proper assessment of the impact of social media usage on children – attracted astonishing levels of media attention in the new year. The report by the College's Child and Adolescent Faculty also called for a tax on tech giants to fund research into how young people are interacting with social media. Faculty chair Dr Bernadka Dubicka told broadcasters – including the BBC's *Today* programme, ITV's *Good Morning Britain* and *Sky News* – that government needed to "step-up and take decisive action to hold social media companies to account for escalating harmful content to vulnerable children and young people." The College's demands received over 2,500 mentions in the press, reaching an audience of many millions.

College voices on other topics also picked up significant coverage. The BBC's *Victoria Derbyshire* show featured Dr Rex Haigh, consultant psychiatrist in medical

psychotherapy, discussing the diagnosis and treatment of personality disorder, following the College's first-ever position statement on the topic. New data showing the sharp rise in NHS hospital admissions for eating disorders was picked up by all the major broadsheets and tabloids like *The Sun*, and featured Dr Agnes Ayton, chair of the Faculty of Eating Disorders. And new figures showing children being refused mental health care for not being unwell enough were published with comment from RCPsych across regional and national papers, such as *The Guardian*. RCPsych in Scotland chair Dr John Critchon also hit the news in support of his campaign against knife crime. *The Times* and BBC 5 Live featured interviews on the announcement that kitchen knives with a rounded end that cannot be used to stab people were about to go on sale, something Dr Critchon has long called for. Commenting on the College's media reach, RCPsych President Professor Wendy Burn, said: "This is a fantastic result for the College. Our use of media allows us to influence policy in a major way. We truly are 'the voice of psychiatry,' advocating for our patients."



A small selection of just some of the important media coverage generated by the College in January

Accolades abound

RCPsych members continue to have their expertise and efforts recognised. The New Year's Honours list awarded a CBE to Dr Paul Lelliott, founder and former director of the College Centre for Quality Improvement (CCQI), which features on page 10. Outgoing chair of RCPsych in Northern Ireland Dr Gerry Lynch has also just been awarded the accolade of Visiting Professor by Ulster University.

News too that Dr John Mitchell is leaving his post as principal medical officer and psychiatric adviser to the mental health directorate at the Scottish Government has inspired tributes. Professor John Crichton, chair of RCPsych in Scotland, said: "We wish John all the best. He's done a great deal for psychiatry and mental health in Scotland and has been a real friend of the College for many years."



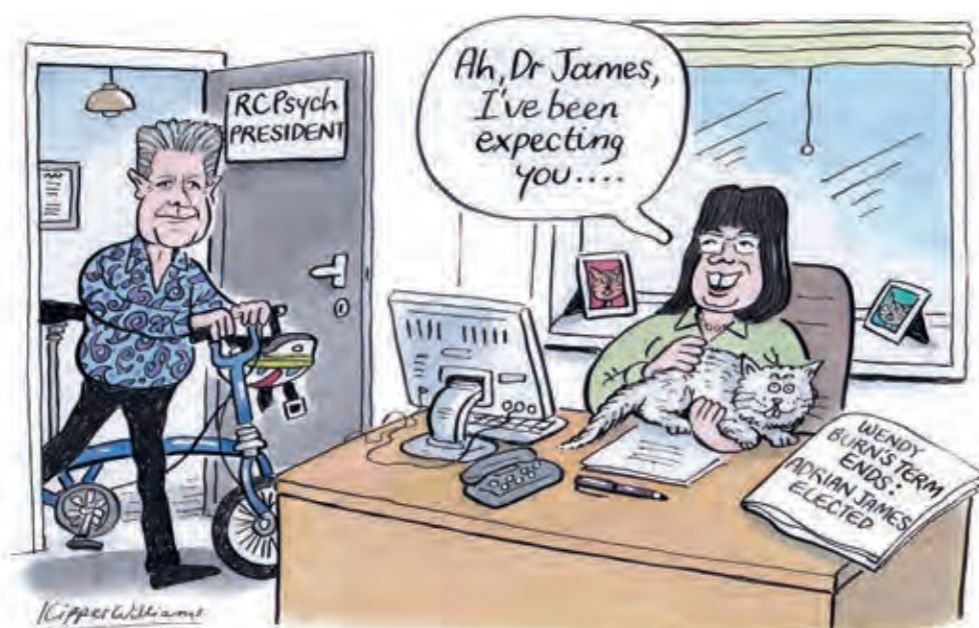
President's update

Welcome to the spring edition of *Insight*. In this issue you can read about Adrian James, who takes over from me at the International Congress in Edinburgh this summer. I'm pleased that he feels he has learnt a lot from me! I hope many of you will be at Congress to see the ceremonial gold chain of office pass from me to him. You can also hear about two new devolved nation chairs, Maria Atkins in Wales and Richard Wilson in Northern Ireland, and their thoughts on the challenges ahead.

We have a very interesting account of Ananta Dave's experience in America. Ananta is a medical director who won a research grant to learn about US strategies for preventing doctors from dying by suicide, and how these might apply in the UK. What she learnt makes important reading.

To mark International Women's Day, Kate Lovett, our Dean, reflects on equality and how things have changed for women. She remembers the generations before us and the struggle that women faced to get to where we are now. So, find a bit of time to relax, look for a patch of spring sunshine to sit in, and enjoy a stimulating read.

Professor Wendy Burn



Keen cyclist Dr Adrian James, interviewed on pages 12-13, was elected the next RCPsych President in January, and will take over from cat-loving Professor Wendy Burn in July

Editors: Gemma Mulreany, Tamasin Cave, Rebecca Couper and Kim Catcheside

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Photography: Grainge Photography, Richard Richards, Emma Phillipson and Alan Richardson

Your Insight



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

Your comments on *Insight* issue 10

Brilliant report in #RCPsychInsight about the psych bed shortages scandal. I cannot help but wonder the outrage that would occur if this was happening across medical or surgical wards. It just wouldn't be allowed.

@Chrisha_Jay via twitter

The article on bed shortages is alarming. Successive governments have promised more for mental health services but each time this has been frustrated, leading to a net reduction of over 30%. A serious increase in community services is needed, supported by an increase in beds.

Dr Mike Harris FRCPsych

The research done by Dr Roswitha Dharampal ('When mum or dad is mentally ill') is hugely important for the success of mental health care. I have personally seen examples of children, as young as 8 years old, walking alone to school, trying to buy groceries with insufficient money, and arriving late to school. This is the need of the hour.

