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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT

New year, New opportunities

Contents

COLLEGE **NEWS IN BRIEF**

Get involved in shaping the future of College

Nominations for a range of elected roles within RCPsych's faculties, divisions, special interest groups and the Psychiatric Trainees' Committee are now open until midday on 17 January 2025.

These roles offer a chance to represent your colleagues, contribute to the College's direction, and support improvements in the profession. They also provide opportunities to develop leadership and communication skills, gain fresh perspectives, tackle challenges, build networks and influence policy. Your input can make a real difference. Consider putting yourself forward.

The College is also embarking on its search for a new Registrar to succeed Dr Trudi Seneviratne OBE when her term ends in the summer of 2025.

The Registrar has overall responsibility for College policy and oversees communications, campaigns, and membership engagement. They also represent the College to key stakeholders, and provide oversight of committees, faculties, devolved councils, divisions, SIGs, as well as wellbeing initiatives. The term of office for this post is five years. Nominations will open on 17 January, closing on 14 February.

See **www.rcpsych.ac.uk/elections** to find out more about eligibility and how to apply for these roles.

RCPsych in the news

Over the past quarter, RCPsych has secured media coverage on a wide range of key issues. Its 'Choose Psychiatry' recruitment and retention campaign made many headlines, securing almost 200 pieces of coverage, with support from high-profile influencers Ruby Wax, Jo Brand, Alastair Campbell and Stephen Fry. The campaign also called attention to high consultancy vacancy rates in CAMHS, leading to prominent coverage in *The Guardian* which included an editorial written by Dr Elaine Lockhart, Chair of RCPsych's Child and Adolescent Psychiatry Faculty, addressing long waiting times for children's mental healthcare.

The Guardian also ran an exclusive article on a recently published report by the College, calling on the government in Westminster to protect the mental health of people seeking sanctuary.

Dr Jane Morris, Chair of RCPsych in Scotland contributed to a joint BBC Scotland and *The Guardian* investigation into the cost of consultant psychiatrist posts in NHS Scotland being filled by locums. Following this, Dr Jess Sussmann, one of RCPsych in Scotland's policy leads, took part in an exclusive with *The Sunday Herald* on the same topic.

Additionally RCPsych in Northern Ireland secured various pieces of coverage on the workforce crisis, reflected in a 30% rise in waiting list times for mental healthcare appointments, to appeal to the Department of Health to prioritise the psychiatry workforce.

New resources for patients and carers

Over the last three months, the College has published three new information resources for patients and carers on the topics of long-acting injectable antipsychotics (depot medication); autism and mental health; and cannabis and mental health.

RCPsych's autism and mental health resource has fast become one of the most popular pages on the College's website and was reshared by wildlife TV presenter and conservationist Chris Packham, who is also a campaigner for autism awareness.

The College has over 100 information resources for patients and carers and over 300 translations in 24 languages. You can find all of these at: **www.rcpsych.ac.uk/mental-health.** Many of these resources, including the autism and mental health resource, are available as printed leaflets which can be ordered to your services. The full list is available from **www.rcpsych.ac.uk/leaflets**

Become a leader of public mental health

Following its successful launch in the spring, the Public Mental Health Leadership Certification Course is running two further cohorts in 2025.

This comprehensive course seeks to develop a culture change from an individualised model of clinical psychiatry to a population-based, preventative public health approach.

Previous delegates have praised it for its clear structure, useful resources, and relevant content. They highlighted the course's variety of formats, such as discussions and case studies, and valued the opportunity to collaborate and think creatively. Many found it particularly helpful for applying public mental health concepts within their own settings.

Find out more and book your place at: **www.rcpsych.ac.uk/pmhlcs**. Group bookings are encouraged, with discounts available. For more details, email **events@rcpsych.ac.uk**. Spaces are limited, so you are encouraged to register as soon as possible.

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To send us any feedback on *Insight* magazine, email magazine@rcpsych.ac.uk or tweet using #RCPsychInsight

President's message

As the year draws to a close, I want to take a moment to thank each of you for your dedication and hard work throughout 2024. This year has brought its share of challenges, and I know that many of you have been working tirelessly to provide treatment and care under demanding circumstances.

