

Issue 28 | Summer 2024



RCPsych INSIGHT

**The power of human connection
in community-based care,
relational prescribing and more**

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COLLEGE NEWS IN BRIEF

New government engagement

Following the results of the general election, the College quickly looked to initiate productive working relationships with members of the new Labour Government in order to ensure mental health is top of their agenda.

Reaching out to key figures, including the new Secretary of State for Health and Social Care – Wes Streeting MP – and the other relevant members of the government's new health team to set up meetings, has been a high priority.

The College was thrilled to see Mental Health Act reform included the first King's Speech of the new government – in which it

set out its legislative agenda for the next year – and has been preparing engagement with the new legislation by promoting key priorities to MPs, Lords and government officials with an interest in mental health.

RCPsych President Dr Lade Smith CBE says: "Over the next five years, there is a real opportunity to make progress towards reversing the mental health crisis, by working across sectors and within communities to implement cross-government policies. The College looks forward to working with the new government to promote mental health interventions throughout the population."

Hitting headlines

Over the past quarter, the College has secured a wide range of media coverage and has voiced concerns on many pressing mental health care issues.

In March, RCPsych collaborated with Bipolar UK on a press release highlighting that it takes on average 9.5 years to receive an accurate bipolar diagnosis. *BBC Breakfast* covered the story initially, and ITV later featured it with quotes from the College. Overall, the coverage included over 45 mentions across various media outlets including BBC, ITV, LBC, and the *Mirror*.

To mark Mental Health Awareness Week in May, RCPsych President Dr Lade Smith CBE warned that "discrimination against people with severe mental illness

is cutting lives short". She called for urgent action to reduce stigma and ensure people receive the care they need.

This was part of a broader campaign that championed the voices of people living with severe mental illness and their loved ones. The College published a poem, a blog post and a podcast featuring a conversation between Dr Jane Morris, Chair of RCPsych in Scotland, and lived experience expert Graham Morgan, who shared his story of living with schizophrenia.

Another piece of work that prompted coverage in key media outlets was the College's press release on postpartum psychosis. Issued in May to mark Maternal Mental Health Awareness Week, it recognised the important role that psychiatrists can play in helping women make a full recovery.

Interim guidance on PAs

As part of an ongoing review into Physicians Associates (PAs), the College has published a set of interim guidelines.

This document is for employers, supervisors and practitioners and includes some basic principles that cover the recruitment, employment, supervision and responsibilities of PAs working in psychiatry to ensure their practice is safe, and that

governance processes are clear around their supervision and employment.

You can access the interim guidance document from the College website: www.rcpsych.ac.uk/improving-care/physician-associates-review

The full review is expected to be completed by the end of the year, at which time a final report will be issued with further guidance.



Read about RCPsych's Honorary Archivist, and former Historian in Residence, and her message for us to use historical knowledge to challenge stereotypes and provoke debate about mental health services today on p20

Deadline for the new curricula

As mandated by the GMC, all trainees are required to be on the 'new' psychiatry curricula by 31 August this year.

The new curricula were introduced in July 2022, with a two-year transition period to allow trainees to move across at a time that worked best. While most trainees will have already moved across, there are some who will have remained on the old curricula – including those who were entering either CT3 or ST6 in August 2022. The College has written to all trainees still on an old curriculum, but would still

encourage all trainees to check which curriculum they're linked to and ensure they have moved onto the relevant 2022 curricula.

Trainees can make the transition by selecting the relevant new curriculum on the PO system, once this has been agreed with their Deaneries. After making this move, trainees will still be able to view PDPs and evidence completed under the previous curriculum.

To learn more about the 'new' 2022 curricula please visit: www.rcpsych.ac.uk/training/curricula-and-guidance.

Become a sustainability scholar

To help address the ongoing climate crisis, the College is looking for higher specialist trainees in psychiatry to become sustainability scholars. Successful candidates will have the opportunity to work with the Planetary Health and Sustainability

Committee and support work to improve the sustainability of mental health services.

The closing date for applications is 11 August. To learn more about the role and how to apply, search 'sustainability scholar role' at www.rcpsych.ac.uk



President's update

Welcome to our summer issue of *Insight magazine*.

It has not been long since our annual International Congress in Edinburgh, at which I was grateful to have had the chance to meet and catch up with so many of you. Coinciding with both Pride month and the year of RCPsych in Scotland's 30th anniversary, it was a fantastic opportunity to celebrate our diversity and efforts to promote EDI, and to consider what more must be done.

Suitably in this issue of *Insight*, we will be hearing from the College's Joint Presidential Leads for Equity and Equality who discuss the importance of achieving equity in mental health care and psychiatry.

We also hear from College Registrar Dr Trudi Seneviratne and CEO of Bipolar UK Simon Kitchen about why a new healthcare strategy is needed to address care delivery for bipolar disorder.

Two of the co-authors of a chapter on relational prescribing in the latest edition of the Maudsley Prescribing Guideline discuss the value of embedding the approach in everyday psychiatric practice.

I'd lastly like to thank the Chairs of RCPsych in Northern Ireland, Scotland and Wales, for appearing in this issue to share their ambitions for their terms ahead and reflect on the challenges they face in their respective nations.

I hope you enjoy the read and look forward to working with you in the following half of the year.

Dr Lade Smith CBE

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DMTs: Prioritising the basics

The emergence of disease-modifying treatments (DMTs) for Alzheimer's disease is cause for both optimism and caution, as members of the Old Age Faculty explain. But, critically, the potential benefits that these medications could offer, if approved, would only be realised by first making significant improvements to services.

In caring for those affected by dementia, Dr Mohan Bhat has two simultaneous areas of focus: his patients and the horizon. It's a natural state of affairs when specialising in a condition which is debilitating, degenerative and for which there currently is no cure.

"I'm always looking out for new developments in dementia management and for new care and treatment options," says Dr Bhat, Chair of the College's Old Age Faculty and practising consultant in

old age psychiatry at Kent and Medway NHS and Social Care Partnership Trust.

Recently, a specific development of this kind has attracted much coverage. Subject to approval by The Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE), lecanemab and donanemab will become the first disease-modifying treatments (DMTs) for Alzheimer's available in the UK.

There is still no "clear line of sight" on

the pathogenesis of Alzheimer's disease stresses Dr Bob Barber – an old age psychiatrist at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and the Faculty's Financial Officer and Lead for New Therapies. However, the development of lecanemab and donanemab has been driven by one of several prevailing theories of the disease's onset and progression – the amyloid cascade hypothesis.

It's been known for some time that amyloid proteins build up in abnormal

levels in the brains of those affected by Alzheimer's, and it is believed that this increase begins years before symptoms emerge, and that, ultimately, levels rise to a certain point, triggering a series of other toxic events in the brain.

Lecanemab and donanemab are monoclonal antibody treatments aiming to interrupt this specific mechanism and, therefore, slow the progression of disease. "They are designed to pass into the brain, find the amyloid, attach to it, and then recruit the body's immune mechanism to remove amyloid from the brain," says Dr Barber.

Clinical trials of these two immunotherapy drugs yielded attention-grabbing outcomes. Lecanemab was reported to have slowed decline in memory and thinking skills by 27% and slowed decline in quality of life by up to 56%. And donanemab was reported to have slowed deterioration in memory and thinking by more than 20% and slowed decline in the

ability to carry out everyday activities by 40%.