Dr Sadaf Asif

I enjoyed your feature 'Leading the way'. My own career started in a large Scottish mental hospital in 1952 and as pointed out, there were good and bad things about those institutions. National service was also in force and in 1953 I found myself in Korea, on my own, as psychiatrist to the Commonwealth division. The '50s also saw the beginnings of child psychiatry but, even when clinics were being set up, none of us had met a trained child psychiatrist. We read about autism using an American textbook. In the '60s and '70s, treatment began to shift to the family as a whole, a movement that Dr Dora Black contributed to significantly.

Dr Leslie Bartlet FRCPsych



Dr Ben Spencer MP with RCPsych public affairs manager Jonathan Blay

New House

As RCPsych embarks on an ambitious programme of lobbying for better mental health services, psychiatrist MPs Dr Dan Poulter and the newly elected Dr Ben Spencer explain how members can amplify the College's voice in Parliament.

When we sit down with Jonathan Blay, public affairs manager at the College, he has just come from the House of Commons. He has been meeting with MPs who he hopes will become new RCPsych allies. "In December's election, we lost a lot of good MPs who we had worked with for a number of years, like Norman Lamb and Luciana Berger, which poses a challenge." But Blay is optimistic. "One big positive of the election was seeing politicians compete not just over the NHS but also over tackling mental illness." Someone who has immediately stepped up is new MP Dr Ben Spencer, who won the Surrey

"I don't think members realise how influential they can be"

seat of Runnymede and Weybridge for the Conservatives. Dr Spencer, a consultant liaison psychiatrist, has just become the new vice chair of the All-Party Parliamentary Group (APPG) on Mental Health, which the College provides support for with Rethink Mental Health. With Dr Dan Poulter, fellow psychiatrist and Conservative MP

since 2010, he brings valuable insight and experience to where it matters: Parliament.

For Dr Spencer, attention must be directed at helping people with the most severe illness and those living with psychosis in general. "We need to refocus the debate away from general mental wellbeing to the care and treatment of mental illness and disorder," he says, adding that he feels that the two areas are often wrongly conflated in public debate.

Dr Poulter agrees: "Undoubtedly, awareness of mental health issues is now much greater, which makes the case for additional funding easier to argue," he says. "However, there



Dr Dan Poulter MP

is sometimes a disconnect between the public perception and our professional experience as psychiatrists, working in secondary care services, looking after patients with chronic and enduring poor mental health." He is concerned that this lack of understanding extends to some MPs too.

This is where College members can have real impact as advocates and educators, says Dr Poulter. "I would urge all psychiatrists to ask to see their MPs at a constituency surgery to talk about the challenges and opportunities in local mental health services," he says, adding that political engagement by psychiatrists "can be very effective".

Blay strongly agrees: "I don't think members realise how influential they can be. Politicians are much more interested in hearing from psychiatrists with real insight into what is happening in their constituency," he says. To make this easier, RCPsych has launched a new way for members to lobby MPs and support its campaigns for better mental health services.

Nearly 700 members subsequently contacted their MP, lobbying for changes to the NHS Finance Bill, which RCPsych identified as a way to push the government to put into law its announced increases of at least £2.3bn a year for mental health by 2023/4. "We saw it as an opportunity for them to make legal their commitment to increase funding until mental health reaches parity with physical health," says Blay.

For Dr Poulter, the extra funding must reach the frontline of care, particularly increased investment in community mental health services, which he says, "have been hollowed out due to chronic under-investment". Additional money and support also need to reach mental health trusts, he believes, "to better recruit and retain staff".

The College is also lobbying for government to follow through on its commitment to implement the recommendations of the Mental Health Act Review, led by former RCPsych President Sir Simon Wessely. This would see "real changes on the ground," says Blay. "We want increased capital spending on infrastructure, but in the right places," he says, citing the upgrading of mental health trusts so that, for example, patients are offered private rooms, and appropriate assessment spaces are created in accident and emergency departments.

Add in workforce issues, including a need to double the number of medical school places, and it is obvious why the College

is seeking allies in Parliament. The College still has influential advocates in the House of Lords, including psychiatrists Baroness Hollins and Lord Alderdice. "Peers have been great in keeping mental health high up on the political agenda," says Blay.

To build support in Parliament, the College is introducing politicians to its Mental Health Watch website, where they can find out what services are like in their constituencies and then use that information to hold local leaders and the government to account. And later this year, the APPG will poll MPs to find out more about the mental health issues that constituents raise with them in their surgeries. RCPsych will then work with MPs on how what they see locally can inform national policy. Members' voices are key, however, says Dr Poulter, especially in "helping to ensure that all MPs are in a better place to understand the issues that face our colleagues and the patients that we care for at a local level." Blay puts it rather more bluntly: "Money will always be tight and if we don't shout, we lose out."

To keep up to date with our political news, sign up to the College's Political Week newsletter by emailing jonathan.blay@rcpsych.ac.uk

Meet psychiatrist Dr Ben Spencer MP

What are your priorities as an MP?

"Right now, it is learning to be a good MP and represent my constituents as best I can. For me, it's all about equality of opportunity, but we also need a safety net of strong public services if things go wrong."

What led you to politics?

"Many mental disorders are highly associated with socio-economic deprivation. As a psychiatrist, I've seen lots of people for whom social interventions and advocacy have been the drivers of wellbeing. I believe influencing national policy is the best way to drive socio-economic change."

How can the profession make sure it is heard?

"Working with charities and liaising with politicians at all levels is very important. It allows us to hear directly from people working on the front line as to where change and improvements are needed."



Dr Kate Lovett, Dean of RCPsych

Female psych

Reflections on equality, by RCPsych Dean Dr Kate Lovett, to mark International Women's Day 2020.