For many of us, the Christmas and New Year period may not necessarily offer a chance to pause or rest. Whether treating and supporting patients, covering extra shifts, or balancing professional and personal responsibilities, I want to extend my appreciation to you.

At the College, we remain steadfast in our commitment to supporting you. We continue to advocate for improvements across the mental health sector, ensuring that your voices are heard at every level, and are always seeking to improve your membership experience. From addressing workforce pressures to championing psychiatry and parity of esteem, we are pushing for change to make your working lives, and the lives of patients, better.

I hope you can find at least some moments of joy and connection during this season, no matter how you spend it. We are here to champion and celebrate you as we look forward to a new year of collaboration, progress, and hope.

Dr Lade Smith CBE

Questions of capacity, coercion and safeguarding

With assisted dying bills advancing across much of the UK and Crown Dependencies, RCPsych has been working with parliamentarians and other stakeholders to draw attention to, and ask questions about, the profound ethical, legal and practical challenges that this highly sensitive and complex topic poses for vulnerable people, doctors, and the NHS and other healthcare systems.

Globally, debates on the issue of autonomy, ethics, and the role of the law in end-of-life care have been gaining traction for some time. In recent years, assisted dying or assisted suicide (AD/AS) has been legalised under specific eligibility criteria in some countries, in addition to a small number of other jurisdictions that made decisions on this matter many years previous.

In much of the UK and the Crown Dependencies, a similarly significant legislative movement is evident, with various bills in development seeking to legalise AD/AS for individuals with terminal physical illnesses. Most recently, at the end of November, MPs in Westminster voted to advance a bill to legalise AD/AS in England and Wales, marking the start of a period of scrutiny before it could become law. The latest proposal in Scotland is progressing at a less accelerated pace, with more time being devoted to considering proposed legislation before an initial vote is held in Holyrood. Bills are also in different stages of progress in Jersey and the Isle of Man (there are currently no proposals in Northern Ireland or Guernsey.)

Although decisions of law are for parliaments to consider, their impact is especially pertinent to anyone working in healthcare. And while the bills currently in progress constrain eligibility to those with a terminal physical illness, there are a range of potential implications for psychiatrists, the services they work for, and their patients – those with mental illness, intellectual disability and neurodevelopmental conditions.

There are a number of unanswered questions about whether it is possible to provide adequate protections and safeguards for everyone and, if so, what these measures would look like. The College believes these details must not be left to the relevant professions to be dealt with through amendments to existing or new codes of practice.

RCPsych in Scotland has been working extensively on this topic for some time, having engaged with a number of proposals brought before Holyrood. Building on this work, and having seen proposals advancing in the Crown Dependencies, the College took steps in early 2024 to ensure it would be well prepared to engage with any proposals across the UK and Crown Dependencies consistently. A dedicated working group was set up, chaired by RCPsych Registrar Dr Trudi Seneviratne, with representatives from across its formal structures, including the Devolved Nations.

There was a clear need to develop a position on this matter that reflects College members' views and expertise, and acknowledges the topic's complexity. The working group has considered not only the topic itself but also questions of implementation – so that the College can be prepared and well positioned to engage with parliaments on potential legal changes, including by asking decision makers to address certain ethical and practical questions before any bills become law.

College members across the UK and the Crown Dependencies have been asked for their opinions on key areas for engagement, including through membership surveys – one in Scotland and another in England, Wales, Northern Ireland and the Crown Dependencies. There was also a debate on AD/AS and mental illness held at the College's headquarters in London.

Much in line with the wider population, members of the College hold diverse and, in many cases, conflicting views on the complex and sensitive issue of AD/AS. But there is a closer alignment when it comes to opinions as to which sociopolitical and legal considerations should be prioritised, should any of these bills become law, for the protection and safeguarding of both patients and doctors.