For the millions of families affected by dementia, these figures have understandably generated hope, especially as existing treatments for Alzheimer's can only help manage symptoms, and not change the course of the disease. But for members of the Old Age Faculty, that optimism must be balanced with caution, as well as a need for expectation management.

The cautiousness partly relates to possible adverse effects of the medications. Monoclonal antibodies, such as lecanemab and donanemab, are known to be associated with amyloid-related imaging abnormalities (ARIA), a type of swelling or bleeding on the brain.

This was seen in a quarter of those on the donanemab clinical trial. In most, it was minor and caused no symptoms. But the effect can be significant – and in the main donanemab study, three deaths were thought to relate to this issue.

Such figures are undoubtedly in the minds of experts at MHRA and NICE as they assess whether the drugs should be licensed for use in the UK and, if so, in which situations they should be used.

But even if these specific drugs aren't licensed, or are only approved for use in very limited scenarios, they still represent the start of what many feel will be a crucial path in Alzheimer's care. Disease-modifying drugs are on their way and, to have the most impact, they will need to be used as early as possible in the course of the illness. That means diagnosing Alzheimer's promptly and precisely.

That presents a challenge in the UK. Around 40% of those aged 65 or over thought to be living with dementia do not have a formal diagnosis, and research shows only 1.4% of all dementia healthcare costs are currently spent on diagnosis and diagnosis-specific treatment.

And to establish whether or not lecanemab and donanemab could be effective for someone, it is not simply the case that a diagnosis is required. The diagnosis needs to be detailed – involving specialised tests for amyloid – and it needs to be early – made at the very earliest signs of Alzheimer's. That means it's likely the drugs will only be suitable for a small subset of patients.

"If the plan is to remove amyloid and hope this will be beneficial, you need to identify people with amyloid in the first place, and at the right time," says Dr Barber. "And so far, we're not geared up to do that at scale. Very small numbers of psychiatrists have access to the tests,

using PET imaging or cerebrospinal fluid, to identify that protein." Although, he adds: "In the future, the availability of blood biomarkers may help to make this step more accessible."

For Dr Mani Krishnan, the immediate past chair of the Old Age Faculty, the worry is that resources will be concentrated on providing access to expensive, new pharmacological developments before ensuring services are set up with the necessary foundations to allow for the potential benefits to be realised.

"It's really important we embrace innovation," he stresses. "But, to use an analogy, there is no point in having a brand new top-of-the-range home cinema system in a home that does not have proper plumbing, electricity or running water. We have to get the basics right first."

"These medicines may help with one unmet need, but this is not the only thing we need to be doing," agrees Dr Barber. "We also need to be fighting unmet need in prevention, diagnosis, treatment, social care, and in end-of-life care."

These are needs that old age psychiatrists encounter every day and, while care provision already involves coordinating with other services, it is likely that certain partnerships may need to be further reinforced as pharmacological approaches develop. Both lecanemab and donanemab are delivered by infusion, so, in most areas, they will need to be given in acute hospitals and, most likely, under the care of neurologists.

"I think care should still sit with memory services because we link up with all services. But, we will need more collaboration with neurologists in this aspect of the pathway," says Dr Bhat.

The Faculty's executive committee is pushing for the profession to start conversations now about this and other changes required to make the most of DMTs. In December, they published a commentary in the *International Journal of Geriatric Psychiatry*. There has also been a partnership with Alzheimer's Research, the outcome of which was a report exploring current capacity to deliver these drugs. Webinars and conferences are providing further opportunities to explore these areas.

"Our view is, yes, we're open to DMTs. But we also need funding and resources allocated to, and commissioned for, getting the basics in place to reach every person with dementia," says Dr Krishnan.

"Ultimately", says Dr Barber, "we can't achieve disease modification without service modification."

A blueprint for bipolar care

With severe delays to diagnosis, inconsistent care and high levels of suicide among patients, bipolar disorder needs a new healthcare strategy.

It takes, on average, 9.5 years for people with bipolar disorder to receive an accurate diagnosis after first presenting with symptoms. This was one of the shocking statistics highlighted in the Bipolar Commission's 2022 report *Bipolar Minds Matter*, which has demonstrated the desperate need to transform services for this patient group.

"It's criminal," says Dr Trudi Seneviratne, RCPsych Registrar and Chair of its Bipolar Collaborative, which was formed in response to the report's recommendations. "Particularly as first presentations of the disorder tend to hit people at such a formative stage of life, just as they enter adulthood and begin working, studying and having relationships. Then they fall off a cliff and spend the next decade trying to get better without the right treatment."

Bipolar disorder often fails to get enough attention. "It is a condition that is often not properly understood and so it is not prioritised as a serious mental illness in the way that schizophrenia is," says Simon Kitchen, CEO of Bipolar UK – which published the report and has joined forces with the College to push for change.

In stark contrast with bipolar disorder, it takes an average of 9 months to get a diagnosis of schizophrenia. Despite being less common, it has its own specialist treatment pathway and there is an expectation that there is an early intervention psychosis team in every mental health trust and health board. This is what is desperately needed for bipolar disorder as well. Without a specialist pathway, and with the shift of care into the community, it is mainly managed by GPs using an episodic approach. But GPs are often not equipped to manage the condition by themselves. People may struggle to see their GP, or they may be misdiagnosed and only reappraised

once they reach crisis point. Sometimes a referral to secondary care won't even be made unless the patient is suicidal – otherwise the referral might be turned down.

"What might have been a 15-minute appointment with a psychiatrist becomes a two-to-three-week delay to treatment and the patient gets so unwell they are



Dr Trudi Seneviratne

sectioned and spend 6 months in hospital. It places a huge burden on GPs, psychiatrists and inpatient care," says Mr Kitchen. "And then people are often discharged without follow-up, education or psychological therapies," says Dr Seneviratne, and it becomes a vicious circle.

This approach comes at an incredible cost – both in terms of quality of life and financially. Delays in diagnosis leave people vulnerable and without appropriate skills to manage the debilitating extremes of mood

and energy that characterise the disorder. Having bipolar disorder increases the risk of suicide by 20 times, and risky coping mechanisms and self-medication with alcohol or drugs is common.

"Bipolar plays a disproportionate role in many social problems," says Mr Kitchen. "About half of people with bipolar have been sectioned and they struggle to stay in work. They are more likely to be divorced, live alone and on average die 10 years earlier than the general population."

Simon Kitchen, CEO of Bipolar UK



Things could be so different. People with bipolar disorder can thrive and have a good quality of life. "What is needed is to identify people early and get them holistic treatment that includes medications but also education, psychological treatment and psychoeducation so they understand what their illness is and understand the signs of relapse," says Dr Seneviratne.

An early diagnosis can be transformative. As one individual with bipolar disorder said after being diagnosed ten years after first seeking help: "The diagnosis completely changed my life for the better because I now know what I'm dealing with. It's always there and some days are difficult, but I manage it a million times better than I did before. Early diagnosis is crucial."

"Given the right support, people with bipolar can reduce the severity of symptoms and elongate the time between episodes so it becomes easier to manage – it creates a virtuous circle," says Mr Kitchen.