As the first woman on both sides of my family to have the opportunity to go to university, as well as being only the third female Dean of RCPsych, this year's theme of International Women's Day – 'I am generation equality: realising women's rights' – certainly resonates. It's heart-breaking knowing the struggles of some of my female

forebears and the opportunities denied to them because of their gender. And as a child growing up in '70s and '80s Britain, the frustration and thwarted ambition of my generation's mothers is indelibly marked in my memory. None before mine came anywhere near being able to call itself 'generation equality'. Indeed, until I was eight years old, it remained legal to

discriminate against women on the grounds of gender. Does my generation, though, get to call itself 'generation equality'? We may have had equal franchise with men for the best part of a century, and gender discrimination has been illegal for nearly half that, yet we know women remain under-represented in senior positions in the workplace. This is even the case within RCPsych

– whose explicit values include respect, of which equality and diversity are fundamental. Among our current officer team, 50% are female, but only one of our eight divisional chairs is a woman despite the fact our membership is now 45% female.

It's no secret that I needed considerable encouragement to stand as Dean (including a threat of divorce – if I didn't do it – from my husband of almost 30 years). It's a decision I have never regretted, and I have achieved things I'd not previously imagined possible. I find it distressing to think of all the potential in the health service that's unfulfilled. The beliefs we develop about

ourselves are established early in life, including about our abilities and whether or not they are fixed or have the potential to develop. It appears that girls are more likely, through social conditioning, to develop fixed ideas about potential. While giving an educational advantage initially, our self-beliefs hold us back later in life. Understanding this is the first step to understanding the limits and expectations we place on ourselves. I think it's important for those of us in senior roles to discuss this explicitly with those coming up behind us. We need more mentoring, combined with effective educational support, to help each other move into our 'stretch zone'. The two most common questions when I became Dean were depressingly about my sartorial choices and 'How is your husband coping?' I have it on good authority that neither of these came up for my fellow male officers.

As Dean, though, I have also been afforded the most extraordinary opportunities to travel widely and meet members throughout the UK and internationally. And often what people want to ask in private conversation, on brief journeys or over coffee, is not about latest policy or research but about how I 'manage'. These conversations are important. Last year I was privileged to visit China and, as is often the case, behind the scenes I was asked lots of questions by women keen to know about my life and about how I juggled my various professional and family commitments. I talked about family support, encouragement from others, and training and working in the early years part time. Intrigued, my colleagues enquired how I had managed to work part time. "I chose," I said. "You chose?" was their incredulous reply. Ever since, when I reflect on the rights and experiences of women throughout the world, these two

words have troubled me: "I chose". Like you, I meet women every day in my clinical practice who had no choice and therefore continue to have limited options in life. For many women in 2020, factors like class, race, sexuality and disability mean that we cannot claim to be 'generation equality'. For the one in five people working in the NHS from a Black, Asian and minority ethnic (BAME) background, for instance, we still have a long way to go. On 8 March (International Women's Day), I celebrated the opportunities that some of my generation have had based on the struggles of the generations who came before us. I celebrated the fact that I personally have been able to make many positive choices and am at the vanguard of 'generation equality'. But in celebrating, I also reflected soberly on how few of my gender throughout the world are able to look back and say: "I chose".

International Women's Day

- 1909: first conceived by the Socialist Party of America
- 1917: became a national holiday in Russia following protests and strikes by women
- Late 1960s: adopted by the feminist movement
- 1975: officially taken up by the United Nations and marked around the world with many countries adopting it as a public holiday. It has since been used as an occasion to celebrate achievements of women, as well as being an annual call to action to accelerate women's equality.



Simon Rose (right), lived experience educator

An end to 'us' and 'them'

Newly appointed patient and carer representatives to RCPsych's governing council make real the College's commitment to co-production.

She's looking forward to getting stuck in and hopes to see "more people who've got a diversity of experience and understanding weaving right through the College". Simon Rose is employed by Derbyshire Healthcare NHS Foundation Trust, working with undergraduate medical students at the universities of Sheffield and Nottingham while they're on their psychiatry placement. "My job is specifically to support students to access the knowledge that comes from the experience of mental ill-health," he says. To that end, he works alongside a group

of some 50 people who have, in his words, "personally experienced mental illness or distress relating to the care of somebody with mental illness". Some members of the group currently access services, several as in-patients. "We don't stop people coming in when they're actively unwell," says Simon, "because the students need to see people as they are." But, he adds, "one of the things that we're really good at is providing a level of pastoral support to people that are involved with the programme and we have links to their care teams". Despite this level of involvement, Simon

doesn't view his work as true co-production. "In its purest form, co-production involves a sharing of power," he says. "But the funding for what we do is provided by universities, so there is a power imbalance. We certainly collaborate, though, and work towards co-production, which brings clear benefits." Simon is excited by his new role at the heart of the College's deliberations, putting across the patient perspective from both a professional and personal point of view. "One of the criteria of the job was that we have lived experience of mental ill-health ourselves," he says, "and I've certainly been around the block." He also doesn't intend to hold back. "I think it's important that the College hears from people who haven't had the best experience with psychiatry, as well as people that think that it's been eminently helpful." Co-production has been made more meaningful at the College through a robust recruitment process for these patient and carer representatives, as well as improved role recognition and better remuneration, says Dr Tony Rao, RCPsych's lead clinician for patient and carer involvement. "It is essential that our patient and carer representatives hold the College to account to achieve common goals," he says. "Only by so doing can we then create a true vision of co-production."

Representing views of carers where it matters

Rachel Bannister, a part-time primary school teacher, set up the campaign group *Mental Health – Time for Action* in 2018 after battling for several years on behalf of her teenage daughter. She found herself increasingly frustrated by the lack of proper funding for mental health services. There were no suitable placements locally for her severely ill daughter and she went from pillar to post, ending up in a hospital 300 miles from home. It was only when Rachel turned to the media, giving press and TV interviews, that things began to change. Her daughter is now, after years of fractured and often inadequate care, well on the road to recovery. But it took its toll, and not just on Rachel's daughter. "I didn't think for a minute of the effect it all would have

on the wider family," she says. "My middle daughter was diagnosed with PTSD and I ended up addicted to benzodiazepines because taking them became my coping mechanism." *Mental Health – Time for Action* campaigns for fully funded mental health services. The organisation has held two annual conferences, attracting some high-profile speakers, including film-maker Ken Loach and the shadow health secretary, Jon Ashworth. "There's nothing special about me at all," says Rachel, modestly. "I'm just a completely ordinary person. But now, after years of feeling voiceless, I'm being listened to. And I intend to make the most of it."

mentalhealthtimeforaction.org



Rachel Bannister, mental health campaigner



Mary Dang (centre), programme manager of NCAAD, with colleagues Natasha Lindsay (left) and Jessica Butler (right)

The importance of being audited

RCPsych's clinical audits have recently won two prestigious national awards. Here's why.