For example, on the nature of psychiatrists' involvement in capacity assessments, which is where they will most likely be brought into AD/AS processes if bills are implemented, some are of the opinion that psychiatrists should only be involved if a case is particularly complex or when a person is suspected or known to have a mental illness. However, others suggest they should be involved in every AD/AS application process as a matter of course. A potential risk of non-psychiatrists carrying out assessments is that the presence of a mental illness might be missed, which is a significant factor in determining capacity.

In addition to the question of *who* should be involved, there should be more consideration of *how many* professionals would take part in these assessments. The College has stated that no clinician should be required to navigate such decisions on their own. Additionally, the moral burden of doing this could be profound, causing a psychological impact on the clinician that should not be underestimated. Assessments should be conducted by a multiprofessional team that might include psychiatrists, other clinicians such as oncologists or palliative care specialists, and, potentially, non-medical professionals, such as social workers.

At the same time, members have brought into question the reliability of capacity assessments in the unique context of AD/AS, stressing how difficult it may be for any clinician to determine capacity, even with the expertise of psychiatric training.

In the College's survey covering England, Wales, Northern Ireland and the Crown Dependencies, almost two thirds of respondents were unconvinced that 'consent' is enough of a safeguard against factors such as lack of information, coercion or the effects of psychopathology on decision-making.

Safeguarding against coercion is a cornerstone of assisted dying legislation, but the current focus on external coercion – such as financial or familial pressures – may overlook subtler forms. RCPsych points to harder-to-detect internalised pressures, by which individuals may feel like a burden to loved ones or caregivers.

There are also questions about the threshold of capacity in this context, as existing assessment criteria are not designed for AD/AS cases and are possibly insufficient. It is possible that the threshold should be higher in this context due to the gravity of the decision and because capacity is known to fluctuate.

The College has also emphasised the need to ensure patients have access to comprehensive palliative care and psychological support as a prerequisite for informed and autonomous decision-making.

The ethical dilemmas associated with assisted dying are profound, particularly for psychiatrists tasked with balancing their role in suicide prevention with potential involvement in AD/AS processes. RCPsych's surveys indicated that approximately half of psychiatrists would opt out of participating in AD/AS due to personal or professional objections. To address this, the College strongly supports an opt-in system, ensuring that involvement remains voluntary.

The College's engagement with the relevant proposals has been ongoing. For example, RCPsych in Scotland submitted a formal response to the latest bill put before Holyrood and attended an oral evidence session on the subject. For the England and Wales bill, RCPsych in Wales briefed Senedd Members ahead of a Senedd debate on the principle of AD/AS in October. (The Senedd will likely be asked to give its legislative consent to pass the bill – although justice is a matter reserved for Westminster, and Senedd decisions on legislative consent are not legally binding.) And, ahead of the Westminster debate, the College also gave written evidence to the HSC select committee inquiry and members also took part in a roundtable event, as well as sending a briefing informed by the expertise of psychiatrists to MPs.

While decisions on legislation rest with lawmakers, RCPsych is committed to advocating for the prioritisation of patient safety and protections for psychiatrists. It is a priority to ensure legislative decisions reflect careful consideration of safeguards, ethical complexities, and healthcare system readiness. As legislative developments unfold, RCPsych will continue to advocate for a compassionate and thoughtful approach to this complex and sensitive issue.

- The results and analysis of the College's surveys on AD/AS will be published in due course on the College website.
- A webpage will also be launched with further details about the various proposals across the UK and Crown Dependencies and the College's engagement with them. This will be updated as the policy landscape changes, and the College's work develops.
- If you have any questions or would like to share your views, please contact Oliver Kavanagh Penno, who provides policy support to the working group: **Oliver.KPenno@rcpsych.ac.uk**

Managing diabetes and mental illness

Emphasising the multifaceted link between diabetes and mental illness, the co-authors of an RCPsych CPD eLearning module highlight the importance of equipping psychiatrists with the knowledge and tools to adopt an integrated approach to care.

Diabetes affects approximately 9.3% of the global population and is commonly comorbid with mental health conditions. The dual demands placed on individuals managing both of these aspects of their health can create significant challenges, meaning they often face poorer health outcomes and a reduced quality of life. Therefore, understanding the intersection between diabetes and mental illness, and taking an integrated clinical approach, is needed for the most effective care.