Lithium is effective but it is underused – perhaps because clinicians lack confidence and because it needs careful monitoring for damaging side-effects. "People are bounced around on medications, without moving to lithium quickly enough," says Dr Seneviratne.

"What Bipolar UK is calling for," says Mr Kitchen, is "the minimum medication – and the best possible combination – as well as advice on managing the condition". And this

would be best achieved by easier access to specialist psychiatrists – preferably as part of a specialist evidence-based care pathway.

Continuity of care and a lifelong approach are also crucial. A Bipolar Commission survey found that out of 550 psychiatrists, 83% said continuity of care was more important than frequency of care or patient choice. It is not only about having access to a psychiatrist with specialist knowledge; it works best when a relationship between doctor and patient has been built up over the years. "You need to be a specialist in the condition *and* the individual," says Mr Kitchen.

Specialist pathways do exist for bipolar disorder – but only in pockets, such as at the South London and Maudsley NHS Foundation Trust, where Dr Seneviratne works, which has had its OPTIMA Mood Disorders Service since 2015. The handful of pathways that do exist have proven to be successful and could be used to inform a national pathway so that care for people with bipolar disorder would no longer be a postcode lottery.

There has been progress since the 2022 Commission report. The profile of bipolar disorder has been raised and the high suicide rates among people with bipolar disorder have now been acknowledged in the five-year suicide prevention strategy for England, which says: "affective disorders,

including depression and bipolar, accounted for 42% of all patient suicides in England between 2010 and 2020".

The College's Bipolar Collaborative brings together psychiatrists, organisations and experts by experience and the College has also released a joint position statement with Bipolar UK calling for five actions from the Government to improve care for people with bipolar disorder, including a specialised national bipolar disorder pathway and action on reducing the time to diagnosis – specifically reducing the average time to five years as a realistic first step.

To support this drive, Bipolar UK is trying to ensure there are diagnosis champions and specialist care pathway champions in every mental health trust and health board, and wants to encourage College members to get involved by joining its clinical advisory panel.

Mr Kitchen is clear that these changes are vital: "More of the same isn't going to work. Specialist pathways are working for schizophrenia, psychosis and eating disorders and would work for bipolar. Doing this could take a lot of pressure off the NHS – it needs to do something different, and this is the answer."

Learn about Bipolar UK's clinical advisory panel and how to join at www.bipolaruk.org/clinical-advisory-panel



Sonia Walter, CEO

Looking ahead

RCPsych's new Chief Executive Sonia Walter talks about the importance of putting the College's core purpose first.

Sonia Walter was appointed RCPsych's interim Chief Executive in November before taking on the post permanently in March, but her experience of the College extends much further back than the past few months. She has been working for the College for more than 23 years and has a very clear vision of what she wants to achieve.

As a top priority, she wants to ensure that the College's core purpose is given the attention it deserves – supporting psychiatrists through education, advocacy and setting standards, so that they can achieve the best outcomes for their patients. "First and foremost, we are a professional association. We are here for members, and we need to serve them," she says.

Her immediate priorities are membership engagement and support. To this end,

"I want people to embrace progress and look to the future but not discard the valuable work that has gone before"

she wants to ensure that members know that the College's door is "always open" and that they feel both represented and valued. There are initiatives in place to encourage open dialogue, such as Question Time with the Officers (monthly video updates providing information about College activities at which members' questions and suggestions are addressed) and a membership survey

to help the College to be clear about, and up to date with, members' needs. She also wants to ensure members know exactly how decisions are made within the College.

Providing the right support for members is reliant on organisational excellence and Sonia is committed to ensuring that College staff have "the right systems and processes to do their job in the most efficient way". She wants to improve staff engagement and is having meetings with every team to help achieve this. These candid discussions will lead to an action plan to address issues and improve morale and retention. Key to achieving this, she says, is to "make sure that every single member of staff understands the role they play to deliver the College strategy and mission".

Attending to these immediate priorities and ensuring that the College is financially viable will put RCPsych in a good position to achieve the goals of the presidential strategy over the next three years.

These goals are ambitious and include reducing the numbers of people waiting to receive treatment; raising standards of care and education globally; and putting mental health at the top of the agenda for governments and decision-makers.

The priorities will be underpinned with robust governance, the College's values, and fairness, allyship and co-production. She also wants "people to embrace progress and look to the future but not discard the valuable work that has gone before." This can help encourage a move away from binary thinking towards common ground, she says. "It is important for our members to focus on experience and evidence."

Another aim is for RCPsych to be an inclusive, global organisation and to shift away from what has been perceived as a London-centric outlook. "We want members and affiliates to have an excellent experience of the College whether they are in Nigeria, Scotland or London," she says. And while she is very keen for the College to grow and excel, especially internationally and in the areas of research and mental health technology, her top priority is making sure that its core business is appropriately resourced and at the forefront of everything it does.

Sonia feels incredibly honoured to have been appointed CEO. She says: "My life's work is to look after psychiatrists. It's what I have done for decades and to be able to do it at this level is amazing."



Our response to the Cass Review

RCPsych President Dr Lade Smith CBE discusses what is at the heart of the College's response to the Cass Review and reflects on the considerations involved in moving forward.

"In April, the Independent Review of Gender Identity Services for Children and Young People, commissioned by NHS England and chaired by Dr Hilary Cass OBE (the Cass Review) published its final report.

Among its findings, it highlighted the fact that children and young people who are gender questioning are not receiving the support they need, and it provided a roadmap for how services can be improved. It also reflected an approach, shared by the College, on ensuring this group of highly marginalised children and young people have access to timely, effective and person-centred care.

This approach was central to our detailed response to the review's final report, published on our website, in which

we welcomed its comprehensive, evidence-based stance and supported its call for more transparent data collection and research. Most importantly, our response emphasised the need for a fully resourced implementation plan to address the healthcare needs of this vulnerable patient group.

As psychiatrists, we know that patients benefit most from a holistic, biopsychosocial approach that takes their personal wishes and preferences into consideration. This is simply good clinical practice and something that all services and clinicians endeavour to provide.

We also know that young people who are gender questioning experience higher rates of mental illness than the general population. They are often marginalised and find it difficult to access care due to a lack of available services and too few practitioners working in the field.

We must be prepared to support the provision of services for this group of young people. This means being able to address the complexity and nuance of their experiences and needs, including the assessment and treatment of any co-existing mental illness. Each person's needs will be different; our role is to help ascertain what those needs are and support the person on the right pathway for them. First and foremost, we are doctors, and we have a fundamental duty to provide care and treatment based on what is best for our patients.

To this end, the College is establishing a working group of experts and stakeholders, based on the College's existing Cass Review Advisory Group, which will seek to ensure that the implementation phase of the Cass Review achieves its aims. This group will include a range of relevant specialist staff from different disciplines, along with patient and carer representatives. As always, the approach taken will be evidence based.

Moving forward also involves facing the reality of the mismatch between demand and availability that exists in mental health services across England. The resulting challenges, particularly in Child and Adolescent Mental Health Services (CAMHS), are highlighted in the Cass Review's final report as a risk to the successful implementation of its recommendations, if not addressed. Additional staff and funding will be needed to ensure changes can be implemented quickly and bring down waiting lists which are already unacceptably high.