Clinical audits are key drivers of improvement in mental health services. RCPsych is currently leading three national clinical audits, of dementia, psychosis, and anxiety and depression. And central to its work has been a commitment to public and patient involvement and to working closely with NHS trusts. Mary Dang is the College's programme manager for the National Clinical Audit for Anxiety and Depression (NCAAD), which has public and patient involvement at its heart. "We recruited a service user and carer reference group from the outset, to help us make decisions in key stages of the audit," Mary says: "for example, in developing the audit tool. They also contributed to the development of the methodology and suggested recommendations that we then put in our report." It's a way of working that has not gone

unnoticed. Last November, the Healthcare Quality Improvement Partnership (HQIP), which commissions national audits, gave the Richard Driscoll Memorial Award to NCAAD for demonstrating excellence in public and patient involvement. The judges said that the NCAAD "impressed us with their responsiveness and flexibility; they made changes to the involvement structure at the request of the service user and carer reference group and adopted a new co-produced reporting model to increase the accessibility of published reports for lay people." At the same time, HQIP also named Wendy Harlow and Linda Chadburn as joint winners of the National Clinical Audit Professional of the Year award. Harlow, audit lead for Sussex Partnership NHS Foundation Trust, and Chadburn, of Pennine Care NHS Foundation Trust, are both members of the steering groups of NCAAD and the National Clinical Audit of Psychosis (NCAP).

"The consultant psychiatrists at the trust I work in," says Harlow, "felt it would be good to have someone representing doctors working in trusts on the development of national audits, which they have to participate in. They felt there was a separation between what they considered to be important and some of the questions and methodology used by the College.

"I meet with psychiatrists very regularly, and other staff like psychologists and nurses, so I'm able to gauge their views about what is important. I think that my voice is certainly heard, and the College has really taken on board what I have to say."

"Wendy and Linda give us a great insight into how things are running," says Dang, "and how, for example, a report will be taken into a trust or service and what they do with the results. And they give us the viewpoint from the staff who have to conduct the audit about what's feasible and what's not."

Clinical audits can effect important changes. Harlow points to NCAP, "which started to look at how many people mental health trusts were screening for physical health and providing interventions. There's been a huge increase in our trust – and nationally, I think, as well – of people's physical health being addressed, as well as their mental health."

Given their importance, then, it comes as something of a shock to realise that of the 30 national clinical audits commissioned by HQIP, only three are concerned with mental health. The much-vaunted parity between mental and physical health is still a fair way off, despite the critical role audits play in improving services.



Wellcome Trust photography prize winner: *Self-harm: The Teenage Epidemic (Alan)* by Jude Wacks

Wellcome investment

Wellcome's new £200m research fund could transform the way we understand, prevent and treat anxiety and depression in young people.

Professor Miranda Wolpert is on the hunt for a very specific list of ingredients – those that form the recipe for successful interventions in youth anxiety and depression.

Professor Wolpert is head of Wellcome's new mental health priority area, a programme that began in January after the foundation committed £200m over five years for additional mental health research. For Professor Wolpert, it's a monetary and time commitment that feels noteworthy. "Any sort of funding is welcome and this is a big chunk," she says. "Relative to the scale of what needs to be done it's still not a huge amount, but it's fantastic to have." As a result, the fund is tightly focused on the common conditions of anxiety and depression and the 14–24 age range



Professor Miranda Wolpert MBE

"because, if we get in early, we may be able to do something radical," says Professor Wolpert. In many ways, the programme itself feels radical. It will be less concerned with the causes of mental ill-health than with what helps people live with and recover from

these problems – and at a level of detail that is novel.

"Where the focus of previous research has been on interventions, it's tended to be on quite complex interventions evaluated in their entirety. There's been less emphasis on disaggregating those into their component parts and assessing the most granular level of active ingredients," argues Professor Wolpert.

That's not to say that complex interventions won't prove to be needed – "we all suspect they will" – but that there is a need to understand their components. What is most valuable in successful interventions for depression, for instance? Is it challenging underlying negative beliefs or, perhaps, developing more supportive relationships? And if it is relationships, how should researchers describe that ingredient? Do the terms 'social connectedness', 'social relations' and 'positive friendships' mean the same thing to everyone?

"The contention at Wellcome was that mental health science, as currently constituted, has some great people in it but is somewhat fragmented and siloed," explains Professor Wolpert. "So, findings aren't being communicated across communities and there hasn't been as much movement as there might have been in terms of the science developing to create new treatments."

It's hoped the new programme will help address that by creating a mental health science community with a shared language and agreed core metrics. The intention is that this community will extend beyond the Western, industrialised countries that typically dominate research, that it will cross disciplines, and include those with lived experience of mental illness.

The first step this summer is to commission individuals and groups to explore different possible core components, so identifying the most promising areas for future research funding.

No area is out of scope, says Professor Wolpert. "It doesn't mean that we're saying abandon all biomedical interventions. But we are saying we don't yet know enough about what the core components of effective interventions are to say that we should narrow our gaze.

In the end, this programme is relentlessly focused on helping create a world where no-one is held back by their mental health problems," she says. "If we can understand why [problems emerge], fantastic, but the key focus is on what helps people move on."

To find out more about the programme, visit bitly.com/wellcomepriority

Meet your next President

Voted RCPsych's next President, taking on the role in July, Dr Adrian James outlines his plans and why he feels optimistic about the future.

The College's next President, Dr Adrian James, is in an enviable position. Mental health has never been higher on the public's agenda, with strong support for more investment in services. "When the public gets it, the politicians get it," says Dr James. "I am going in positive," he says. "The government is saying that health is their number one issue and I'll be reminding them that spending on mental health services is top of the public's priorities," a position he credits to the steady work of the College and others over many years. "This is a brand-new government and so we need to work with them early on to develop their policies. I need to make sure we get the very best deal we can."