To help promote awareness and understanding of this topic, Dr Tomás Griffin, consultant diabetologist at Galway University Hospitals, and Dr Anne Doherty, consultant liaison psychiatrist at Mater Misericordiae University Hospital, Dublin, co-authored the RCPsych CPD module *Diabetes and the Psychiatrist: Optimising Patient Care*, a little over a year ago. The module, which takes around 60 minutes to complete, provides an overview of the evidence-based treatment of diabetes, managing comorbid mental disorders, and optimising glycaemic control in patients with diabetes. The last point is essential to avoiding the complications of diabetes.

Dr Griffin highlights that one of several key reasons it is so important for psychiatrists to be informed on this subject is that poor mental health can negatively affect one's ability to self-manage diabetes, which in turn can exacerbate mental health. "Self-management can be a relentless burden which means you have to constantly make decisions, often with less than satisfying outcomes," he explains. Various factors, like reduced motivation and energy, can disrupt self-management behaviours, such as monitoring blood glucose levels, following dietary plans, and taking medication – key aspects of maintaining glycaemic control.

Diabetes distress – the emotional impact of living with this chronic condition – is also a major challenge for many individuals with both type 1 and type 2 diabetes. "The shock of getting diagnosed can be so great that it can be overwhelming," he says, "particularly with type 1 diabetes because this is a lifelong condition for which there is currently no cure."

Fortunately, as explored in the module, technology has advanced. "We now have continuous glucose monitoring and insulin pump therapy, which have been shown to reduce diabetes distress and reduce scores related to depression and other psychiatric illnesses," says Dr Griffin. "We know that over 96% of people have a better quality of life with these new therapies. Diabetes technology has the power to change a person's life story."

Being clued up on what technologies and medicines are available helps to build a better therapeutic relationship. "Knowing what to say and ask builds trust between the person living with diabetes and the psychiatrist," he says. "They won't expect you to understand all the ins and outs. But knowing the basic principles of how the devices work adds real value."

In addition to having this knowledge, it is still important for clinicians to always be cognisant of, and alert to, people struggling to manage diabetes effectively, the mental health difficulties that might be influencing this, and how this can trigger a chain of adverse effects.

Before co-authoring the diabetes CPD module, Dr Doherty co-wrote the book *Mental Health, Diabetes and Endocrinology*, an exploration of the clinical overlap between diabetes and mental health, which was used as a basis for the module's content, in addition to the Joint British Diabetes Societies' inpatient guidelines and proposed standards of care within secondary care organisations.

As both the book and the module highlight, depression, anxiety disorders, disordered eating behaviours, and severe mental illness are common among individuals with diabetes, often functioning as both a cause and consequence of the condition. Co-morbid psychiatric conditions, their impact on self-care, and the potential side-effects of some treatments all make for a complex relationship with diabetes, influencing the management and overall care of both aspects of someone's health.

For instance, people with type 1 or type 2 diabetes are at least twice as likely to experience depression, which, in turn, is associated with worse outcomes across the spectrum of diabetes severity – from an increased risk of developing prediabetes to higher mortality rates. Effective care needs to address these overlapping risks.

Psychiatric medications are also part of the equation. Certain antidepressants, such as SSRIs, can increase the risk of hyperglycaemia, while others can contribute to hypoglycaemia. This underscores the need for careful prescribing that considers and accounts for the management of comorbidities such as diabetic neuropathy and the potential effects on glucose metabolism.

Psychotic disorders are another significant risk factor for diabetes, particularly type 2. Complicating this relationship, second-generation (atypical) antipsychotics are known to impair glycaemic control and elevate the risk of metabolic syndrome and type 2 diabetes in a way that first generation ones don't. "It's important that clinicians are empowered to carefully balance the benefits these medications offer against their potential impact on glycaemic control, and consider metabolic factors in choosing medications, where possible," says Dr Doherty.

The connection between diabetes and eating disorders is equally complex. People with diabetes, particularly type 1, face specific challenges that can increase their vulnerability to eating disorders, and there's a higher mortality rate associated with anorexia nervosa when diabetes is comorbid.