We are conscious that the nature of the discourse around gender care and the Cass Review may leave gender-questioning children and young people feeling more vulnerable and unsure about what their future holds but, in addition, may also cause similar distress to non-binary, gender-questioning and transgender adults.

As a profession, we must work together to improve services across the board to ensure that going forward, evidence-based, inclusive, non-ideologically driven support will always be available to those who are gender questioning."

See RCPsych's response to the Cass Review by searching 'Detailed Response to the Cass Review's final report' on www.rcpsych.ac.uk

We will continue to proactively support transgender, non-binary and gender-questioning members of the College. Any of our members who experiences distress or difficulties in relation to this subject – or any other – can access the full range of College support, including the Psychiatrists' Support Service (PSS): pss@rcpsych.ac.uk or **020 8618 4020**

Community cares

A remarkable project in Kerala, south-west India, is pioneering a new way of providing community mental healthcare.

We must provide mental health treatment via whoever is available and in an inexpensive way to our communities," says Dr Manoj Kumar, summarising the ethos behind the Mental Health Action Trust (MHAT) – a charitable organisation that he founded in Kerala, India. Based entirely in the community, the trust provides care to people with severe mental illness from the poorest sections of the rural population it serves, with the community itself playing an integral role.

Dr Kumar – who is also chair of the College's South Asian International Division – was born and raised in Kerala, and trained in Tamil Nadu before working for 15 years in Leeds as a consultant liaison psychiatrist specialising in psycho-oncology. "Although I was happy with what I did, I felt that there was more I could do," he says. So, in 2008, he made a significant decision: "I came back to India to try to do something on a larger scale." That 'something' was to found MHAT and

"Volunteers are our grassroots workers"



Dr Manoj Kumar

Radhika Kidao

strive to address mental health care needs in the region.

This is no small feat as demand for mental health services in India, like in the UK and the rest of the world, is increasing at an alarming rate, but there aren't enough psychiatrists and other mental healthcare professionals to go around. And like in many other countries, the challenge

in India is exacerbated by several factors including large-scale poverty and the fact that access to healthcare is dependent on one's ability to pay and proximity to the major urban centres. The result is a vast and ever-widening treatment gap. Even in the south-western state of Kerala, one of the first states in India to adopt a mental health strategy, the poorest and most marginalised communities have effectively been cut off from mental health support.

To deliver effective care despite such limitations, MHAT took an approach that is volunteer-led, community-driven, recovery- and rehabilitation-oriented and based on the principle of 'task sharing', in which psychiatrists delegate non-critical aspects of care to individuals with less training. Dr Kumar explains that this model is particularly suitable for this part of the world, "where there is a lot of emphasis placed on the role of the family and the community."

MHAT's community-based approach is also reflected in the fact that its 75-strong clinical team not only includes psychiatrists, junior psychiatry fellows and psychologists,

psychiatric social workers and social development officers, but also mental health lay workers – who make up over a quarter of the team. "These are people who have come in contact with MHAT because their family members were using our service, or they started as volunteers, and they subsequently joined our staff," explains MHAT trustee Radhika Kidao.

Ms Kidao, who supports the continuing professional development of MHAT's team, is a Kerala-born, retired occupational therapist, who has worked in countries as different as the UK and the Seychelles.

In the 1990s, while working in the UK, she helped former residents of long-stay mental health institutions reintegrate into the community. "I had been following, with interest, the growth of MHAT from a distance," she says, "and so, when I returned to India, I felt that there might be something that I could offer."

Supplementing the staff team are over 1,000 volunteers, "who are our grassroots workers," says Ms Kidao, "and they are crucial to the model of care. They are very often the first point of contact for patients and their families." The volunteers, who are from the communities they work with, identify people who might benefit from MHAT's services and then become the link between MHAT and the patients and their families. Together, the staff team and its volunteers have assisted almost 8,000 patients. But, factoring in the support also provided for family members, MHAT estimates its work has reached around 34,000 people.

In each community base that MHAT sets up, it runs regular clinical appointments, for which clinicians travel in from other parts of the state or, sometimes, they conduct them virtually. In between, it is the volunteers who keep things going –

supporting patients and working with their families and wider community. Wherever possible, the patient will have a volunteer assigned to them, who will support them in their community and at future therapy appointments for as long as they are needed. This continuity of care is a key part of the MHAT ethos.

Around 95% of MHAT's services are provided free of charge to the poorest sections of the population, with the remaining services provided for a moderate charge to those who can afford to pay. But, Dr Kumar stresses, there is no compromise on quality in anything MHAT does.

In the early days, MHAT was largely reliant on donations. Then, about four years ago, two big Indian philanthropic foundations stepped in with financial support, allowing for a big expansion of the Trust's services.

As MHAT has expanded in recent years, it has increasingly worked with communities as a whole rather than just individual patients. Dr Kumar explains: "There might be one or more people living in squalor in a hut on the edge of society because of their mental disorders. They might be dressed in rags, or with very few clothes, and may not have had a shower in years. So, our team goes in and starts proper medical treatment while the community pitches in to improve their circumstances of living and look after their basic needs. And then they start to feel human again: better fed, better looked after, mental illness under control and, after years of isolation, they begin to come back into the social mainstream, being accepted by the community which had given up on them."

This all-encompassing model of care is called 'Samagram', a Sanskrit word that means 'comprehensive' or 'holistic'. It incorporates several of the basic tenets of a recovery-oriented service. "Comprehensive care begins with managing the condition that they are suffering from," says Ms Kidao, "but then goes on to their wider life as a citizen in the community, with support for their families and caregivers. We are working at several intersections – of poverty, stigma and discrimination, and gender. The fact that we are willing to address many of these issues has a positive impact."

MHAT's model of care provision encourages a broader focus on the wider social, cultural and environmental influences on mental health – not only for those based in similar populations. But a social model of mental health care provision will need to look different depending on where you are in the world. "The model has to be tailored to suit local realities," says Dr Kumar.

In January, College President Dr Lade Smith CBE visited MHAT, along with other RCPsych colleagues, to learn first hand about its work. Reflecting on the trip, she said: "We have a huge amount to learn in the UK about collective responsibility and collective decision-making, and how this can be a protective measure to support people to stay well in the community."

As MHAT expands, so too does its requirement for clinical support. "As we have grown, our needs have also grown," says Dr Kumar "and any volunteering by the members of the College would be very welcome and useful."

Read more about MHAT, including how to volunteer, at mhatkerala.org



Thinking beyond symptoms

With a chapter on relational prescribing included in the latest edition of the Maudsley Prescribing Guidelines, two of its authors talk about why the approach should be embedded in psychiatrists' everyday practice.

Relational prescribing is an approach that considers the relational, emotional, and psychological aspects of prescribing and taking medication, with an emphasis on the relationship between the prescriber and the patient. The term was coined by the group Psychodynamics of Prescribing UK (PoPs UK). Two of its founding members and consultant psychiatrists, Dr Haroula Konstantinidou and Dr Dimitrios Chartonas, advocate for embedding this practice into the profession and for all psychiatrists – as well as GPs, medics and pharmacists – to capitalise on the benefits it can bring the patient by attending to the person and their story rather than just their symptoms.