Dr James, who will take over from Professor Wendy Burn at RCPsych's International Congress in July, will be hitting the ground running. As Registrar for the past four years – during which, he says, he "personally learnt a lot from Wendy" – he has led on policy, driven many College campaigns and been a vocal

"I feel optimistic about the future in a way that I never have before"

advocate for issues affecting the profession and patients, including around parity and recruitment. He has also put equity at the top of his presidential agenda. "If we get equity right – all aspects of it – we'll get the rest right," he says. That obviously means parity in funding with physical health; parity in terms of access to treatment – currently only a third of people with mental illness have access to evidence-based treatments, as opposed to 98% with cancer; and tackling the stigma that is still associated with mental illness. "In the same way that campaigns urge people to look for signs of cancer, we need to make sure that people come forward and seek help." At the same time, Dr James – a front-line clinician for 33 years, including as a consultant forensic psychiatrist in the south west

of England – fully understands the current strain in the system. "Clearly, we don't have enough people," he says. He points to the good programmes now in place to attract people into psychiatry, like Choose Psychiatry, which mean that "upstream, we're on a bit of a roll, but the downstream losses, including many trainees, are a tragedy". "We can do an awful lot more," he says to create more supportive workplaces. "It will get better," he asserts, citing the ambitious plans being developed by the College's Workforce Wellbeing Committee as a cause for optimism. Psychiatrists from diverse backgrounds can also

expect more support from Dr James, who recognises the hard work the College has already done but warns "early gains can be lost very quickly and there are lots of people who still find they can't give their best because of the barriers in their way". His commitment to involving patients in the work of the College is also firm. "We need to get over this separation between 'what the users have to say' and 'what the professionals think'. I want us to get past this," he says. "We are all in this together." As a psychiatrist who has experienced mental illness – Dr James has had two periods of depression, the last being successfully treated in 2009 – he is well-placed to be a champion for both

the profession and patients. "I feel optimistic about the future in a way that I never have before," he says. With the public – and potentially politicians – onside, you can start to see why.

Results of the presidential election

Three candidates stood in RCPsych's 2019/20 presidential election: Professor Kam Bhui, Professor Pamela Taylor and Dr Adrian James. Professor Bhui and Dr James went through to the second round, which was won by Dr James with 1619 votes to 1530. The results were announced on 8 January 2020.

In brief: Dr Adrian James

- Dr James is a consultant forensic psychiatrist at Langdon Hospital in Dawlish, Devon, and currently works for Devon Partnership Trust.
- He has been Registrar of RCPsych since 2015 and before that was clinical director for mental health, dementia and neurology, working for NHS England South West.
- Dr James is a keen cyclist (recently tackling the Route des Grandes Alpes), loves a big family gathering, and owns not one but two disco balls!

RCPsych's President-Elect Dr Adrian James





Dr Ananta Dave, medical director at Lincolnshire Partnership NHS Trust

Lessons from **America**

Psychiatrist Dr Ananta Dave travelled to the United States to learn from areas of good practice in preventing suicide among doctors.

There is such an unmet need around doctors' mental health and wellbeing. We are at increased risk of mental health problems and death by suicide, but we are so afraid to speak out and ask for help." This was the conclusion that led Dr Ananta Dave, medical director at Lincolnshire Partnership NHS Foundation Trust, to travel across America last summer

"There are all these doctors suffering and we're losing them needlessly"



in search of solutions. Dr Dave was awarded a 2019 Churchill Fellowship, an overseas research grant by the Winston Churchill Memorial Trust, which she used to learn about US strategies for preventing doctors from dying by suicide, and how these might be applied in the UK. "Not only are medical professionals at higher risk of suicide than the general population, but they also

also brought her into contact with doctors and trainees with mental health problems. Unsure what she could do as an individual practitioner, the pivotal moment in deciding to apply for the Fellowship was hearing at a conference "one of the most moving talks I've ever heard on the topic," she says. The speaker was Professor Michael Myers, an American psychiatrist and expert on doctor suicide prevention. For six weeks last summer, Dr Dave spent time in America learning from Professor Myers and how he and others have approached the issue. It was a "once-in-a-lifetime experience," she says. Shadowing Professor Myers and attending his specialist clinics – one solely for doctors, another just for medical students – Dr Dave was able to find out in detail how the service worked: everything from managing referrals, maintaining confidentiality, raising awareness among doctors to dealing with stigma. She also learnt about how they have gone about training and supporting doctors who are willing to treat colleagues.

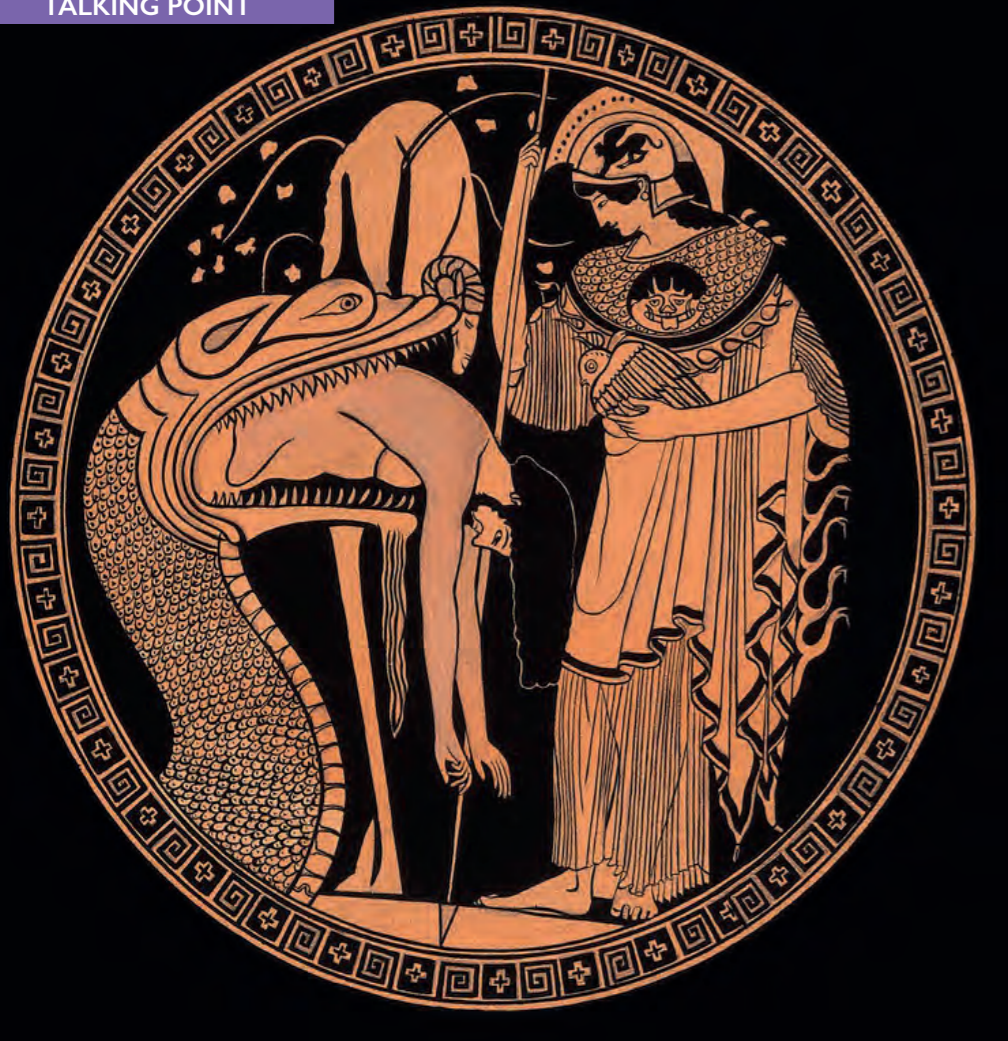
Travelling between New York City, Washington DC and California, she spoke with many other mental health and medical professionals and trainees, the psychiatrist-led American Foundation for Suicide Prevention, and a number of 'chief wellness officers' working in the US healthcare system. This is a senior role – pioneered by the Mayo Clinic and now adopted by several other US healthcare organisations – with responsibility solely for the emotional and mental wellbeing of staff. "The creation of chief wellness officers was just one practical step they took in America that I was interested in researching," says Dr Dave. The importance of accountable leadership is the first of several lessons Dr Dave wants the NHS to learn. "You have to first create that leadership in an organisation, where there is clear responsibility for the health and wellbeing of staff." Whether it's the CEO of a trust, the medical director, or someone specifically appointed to that role, she explains, "you need someone whose remit is to raise awareness, set up services, develop policies and destigmatise seeking help in order to make change happen." In the UK context, it is critical that this role doesn't conflict with the regulatory role of revalidating doctors with the General Medical Council, says Dr Dave. "In my