Purging in the form of insulin omission can be commonly seen in young women with type 1 diabetes and an eating disorder. "This can quickly set someone on a pathway of complications which can be very serious," says Dr Doherty. In such contexts, it's crucial for psychiatrists to work with diabetes teams to provide integrated care.

Dr Griffin agrees. "When one speciality team manages type 1 diabetes and another separately manages disordered eating, it doesn't work out as well as when you can use a joint approach to put a pathway in place to meet the person's needs, rather than two people steering the ship in slightly different or opposing directions," he says.

Dr Doherty draws on her extensive clinical experience to advocate for the value of a shared-care model and joint care plans. "Previously, I worked as part of the '3 Dimensions of care for Diabetes' team at King's College Hospital, London, which involved providing mental healthcare in that context," she says. "The impact that this made, not just to people's mental health, but also their glycaemic control, showed that integrating these two components of healthcare can make a huge difference to people's quality of life."

Psychiatrists working in these settings are likely to be the health professionals most in contact with patients and, therefore, best positioned to identify health risk behaviours, promote diabetes management techniques and remind them of the recommendations of their diabetes healthcare services. "You can get a sense of what the person with diabetes is being told to do and can integrate this into their mental healthcare plans," she says.

The popularity of *Diabetes and the Psychiatrist: Optimising Patient Care*, which was the most accessed RCPsych CPD module in 2023/24, may reflect a growing recognition of the importance of integrated care in this area. Both authors, Dr Griffin and Dr Doherty, hope it is the beginning of a broader shift in how care is delivered.

"It can be a challenge for people to manage their diabetes and mental health together," says Dr Doherty. "This is about trying to empower clinicians to recognise the problem and ensure joined-up specialty treatment on both sides, with a view to providing integrated care. And if psychiatrists can feel empowered to provide this integrated care, it can make a significant difference, particularly to psychiatric inpatients or those attending a day clinic regularly."

The CPD module *Diabetes and the Psychiatrist: Optimising Patient Care* is available from RCPsych's eLearning Hub: **www.rcpsych.ac.uk/diabeteselearning**

Acting on your feedback

Membership feedback from earlier this year has helped shape an action plan and recommendations to improve membership engagement and experiences.

In the summer, all College members were invited to share their experiences of being an RCPsych member and give feedback on how they engage with the College, what they value and, most importantly, how they can be better supported.

Valuable feedback from 2,321 RCPsych members has since guided efforts to improve engagement with the global membership of over 21,000, beginning with the development of an action plan.

The responses highlight that many members highly value key College functions. RCPsych's promotion of standards and quality improvement in mental health services, as well as its training and education provision, were particularly well regarded, with a rating of 'valued' or 'highly valued' from 76% of respondents.

RCPsych's work as the voice of psychiatry – influencing decision-makers and stakeholders, such as politicians and health providers – was rated as 'valued' or 'highly valued' by 67% of respondents.

A number of College benefits were also viewed favourably. For instance, 72% of members rated RCPsych's webinars and events as 'valued' or 'highly', and for CPD eLearning this figure was 64%. Among trainees, Portfolio Online and eLearning were amongst the highest rated benefits.

Members in College roles felt supported and would recommend taking on such positions, but some noted barriers to doing so. Time constraints were indicated as the main barrier (47%), followed by uncertainty about what the roles would entail (40%) and not feeling confident or experienced enough to apply (32%).

Additionally, 70% of respondents felt they had little to no influence over decisions, with some expressing that elected representatives often represent their own personal views, rather than a consensus of members' views.

Overall, 66% of respondents agreed that the College represents and advocates for the profession, although some called for clearer communication about activities, decision-making processes, and better engagement with international members.

"We are so grateful to all the members who provided feedback," says Sonia Walter, RCPsych CEO. "Now that we have reviewed the responses, we have put together an action plan to implement suggestions from respondents to improve membership experience and engagement."