A framework published in *BJPsych Advances*, which the pair have created along with advanced specialist pharmacist Mr David Rogalski and consultant psychiatrist and psychoanalyst Dr Tennyson Lee as part of PoPs UK, boils it down to three essential factors to consider when prescribing: the patient factor, the clinician factor and the relationship factor.

Patient factors include beliefs, expectations, attachment style, readiness to change and personality type. Clinician factors can include internal and external pressure to get results, workload, and reflectively attending to the way the clinician feels about their patient. The relationship factor refers to the therapeutic alliance between the patient and the psychiatrist.

The framework draws on work led by Dr David Mintz – a psychiatrist based in the US – who developed the discipline of

psychodynamic psychopharmacology based on the patient-centred care model. Dr Mintz has collected evidence that repeatedly shows that psychosocial and relational factors have a huge effect on pharmacological outcomes and that mastery of such factors can optimise pharmacotherapy. One key study showed that highly effective prescribers would get consistently good results from patients with depression, even when prescribing placebos, and achieved better outcomes than less effective prescribers who had been prescribing active medication. “We know that the placebo effect is real,” says Dr Chartonas. “The more placebo effect we can harness, so to speak, on top of the drug effect, the better for patients.”

The importance of attachment has also been shown in long-term conditions, such as diabetes or chronic pain, which require an ongoing relationship with a prescribing clinician. The doctor–patient relationship is crucial for a better understanding of the meaning patients attach to medication. A solid alliance can improve adherence to regimens and influence the patient's expectations of outcomes.

It has been shown, for instance, that explaining possible side-effects within the context of a therapeutic relationship can encourage drug adherence, whereas a ‘nocebo’ effect is more likely when patients have expectations of harm that remain unattended.

This work was important in redressing the overwhelming enthusiasm for antidepressants and anti-psychotics in the 1990s and early 2000s when, Dr

Chartonas says: “psychiatrists perhaps lost sight of the psychological aspects” when prescribing. “We now see the limitations of the strictly biological model which can result in polypharmacy and iatrogenic harm,” says Dr Konstantinidou. “All the evidence shows that ‘soft skills’ such as good communication with patients and curiosity about their story, can be crucial to successful outcomes and can be taught.”

A new chapter on relational aspects of prescribing practices written by the PoPs UK team will appear in the next Maudsley Prescribing Guidelines in Psychiatry. It details practical advice for psychiatrists on considering relational and psychological aspects of prescribing and optimising medication outcomes. The pair are excited about its publication: “It acknowledges that something has been missing,” says Dr Chartonas.

Busy psychiatrists might be sceptical about the feasibility of applying these ideas given time pressures and workloads. And yet, Dr Chartonas says: “It can save time because when we rush prescribing decisions we may then have to deal with the consequences of treatment failures and persistent treatment resistance. We find ourselves having to constantly review

treatments and we often keep changing medication, which of course can make both us and our patients feel increasingly hopeless. Changing the culture within our organisations can allow us to step back and create the space to think about complex prescribing dilemmas.”

Relational prescribing has received a lot of interest at RCPsych, which has been championing a biopsychosocial approach. There is an existing webinar on the art of psychopharmacology available to College members. PoPs UK is planning to add more CPD learning modules and to work more closely with the sustainability group, given that medicine use accounts for a large percentage of the NHS's carbon footprint and a more considered form of prescribing avoids polypharmacy and wastage.

“It's a real opportunity for psychiatrists to refocus on the person behind the symptom and to consider the patient's personality and psychological formulation. It truly integrates the psychiatrist's knowledge of psychopharmacology with a sophisticated understanding of the patient's psychology and wider systemic issues,” says Dr Konstantinidou. It also broadens the role of psychiatry, she says, overturning the view that psychiatrists are

simply medication dispensers.

Curiosity is the key to the approach. A curiosity about the patient and the psychiatrist's own role in the relationship – which would include their own motivations for prescribing or not, or choosing certain medications over others. “What we do in our training events is to try to give people permission to feel things and be curious about them,” says Dr Konstantinidou. “It is important that psychiatrists are curious about their own minds and emotional responses.” They have found there is lots of interest in their webinars and training, especially with younger doctors and trainees. “It resonates out there,” says Dr Chartonas.

Both doctors work with patients with personality disorders and have found the approach to be particularly beneficial for this patient group because their difficulties are often displayed in relationships. There is also an increased danger of overprescribing and polypharmacy for this patient group, which can be avoided using a relational approach. Additionally, there is evidence it is relevant to working with people with severe mental illnesses, such as schizophrenia and bipolar disorder.

Dr Chartonas, in partnership with Mr Rogalski, has authored an updated

prescribing guideline for personality disorder in his organisation. In addition, both Dr Chartonas and Dr Konstantinidou have tried to “embed the culture of thinking relationally about pharmacology” into their services, by creating peer supervision groups, optimising prescribing and deprescribing processes and emphasising the evidence base. They have also ensured there is multidisciplinary support when doctors face prescribing dilemmas.

The two doctors are ambitious about the future and are pleased with their progress and the involvement of RCPsych. “The College has begun to redress the balance by bringing the psychosocial in parity with the biological,” says Dr Konstantinidou. But she is also keen for the approach to be mirrored in various aspects of College work and across faculties.

Dr Chartonas and Dr Konstantinidou are clear that they want colleagues to “be more secure in thinking relationally and psychologically about prescribing”. They are hopeful that the growing interest in relational prescribing is part of a wider movement to reinstate biopsychosocial approaches, with the ultimate goal of improving patient outcomes with enhanced person-centred care.



All change in the devolved nations

The incoming Chairs of RCPsych in Northern Ireland, Scotland and Wales are taking up the reins at a time of great political change. Here, they reflect on what lies ahead.

The challenges facing the three new Chairs of RCPsych in Northern Ireland, Scotland and Wales are formidable: underfunded mental health services, an over-stretched workforce, and a background of destabilising political upheaval. Nonetheless, when the three came together to talk about their hopes and plans for their four-year-term ahead, they were undaunted.

They began by paying tribute to their predecessors, who all began their terms of office in the early days of the pandemic. “Having any kind of member engagement at that time was challenging,” says consultant child and adolescent psychiatrist Professor Alka Ahuja MBE, the new Chair of RCPsych in Wales. “The approach taken by my predecessor, Dr Maria Atkins, was to set up these short virtual meetings which weren’t treated as executive meetings; they were just a safe space where people could talk about any concerns they had.”

In Scotland, Dr Jane Morris, a medical psychotherapist who has worked in both adult and adolescent settings in a variety of specialties, has been the interim Chair since last year, when her predecessor, Dr Linda Findlay, stepped down for personal reasons. “I very much want to take forward Linda’s style of leadership,” says Dr Morris. “Her way of doing things was to set up a series of virtual road shows for the members, one for every health board in Scotland and, based on the views expressed, put together an agenda for her term in office.”

In Northern Ireland, the new Chair, Dr Julie Anderson, a consultant psychiatrist

“My agenda is workforce, workforce, workforce”

specialising in perinatal mental health, also pays tribute to her predecessor, Dr Richard Wilson. “He’s very good at listening to other people’s opinions and one of his biggest achievements was to broaden the base of membership involvement.”