own case, I'm both the responsible officer and the medical director, so I look after the wellbeing of staff but I'm also acting on behalf of the GMC. If one of my doctors was unwell, would they be afraid to come to me, perhaps thinking I'm going to report them? Having a sole person decide on all these things isn't good for anybody," she concludes. "We need to create new systems and break that culture where doctors fear they will be reported if they say they're depressed or suicidal."

"It's about creating systems and processes that enable doctors and other healthcare staff to feel supported when something happens, so that they seek help early," she says. This means being clear about what services are needed at every stage. "There's a whole spectrum of help that's needed right from wellbeing services to providing services to those doctors who are really ill with serious mental illnesses and suicidality," she says. As experts in mental health and treatments, psychiatrists need to take the lead in developing these services, believes Dr Dave. "But we can't do everything," she adds. "We need to work closely with our non-mental health colleagues – whether they're from other royal colleges, HEE, or the Department of Health – and say: 'we will help you in thinking about how to set this up'."

RCPsych's Wellbeing Committee, of which Dr Dave is a member, has made a good start, she says, citing the leadership role it is playing in raising awareness and breaking down stigma. The Committee is also starting to develop policy on how best to support members' wellbeing and mental health. "The next step is how we influence beyond the College," she says. Dr Dave describes her time in America as "very intense" and talks about the privilege of listening to psychiatrists working in doctor suicide prevention. "It is very distressing talking about colleagues killing themselves," she says. "It hit close to home in many ways. I could be one of those affected. Would I be able to stand up and say I'm unwell?"

"We need people to talk about this, especially senior medical professionals," she says. "We need them to speak up about their experiences, how they've sought help and how they've recovered and flourished afterwards, so there is hope and possibility."



Athena, goddess of wisdom, with hero Jason being vomited from a dragon (Image: Wellcome Collection)

Mental health and #MeToo

What does the enduring movement against sexual harassment and sexual assault mean for mental health workers?

It's been just over two years since the #MeToo movement exploded on social media.

After women stepped forward to accuse the film producer Harvey Weinstein of sexual misconduct, and celebrities started to open up about the sexual abuse they'd suffered, previously unheard victims of sexual harassment and violence all over the world used the hashtag to find their voice.

Millions of tweets revealed the extent of such abuse, prompting calls for greater awareness and support for survivors, as well as wider societal change.

It also raised a question for mental health workers: what is their role in this new era? "This is a moment of change we should grasp and use," says Dr Jennifer Parker, psychiatry trainee at Avon and Wiltshire

Mental Health Partnership NHS Trust and recent winner of RCPsych's Women and Mental Health Special Interest Group (WMHSIG) essay prize for her writing on #MeToo.

Dr Parker believes that psychiatrists can do more than ensure that they are informed and trained in trauma and treat patients appropriately. "We can change the way services deal with sexual violence," she says, with different measures for different people for a much longer period of time, using evidence-based therapies for trauma that aren't yet widely available.

The process of gathering evidence, she says, has been held back by "sexism in academia" and hopes that the #MeToo movement might spark more research into thinking about the impact of sexual harassment.

In the wake of the movement, more people in the UK are now asking for help and acknowledging they are survivors, says Dr Ruth Reed, co-chair with Dr Beena Rajkumar of the WMHSIG. "The most stimulating discussion," at RCPsych's December conference on Sexual Violence and Mental Health, says Dr Reed, "was around listening and learning from survivors and being ready to accept criticism of our services and responsively change them." She believes psychiatrists should avoid making assumptions about how an event might affect a victim. "We sometimes narrowly focus on symptoms at the expense of meaning and assessing broader social and functional impact. I see a lot of people who are severely affected, but do not meet the criteria for any of the conditions in the common triad of depression, PTSD and generalised anxiety. These people have a mixture of symptoms from different diagnoses," she says, "and having an overly rigid symptoms-and-diagnosis approach, rather than a formulation-driven one, can lead to their needs not being identified successfully."

Dr Reed believes neither the field of psychiatry nor other agencies have responded effectively to survivors of sexual harassment in the past, describing training in sexual violence as "patchy" and often voluntary, with male clinicians noticeably under-represented among attendees at events on sexual harm and domestic violence.