Relationships with the devolved governments in the three nations are a key aspect of the job of Devolved Chair. And that’s where things have been tricky in Northern Ireland. It was only in February this year that the Stormont government was restored after being in abeyance for almost two years. In both Scotland and Wales, the governing parties have changed first minister (twice, in the case of Scotland) in the past 18 months. And with the recent UK general election producing a new government and elections to the devolved parliaments due in the next two to three years, change is still very much in the air.

In Wales, the College has long had strong links with all the parties in the Senedd. But, says Professor Ahuja, it was during the pandemic that the ties became a lot closer. She was then leading a pilot project using video consultations in a CAMHS service. “That was used as an exemplar by the Welsh government for roll-out across the country,” she says. “It

gave us an opportunity to put across our views directly to government and we’ve had regular meetings with the Minister for Mental Health ever since. This has led to ‘Dyfodol’ (‘Future’), a unique partnership with NHS Wales’ Joint Commissioning Committee, which brings together mental health commissioning and the College.”

“In Northern Ireland, we have very open engagement with the Department of Health,” says Dr Anderson: “short lines of communication”, in the words of the Chief Medical Officer. But she laments the fact that the Health Minister, Robin Swann, stepped down in May to run for the Westminster parliament. “He’s been really approachable and supportive of the College, of which he’s an honorary member,” she says. There are encouraging indications from his successor, Mike Nesbitt, that he will fight to protect the health budget.

“Like Julie and Alka, we enjoy some good, respectful relationships with members of the government and all the parties in Scotland,” says Dr Morris. “But we often struggle to hold politicians to account, even where they have made promises.” She

cites the Scottish government’s pledge to increase mental health spending to 10% as a proportion of the overall health budget. “It’s a ridiculously low figure,” she says; “the lowest of all the UK nations. But even using it as a relatively modest marker of progress, we’ve moved away from it. We’re now down below 9% – the worst we’ve been, and in real terms, for a long time.”

The College has been “actively consulted on recent legislation, some of which has been highly controversial, such as gender reform, neurodiversity and assisted dying,” says Dr Morris. And she’s been heartened by the way College members have debated these subjects at meetings she’s chaired: “They’ve had diverse and even opposing opinions, but have also been respectful and considerate of each other’s views.”

In Northern Ireland, the groundbreaking Mental Capacity Act (2016) has yet to be fully implemented. “The part of the Act dealing with deprivation of liberty safeguards has been in place for a good number of years, but there hasn’t been much progress since then,” says Dr Anderson. There have been discussions with the College about section 12 of the Act, which deals with acts of restraint.

But, says Dr Anderson, the Act has been around for such a long time that there may need to be a further review and appropriate funding will need to be allocated, including for staff training, given the far-reaching consequences of full implementation of the Act across health and social care in Northern Ireland.

Reform is proceeding more smoothly in Wales, with the rights-based, patient-centred Mental Health Standards of Care (Wales) Bill proceeding through the Senedd with cross-party support. “It’s one of the few occasions where we’ve had the opposition support the government in power on a piece of work,” says Professor Ahuja. “Nothing is guaranteed, but, fingers crossed, something good will come out of it.”

As to their priorities for their term of office, there is broad agreement. “My agenda is workforce, workforce, workforce,” says Dr Morris. “If we don’t look after our workforce, we can’t look after the health of our patients. I’m so fortunate that Ihsan Kader has produced such a beautiful piece of work that can give the structure and levers to make that a reality.” Here, she is referring to the *State of the Nation*

report on Scotland’s psychiatric workforce, led by Dr Kader, which made detailed recommendations for change.

“Happy staff means happy patients,” says Professor Ahuja. Member engagement is a key part of that, but she also points to what might seem like small things, but which can make a big difference. “We’ve just done a piece of work around community mental health teams and the physical environment they work in. It’s not just about good WiFi and clean toilets; it’s also about having a coffee room or staff room – we forget how important these things are. These are the places where you get to talk to other people and really feel part of the team.”

“In Northern Ireland, our vacancy rate for consultants, at 25%, is the highest in the UK,” says Dr Anderson. “And in some of our trusts, it’s even higher. So the workforce is my main priority. Another priority is perinatal mental health. We’ve only had perinatal community teams in every trust in the last two years, and we still have no mother-and-baby unit anywhere on the island of Ireland. Seeing that realised is huge for me.”



Dr Jane Morris, Professor Alka Ahuja MBE and Dr Julie Anderson



Dr Amrit Sachar



Dr Rajesh Mohan

From equality to equity

The College's Joint Presidential Leads for Equity and Equality explain why achieving equality alone in mental health care and psychiatry is not enough.

The College prides itself on its commitment to equality, diversity, and inclusion (EDI), and has made significant strides in enhancing equality for members in psychiatry and mental health care. However, Dr Raj Mohan and Dr Amrit Sachar, Joint Presidential Leads for Equity and Equality, say that equality alone is not enough.

"It is easy to think that treating everyone equally is the best way of ensuring fairness," says Dr Mohan. However, given the same resources, some people would fare worse than others, as social and structural injustices perpetuated through policies and practices over time have disadvantaged certain groups.

"In an unequal world, equality without equity is still fundamentally unfair," says Dr Sachar. Going a step further than equality, equity asserts that the best way to achieve fairness is to give each person the resources they need to progress. "Support provision opportunities need to be targeted at the most marginalised and the most in need."

Healthcare models that treat everyone equally may fail to serve marginalised communities effectively. For instance, a CAMHS service that uses self-harm as its primary referral criterion might support more young white girls while overlooking young Black boys whose emotional struggles may present as behavioural challenges.

"One group of people is going to get

access to psychological services, and the other's more likely to end up on the school-to-prison pipeline," says Dr Sachar. "But the underlying problem is the same; just the way it manifests is different." Examining policies and protocols with an equity lens means asking, 'who is this leaving out?' and, 'who is disadvantaged?'

"Equity means that you realise the current way of doing things has led to disparities or widening disparities, and then you embed new systems that can change it or reverse it," Dr Mohan adds.

As such, equity requires structural competence, which the College is improving through initiatives like the Advancing Mental Health Equity (AMHE) Collaborative, which supports locally based quality improvement efforts in trusts in England.

"As long as people are willing to learn from their own experience, their data, and the people who would be affected by their care, you get things done the right way," says Dr Mohan. He adds that the College will continue to support the England-wide rollout of the Patient and Carer Race Equality Framework (PCREF), which centres co-production in service design and delivery, and champion equivalent initiatives in the devolved nations.

RCPsych's commitment to equity also includes recruiting equity champions and presidential lead scholars for strategic priorities, sharing best practices, and

influencing policy at the highest levels.

The journey towards equity is not without challenges. Underinvestment in social and community services disproportionately impact the health of marginalised groups. Moreover, there's significant pushback against EDI initiatives in the current climate. "If you are already ahead in what we call 'the privilege race', you might see it as a zero-sum game," says Dr Sachar. "It can be seen to be a case of 'if somebody else is going to get more, I'm going to get less'."

However, Dr Mohan argues that an equity-based approach benefits everyone. "If you deprive people of certain resources and goods that they should have in order to progress in life, you will end up spending a larger share of your money picking up the cost of it. We would all stand to gain, without a doubt, by re-designing our solutions for health inequalities using an equity lens."

Dr Sachar agrees. "The 'head' reason for using equity-based approaches is that it makes sense financially and in terms of resources. The 'heart' reason is obvious: it helps the people who are struggling the most."

Dr Sachar invites any psychiatrist who is still unconvinced by the approach to think about what drew them to the profession. "If it's anything to do with helping people, then I would ask you: Do you want to help the people who are most in need?"

If you'd like to get involved in RCPsych's EDI work, contact Dr Sachar or Dr Mohan via X (formerly Twitter) at [@apksachar](#) and [@raj_psy](#) respectively, or email Ruth Adams, Head of EDI Strategy: ruth.adams@rcpsych.ac.uk



A trusted source

Aimed at patients, carers and the general public, RCPsych's mental health resources offer accredited, accessible, and reliable health information.

Ensuring that the public has access to high-quality health information is vital, especially as poor health literacy is linked to negative health outcomes. While there are endless online sources offering information and guidance, much of it is simplistic, and can be misleading and potentially harmful.

RCPsych is playing a part in addressing this by producing accurate, evidence-based resources designed to improve awareness about mental health issues, intellectual disabilities, and neurodevelopmental disorders.

Co-produced with patients and carers and written by psychiatrists and other mental health professionals, the College's resources are available in online, print and video formats, with 80 aimed at adults, 50 aimed at children and/or their parents and carers, and 300 translations in 26 languages.

Last year, the web-based resources received over 1.6 million views, with the most highly read topics for adults being ADHD, stopping antidepressants, and coping after a traumatic event. When it comes to information for, or relating to, children and young people, the most sought-after subjects include soiling and bed-wetting, divorce and separation, and cannabis use.

amongst medical professionals," he says. "The information we produced is a resource both for a layperson, but also for a professional who wants to get an overview of ADHD as a condition and its management."

This particular resource was 'highly commended' at the BMA PLG (patient liaison group) Patient Information Awards 2023 and, among other things, was praised for its use of language and recognition of the difficulties faced by people with ADHD.

Dr Hank describes the comprehensive governance involved in the development of the resource he worked on: "It was an iterative process that included a workshop with lived experience collaborators, and then successive drafts were developed with input from myself, other clinicians, patient representatives, and the College's Mental Health Information Manager," he says. "The finished product was then approved by the College's Public Engagement Editorial Board."

Co-production with patient and carer involvement has been instrumental. When developing the ADHD resource, for example, lived experience collaborators were involved in guiding the resource's messaging and scope, and in overseeing it throughout its development. "It also contains verbatim quotes from patients sharing their personal experiences," says Dr Hank "helping to offer a more nuanced, person-centred perspective of the condition and its management."

Building on its approach so far, RCPsych is working towards having a gold-standard lived-experience model for all of its resources, in which a patient and carer voice is involved at every step of the process.

Reflecting on his experience with co-developing the ADHD resource, Dr Hank says: "Being involved in such a publication felt like a big responsibility, but it was also a good learning experience, and one with a rewarding outcome."

The next steps for the information resources will be to identify potential opportunities for development by understanding the existing demand and untapped potential in mental health information – both in the UK and internationally. The number and quality of translations on offer continues to grow following the start of a partnership with translation company Translators Without Borders and the valuable input of the College's international members. And the College's intellectual disability information is currently being updated so that people with accessibility needs can find clear, usable information on topics that matter to them.

One patient who accessed the College's resource on stopping antidepressants commented: "This was very useful information for someone trying to come off antidepressants after several years. I was unaware what the weird brain zaps were – it can be worrying if you don't know why something is happening."

RCPsych's mental health resources received certification in March 2023 from the Patient Information Forum's PIF TICK scheme – the only UK quality mark for health information – and were re-certified this year. This accreditation means that anyone accessing College resources with the tick can be assured they are evidence based, comprehensible, up to date and produced to the highest possible standard.

Dr Dietmar Hank, consultant psychiatrist and clinical lead for the Adult ADHD Service with the Avon and Wiltshire Mental Health NHS Partnership Trust, is the co-author of RCPsych's ADHD in adults patient resource (2nd edition) which was published last year. He explains why he thinks producing this was so important.

"Public awareness of ADHD is a growing reality that is not matched by the resources we have to support people with ADHD, nor the expertise and the knowledge of ADHD

You can view RCPsych's mental health information at www.rcpsych.ac.uk/mental-health

In mid-June, RCPsych's highly anticipated annual International Congress returned to the Edinburgh International Conference Centre (EICC), offering delegates the opportunity to learn, share valuable knowledge, and meet and network in person. Attendees travelled in from 49 different countries, including from all across the UK.

The event's return to Edinburgh fell only a few months ahead of RCPsych in Scotland's 30th anniversary (this October). So, to mark this, and proudly on display on banners around the venue, was a new tartan – the winning entry of an RCPsych in Scotland membership competition to come up with a new design, which then was professionally drafted by a tartan designer.

Over the four-day event, sessions on mental health care and psychiatry covered everything from research to clinical knowledge, some featuring experts by experience.

In total there were 16 keynote speeches, including one by Professor John McGrath, whose research-focused session provided a concise update on the age of onset and cumulative risk of mental disorders.

Dr Hilary Cass OBE delivered a keynote on the main findings of the independent review of gender identity services for children and young people in England of which she was the chair. She covered what had informed the review, its main findings, the implications for clinical practice and research, the challenges in achieving consensus on best approaches to care and practical dilemmas in developing a stronger evidence base in the area.

Other keynotes took a more conversational, interview format to explore the lived experience of clinicians, such as Dr Rebecca Lawrence's session in which she shared her personal account of being a patient with severe mental illness before going on to become a psychiatrist, and how her experiences as a patient have influenced her outlook and practice as a doctor. Similarly, Professor Kenneth Kaufman was also interviewed for his keynote about stigma in the context of his experience of having epilepsy and how it has impacted his journey as a psychiatrist.

Among numerous other well-attended sessions was one that examined the rising rate of involuntary detentions – exploring the potential causes and how



Fringe session 'Theatre of the Oppressed' (immediately above) and a delegate at the Fringe stage (top)

Congress reflections

Some highlights from this year's International Congress in Edinburgh, as well as tips on submitting a session or masterclass proposal from Dr Jonathan Gibb of the Congress Advisory Board.

best to respond, as well as how involuntary hospitalisation rates could be reduced and, to aid this, how therapeutic relationships could be improved. It also included a segment on ethnicity and the Mental Health Act, discussing disparities in rising detention rates.

Also highly attended was a session on the connection between sleep, circadian rhythms and mental health which addressed the seasonal variation of diabetic markers

in bipolar disorder, the light hypersensitivity hypothesis of bipolar disorder and its potential implications for treatment, and stratifying the circuitry of disordered cognitions through the lens of sleep.

Other popular sessions included 'The sexual and reproductive health needs of people with psychiatric illness'; 'Menopause – what every psychiatrist needs to know'; 'Pragmatic approaches to assessment and management of bipolar

disorder'; 'New guidance for self-harm: an opportunity not to be missed'; 'Co-production made easy'; and '10 simple rules you can implement today to create patient designed and led care', among many more.

Interest in the topics covered was not only evident in the conference rooms, but also on social media, where many delegates shared their personal highlights.