And while psychiatry is moving forward, she adds: "There is limited value in improving our own response unless we also create and maintain good relationships at national and local level with other agencies and services." Black, Asian and minority ethnic (BAME) survivors can also face additional barriers in reporting sexual harm and accessing services, says Dr Reed. "We need to ensure that quality services are equally accessible to all and that they meaningfully engage survivors from diverse backgrounds in shaping services and co-delivering training." Psychiatrists, says Dr Parker, are in a position to change culture, as well as help their colleagues and patients. "Medicine is an unequal profession with fewer women in leadership positions, and female doctors and trainees experiencing sexist or sexual comments from senior males. "With overt sexist situations, zero tolerance is in place but for hurtful or offensive comments there needs to be a new approach. We need to get men on board advocating for equality for women."

Leading nations

Alongside a new President, RCPsych recently elected two new devolved nation chairs to lead and represent their country externally and within the College. Dr Maria Atkins in Wales and Dr Richard Wilson in Northern Ireland recently exchanged thoughts on what lies ahead.



Dr Maria Atkins



Dr Richard Wilson

"The challenges in Wales are the same as those faced in England and, I'm sure, reflect the situation in Northern Ireland as well: inadequate resources trying to meet increasing demand," says Dr Maria Atkins as she prepares to take over from Professor Keith Lloyd in July as the next chair of RCPsych in Wales. "Absolutely," agrees Dr Richard Wilson, RCPsych in Northern Ireland's newly elected chair, who also takes up his post in July. "In Northern Ireland, we have one of the most unequal societies in the developed world," he says, adding that the gap between rich and poor is greater than in the rest of Britain or Ireland, in addition to the country's complex issues of identity and simmering conflict. He describes the consequent level of mental health need as a "challenge to service provision". Another shared issue is the sometimes patchy mental health provision across each country. "Delivering services consistently across the region is a

challenge," says Dr Wilson, who is a consultant CAMHS psychiatrist at the Northern Health and Social Care Trust. "For a small country of 1.8 million, this shouldn't be an unreasonable aim." He adds that he will use his new role to encourage the development of infrastructure between providers in Northern Ireland, where appropriate, to help promote equity of access. For Dr Atkins, a consultant adult psychiatrist at Hywel Dda University Health Board, the staffing of rural areas is a big challenge, despite recruitment and retention across Wales showing signs of improvement, including all core training posts being filled last year. "The health board I work in is pioneering new ways of delivering rural services through an international collaboration, and there should be some exciting developments from that," she says. With the Welsh and Northern Ireland Assemblies both having devolved responsibility for health, maintaining a close relationship with their respective decision-makers is important. "It helps that

we are close to the Welsh government," says Dr Atkins. "We're in a position where we can influence policy." She cautions, however, that devolution also brings complications. "With many related areas – such as criminal justice and welfare – not devolved, when it comes to policy consultations it makes it difficult to integrate the different elements."

Dr Wilson sees "enormous opportunity" in the recent return of the Northern Ireland Assembly. "Mental health is at the top of its agenda and we are in a strong position to focus minds," he says. He credits this to the excellent relationships built by his predecessor, Dr Gerry Lynch. "We're aiming to influence the development of policy and resource allocation as early as possible," he adds.

While ensuring the proper funding and staffing of services is at the top of their list of priorities, both new chairs have particular areas of interest they would like to encourage.

For Dr Wilson, this is the development of new ways of working with young people and young adult services, with more substantial input from experts with lived experience of mental illness. "Having involved recovering and recovered patients in the design and delivery of CAMHS services, I'm convinced of its value," he says.

"I want to see us psychiatrists developing psychotherapeutic skills and less risk-averse ways of thinking," says Dr Atkins, something she believes will improve patient outcomes. "It should also mean we work more collaboratively with patients, which will help them to manage their health better and us to develop better services."

Improving services is what matters, both agree. "We have an opportunity to make a difference," says Dr Wilson.

Sight unseen

Vision loss has far-reaching mental and emotional implications, yet this is rarely recognised or supported.

We were involved in the case of a woman who had been totally blind from quite a young age,” says Amanda

Hawkins, specialist lead for counselling and wellbeing at the Royal National Institute of Blind People (RNIB) and chair of VisionUK’s mental health committee.

“By the time she presented at her local trust, after a series of significant losses in her life, she had quite severe depression. She was told that her depression wasn’t related to her sight loss. Nobody saw her real distress and she eventually took her own life. We all know that people have breaking points: that was hers.”

RNIB estimates that over two million people in the UK have a significant degree of sight loss, including around 350,000 who are registered as blind or partially sighted, most of whom weren’t born visually impaired. The number is set to grow dramatically, mainly because of the ageing population. A lot of eye conditions increase with age, including age-related macular degeneration, the most common cause of blindness in the UK.

Polls show that an overwhelming majority of people fear losing their sight more than any other sense, perhaps with reason. The charity Fight for Sight found that a third of people with significant sight loss have experienced mental health issues. A 2016 study showed that more than four in 10 people attending low vision clinics experienced symptoms of clinical depression.

Dr Mhairi Thurston, a senior lecturer in counselling at Abertay University, is

“The mental health pathway and the sight loss pathway don’t usually connect”

registered blind. She was diagnosed with the condition retinitis pigmentosa (RP) at the age of 40 when pregnant with her third child. Her research focuses on the social and emotional impact of sight loss. Her first piece of research identified a five-stage process model of acquired sight loss. “One of the really important things for mental health professionals to understand is the process of going blind, though the stages are aren’t necessarily linear.

The first stage is diagnosis and there are three common reactions – shock, panic and/or disbelief. The next is trying to ‘keep calm and carry on’. During this stage, people tend to use strategies to hide their sight loss. The third stage is when the sight loss impacts on someone’s life and they cannot carry on as ‘normal’. For example, they can’t drive, they can’t read, and they’re confronted with the loss of all kinds of things – income, aspiration and hope. That’s a really pivotal stage in going blind. “In the fourth stage, people realise they have to engage with rehabilitation services in order to carry on. In mobility terms, this means using a white cane or a guide dog to get around. That is incredibly challenging socially, because they have to ‘come out’ as a blind person and take on society’s awkwardness

and preconceptions of what being blind is. Most people struggle to accept this change in identity. Finally, in the fifth stage, people come to accept all these changes and move on to a ‘new normal’ life as a blind person. But not everybody makes it to stage five. That’s why different types of psychological support are necessary at all points during the process.”