In addition to the extensive programme of academic talks, there was, as ever, a selection of fringe events. Some involved active audience participation, such as the session on the Theatre of the Oppressed, a form of interactive theatre in which spectators become performers who act out solutions to social problems. This session's focus was on using participatory art methodologies, such as this, to support and empower communities with severe mental illnesses in India and Pakistan.

There were a number of new features at Congress this year, including a nature walk, the 'Climate Café', and The Atrium Stage which featured different performers every day, such as Dr Rosemary Gordon teaching the Highland fling. And this year's Congress party included a traditional Scottish

ceilidh, an evening meal, dancing and socialising, as well as the Student and Trainee social.

With over 2,600 registered delegates, this was RCPsych's second largest in-person International Congress ever, and the largest ever hosted outside of London. The event's success was also evident in the ratings of delegates who completed the feedback form – with 90% saying their experience was either excellent or good.

Looking to next year, work is already under way for International Congress 2025, which will take place in Wales from 23–26 June. Join the mailing list to keep up to date with plans as they develop: www.rcpsych.ac.uk/events/international-congress-2025

Missed out this year?

For anyone who did not attend this year, missed certain talks, or would like to see a talk again, recordings from each of the sessions (where speaker permission is granted) will be available on the eLearning platform by mid-August: www.rcpsych.ac.uk/events/congress From here, you can also sign up to be notified once the recording package for Congress 2024 is available, and see the related pricing information.

Session submission tips

Applications will open in the coming weeks for members to submit their proposals for sessions or masterclasses to be held at next year's International Congress.

Submissions are reviewed and approved by the College's Congress Advisory Board which is made up of 34 members. One of which is Dr Jonathan Gibb, who is currently an NIHR Academic Clinical Fellow in General Adult Psychiatry at the University of Bristol.

Drawing from his experience having submitted and chaired a session while a medical student and, now, as a board member, he shares his top tips for submission:

- 1. Select appropriate subject matter.** Focus on scientific discovery, open dialogue, and new learning that is clinically relevant.
- 2. Remember that balance and expertise of speakers is just as important as subject matter.** Think about how your panel will reflect the diversity of the workforce. You should avoid proposing, for example, a panel with three speakers from the same institution. The board is very interested in multi-professional viewpoints, and international voices are also valued. (It is an international Congress after all!)
- 3. Make sure your proposal is as focused as possible.** Avoid making it too wide or diffuse – think about who you will be speaking to, considering the broad crowd Congress attracts. In addition, remember that detailed, intriguing, and topical pitches score highly.
- 4. Don't be disheartened if unsuccessful.** Take feedback and consider re-submitting.
- 5. For Special Interest Groups: Consider cross-collaboration with other SIGs or faculties.** This can be helpful, even if informally, to gather a different perspective on the proposal. Specifically, co-chairing is an option we've seen work well.

Watch this space to join the Advisory Board

The 34-member Congress Advisory Board has representation from the SAS committee, the PTC, and patient and carer reps, and both includes members who applied for the role and those co-opted due to their College positions, such as College officers.

The College is looking at expanding the Board this year, so you can expect to see an open call for applicants later this summer.

Time will tell

Highlighting the work of Dr Claire Hilton during her tenure as RCPsych Historian in Residence and how historical knowledge can help us challenge stereotypes and provoke debate about mental health services today.

For Dr Claire Hilton, understanding the historical context of patients' lives is as crucial as understanding cross-cultural differences. "I can't understand why all old age psychiatrists aren't fascinated by 20th-century history – because that's our patients' background," she says, by way of example.

Dr Hilton was RCPsych's first Historian in Residence and, starting this year, has moved into the Honorary Archivist role. This work requires experience both as a clinician treating mental illness and as an academic with knowledge of historical and archival research.

Dr Hilton's interest in history has been lifelong. In medical school, for example, her first research funding was granted for a history project. And after six years as a consultant old age psychiatrist, she took a history-related sabbatical, completed a master's in history, and eventually earned a PhD focusing on the development of psychogeriatric services in England from 1940 to 1989. These academic pursuits deepened her conviction that understanding the past is essential to navigating the complexities of psychiatric care today, leading her to spearhead the creation of a Historian in Residence role at the College.

A key achievement of Dr Hilton's tenure was the witness seminar she organised about psychiatric hospitals in the UK in the 1960s. This type of event is a form of oral history that brings together individuals connected to a particular experience or topic to discuss their recollections, the transcripts of which become important historical documents.

"Part of my reason for doing oral history – witness seminars and individual interviews – is to record something that's going to disappear," she says. "The papers might live forever. But the people don't." And the personal recollections shared are a source of fascination. "It's about time travel. It's about going back, exploring and almost reliving those experiences."



Drawing of Mnemosyne, Goddess of memory

Dr Hilton also contributed to various initiatives commemorating the College's 180th anniversary in 2021, including a booklet providing a concise history of the College, and the Future Archives' competition. The latter aimed to "capture people's thoughts and impressions of psychiatry and mental health services at the time," she explains.

She also helped organise 12 free history webinars covering various topics, including a debate on whether psychiatrists should be judged by today's standards. This inspired her to write a paper on the values and historical understanding of psychiatrists, published in *BJPsych Bulletin*, in which she writes: "The assumption that we are better than our forebears may foster complacency about present-day psychiatry and discourage learning from

our predecessors' decisions and actions." The piece was named RCPsych Article of the Month in April.

One of her more recent projects fused art and oral history, capturing the stories behind the portraits of RCPsych's past presidents that hang at the College headquarters. Through interviews with both the artists and the sitters, where possible, the personal narratives behind the paintings emerged, humanising psychiatric practice and challenging stereotypes.

Over her time in post, Dr Hilton received a growing number of queries from around the UK as well as Australia, Germany, Luxembourg and Malawi, seeking her expertise on various topics. "A journalist wanted advice about a mental hospital, for which there were plans to concrete over its cemetery to make a car park," she recalls as one example.

Her work has also intersected with television. She advised on a script for an episode of *Call the Midwife*, ensuring accurate depictions of schizophrenia in the 1960s, and appeared in historian Lucy Worsley's documentary mini-series on Agatha Christie. She will also appear in an upcoming episode of *Who Do You Think You Are?* "For each appearance," she says "my one minute on screen had two weeks of research behind it. But I was able to add things they didn't already have."

Among all her activities, a quieter but consistent effort has been her blog posts. "It's always good to get feedback on the number of people who read them," she says. And, generally, across her tenure, she describes her satisfaction in seeing interest reflected back from the College and its members. "Also, the fact that somebody wanted to take over from me was wonderful," she says, referring to her successor, Dr Gordon Bates.

Now as Honorary Archivist, Dr Hilton remains committed to preserving and interpreting psychiatric history, starting with aspirations to improve and promote the obituaries page of the College website. She views history not just as a collection of facts but as a lens to understand and improve psychiatric practice. "We daren't be complacent," she warns, highlighting the ever-present relevance of historical insights in shaping the future of psychiatric care.

The witness seminar transcripts, Future Archives competition entries, RCPsych's 180th anniversary celebration webinars and booklet, the stories behind RCPsych's past president portraits, and Dr Hilton's blog posts are all available from www.rcpsych.ac.uk