Hawkins and her RNIB colleagues have dealt with a lot of cases that show the impact of the third stage. “We worked with a guy who was diagnosed with RP aged 10. Over the next 33 years he lost significant vision, but he found ways of coping until the day he walked into his office and couldn’t find his desk. At that point, at the age of 43, it all just hit him. He went from someone who was visually impaired to someone who was blind. There is a world of difference.”

The prevalence of depression, anxiety, agoraphobia and other mental health co-morbidities is likely to be even higher than official estimates, says Dr Stephen

Orleans-Foli, consultant psychiatrist and honorary senior clinical lecturer at Imperial College School of Medicine. “Many standardised tests aren’t sensitive to those sub-threshold levels of anxiety and depression which may not meet clinical criteria but still affect people profoundly.” Dr Orleans-Foli feels very strongly that it is incumbent on clinicians to build regular questions about vision into risk assessments and other meetings – both for people who are known to be visually impaired and for those who aren’t – in the same way that they ask about chronic pain and lifestyle risk factors.

“We need to be aware that people presenting with depression, social phobia, agoraphobia and so on could have visual impairment as an underlying or contributing factor, and ask them about any difficulties they are having – like knocking into things or difficulty reading – as well as checking for any obvious difficulties or eye problems.” Even if there are no noticeable signs of these, he advises routinely asking

the patient if they have had an eye test in the last two years.

“Any risk assessment of someone known to have visual impairment should always look at the impact of that impairment on their emotional state. Even if their sight hasn’t changed, other stressors or losses may be affecting them and can increase the risk of self-harm.” People who’ve coped surprisingly well for years may suddenly hit a crisis point, for instance, when their partner dies. Not only are they losing a loved one, but they are also losing the person who provided all the strategies and mechanisms for handling day-to-day life. Isolation can very quickly become another factor in their mental health. Many medications prescribed for mental illnesses can also cause or exacerbate eye problems and conditions that are likely to lead to them, explains Dr Orleans-Foli. SSRIs and anticonvulsants, for example, are associated with a number of eye conditions, including glaucoma and cataracts. There’s also the issue of how

people with visual impairments actually manage their medication. “Some people use the shapes and colours to determine the drugs they are taking,” he explains. “If they receive a generic form of the drug, they can’t identify the different medications and that may affect adherence.” Finally, Dr Orleans-Foli points out that people with visual impairments are particularly prone to experiencing visual hallucinations. But he stresses that in many instances, patients may not mention their hallucinations without prompting, for fear of being stigmatised, so it is crucial for clinicians to ask. “The mental health pathway and the sight loss pathway don’t usually connect,” Hawkins concludes. “It may be that the patient isn’t making that connection themselves. Many people are diagnosed and told there is nothing more that can be done, and their sight loss stops being considered as an ongoing issue. So just ask them. Ask them how their sight loss affects them, and you may be quite surprised at what you hear.”



Dr Mhairi Thurston, senior lecturer in counselling at Abertay University, with her guide dog Meadow



Professor Dawn Edge

Family matters

How a ground-breaking talking therapy programme aims to improve the experience of psychiatric services for people of sub-Saharan African and Caribbean origin diagnosed with schizophrenia.

In the UK, people of African and Caribbean origin are significantly more likely than the white British population to be diagnosed with schizophrenia and related psychoses. They also report worse experiences of mental healthcare and generally have poorer treatment outcomes. NICE recommends talking therapies like family intervention for the management of psychotic disorders. Evidence clearly shows that both patients and carers who receive family intervention do better. More benign family environments and positive relationships also reduce social isolation, which is associated with higher rates of relapse. However, people from Black, Asian and minority ethnic (BAME) backgrounds are less likely to be offered psychological therapies than their white British counterparts. Also, current approaches to family intervention do not explicitly address culturally relevant issues like faith, beliefs

about what constitutes mental illness, or people's perceptions of links between racism and discrimination and the onset of symptoms or their experience of services.

To address inequalities in access to psychological therapies, Professor Dawn Edge at the University of Manchester and her team of co-investigators designed and piloted an innovative programme of Culturally-adapted Family Intervention, or 'CaFI', with people of Caribbean descent with schizophrenia diagnoses and their families.

"Black service users and their families highlight cultural insensitivity as a significant barrier to service engagement and recovery from psychotic episodes," says Professor Edge. "Lack of cultural awareness and competence might partly explain Black service users' persistent fear and mistrust of services, low levels of engagement, and inferior outcomes." Findings from the CaFI pilot study indicated that racism is often the 'elephant

in the room' and inability to explore its relationship with mental illness impedes therapeutic alliance with predominantly white therapists. Despite the College and other organisations acknowledging racism in mental healthcare, "service users report that professionals sometimes respond to their experiences of racism and discrimination with scepticism or as evidence of pathology – specifically, paranoia. Some practitioners also regard such disclosures as personal attacks, leading them to become defensive," says Professor Edge. This correlates with health professionals' reports of lacking the confidence to talk about race and mental ill-health. "As a consequence," she explains, "equipping practitioners with cultural competence training to better enable them to address difficult issues, such as faith and race, is integral to the CaFI model."

Despite CaFI being co-produced by service users, families, carers, advocates, health professionals and community and faith leaders, "recruiting families for the pilot trial wasn't easy," says Professor Edge. "Many service users have had negative experiences of mental health services. Community-level stigma and cultural taboos about discussing family matters with outsiders also persist, even among those born in the UK."

Yvonne, an expert by experience and member of the CaFI Research Advisory Group, thinks the effort was worthwhile. She believes access to culturally appropriate psychological therapy will help "Black people have a less damaging experience of psychiatric services". As a Black former service user, she says, "I know from experience that we do get the raw end of the deal."

The success of the pilot trial has led to the National Institute for Health Research funding Professor Edge's research team to test CaFI's clinical and cost-effectiveness in a national randomised control trial with participating sites in the North West, Midlands, London and South. The study population in the full trial has been expanded to include people of sub-Saharan African origin alongside those of Caribbean and mixed heritage. "This is challenging work," says Professor Edge, "but hugely rewarding."

For information about referring families to and getting involved in CaFI, please visit: sites.manchester.ac.uk/cafi