Action plan

Informed by the membership feedback, the College has identified the following actions:

1. Improve communication around College governance and decision making (including a video explaining our governance and developing a scheme of delegation).
2. Create more engagement initiatives for Fellows of the College.
3. Introduce new staff roles to further improve membership engagement, including a Head of Engagement and additional administrative support for special interest groups (SIGs).
4. Streamline the governance of College committees and their reporting structures.
5. Improve communication around roles at the College and how members can apply and contribute to the work of the College.
6. Improve awareness of 'Question Time with the Officers' (monthly video updates on College activities at which members' questions and suggestions are heard and addressed) as an opportunity for any member to communicate directly with the College's Officers.
7. Enhance the induction process for members in College roles, giving them a broader understanding of the College and how their role fits within the organisation.
8. Encourage members to utilise the spaces available to them at RCPsych offices across the UK.
9. Improve ways for members to communicate with the College and to voice their concerns.
10. Ensure members know who their accountable representatives are on Council and what they do, and that elected members understand their roles in full.
11. Review the College social media strategy.

You can download the full feedback report and recommendations from **www.rcpsych.ac.uk/members/members-feedback**

Dr Mayura Deshpande, Clinical Advisor of the IRS

Collaborating to improve services

If you're interested in taking part in reviews of services alongside a multidisciplinary team of peers to offer support and advice, the College's Invited Review Service (IRS) is looking for new recruits.

When challenges arise in mental health services that cannot be resolved by internal processes, external formal regulators will usually investigate. But in cases that do not meet the criteria, RCPsych's Invited Review Service (IRS) can step in to help. From addressing serious incidents to navigating staff workloads and team dynamics, the IRS provides independent, professional advice to identify problems and offer solutions.

It's not just a reactive service. Increasingly, the IRS is asked to carry out forward-looking developmental reviews to help organisations prepare for future challenges. This expanded remit has created greater demand for reviewers, and the IRS is inviting College members to join its dedicated review teams.

Dr Mayura Deshpande, a consultant forensic psychiatrist, has been the IRS's clinical advisor for just over a year. "It's been an absolutely fascinating experience," she says. "It's a very valuable service, and the feedback we've had, during my period of involvement alone, has been overwhelmingly positive."

Each review starts with detailed information-gathering, including the analysis of clinical documentation, policies, and procedures. This is followed by site visits and concludes with a comprehensive report and actionable recommendations.

Dr Deshpande highlights that the success of the service lies not only in its final reports but also in the process itself. "The team puts as much thought into the review process as it does into the recommendations," she says.

The service operates UK-wide, assembling multidisciplinary teams for each review. These include mental health professionals, such as nurses, psychologists, and social workers, and lay experts. "We always have substantial input from patients, carers, or lay experts," says Dr Deshpande. "We couldn't carry out a review without them."

Selecting the right team is key. "When we're asked to do a review," says Dr Deshpande, "we think carefully about the most appropriate team – whether we need experts in clinical governance, incident management, safety concerns, or a particular psychiatric specialty."

Reviews are commissioned by senior healthcare leaders, such as Chief Executives or Executive Directors of Medicine, Nursing, or Social Work, and can only proceed with consent from any doctor or member of staff who might face scrutiny.

The process is collaborative by design, with the terms of reference of each review drawn up in consultation with the staff involved. "We need organisational buy-in so that we can be confident our recommendations will be implemented," says Dr Deshpande. "We're very aware of the importance of ensuring that everyone involved knows the review is a collaborative and constructive process."

A review can take up to several months to complete, depending on its complexity, "but there's flexibility in the time commitment we ask from our reviewers," says Dr Deshpande.

"Some reviews can be intense, especially retrospective ones, many of which are conducted after serious adverse events," says Dr Deshpande. These may involve clusters of inpatient deaths or concerns around governance or about culture and team dynamics. "Sometimes, our reviewers see and hear very difficult things," she says. Supporting those involved is a priority. "We build time into the process to consider the impact on our reviewers." However, the camaraderie with colleagues, positive feedback and knowing you've made real impact all make for a rewarding counterbalance.

The rise seen in forward-looking reviews reflects that "providers are looking ahead over the next five years, thinking about how they can remain fit for purpose," says Dr Deshpande. "Organisations want to ensure they're ready to meet the demands of a changing regulatory landscape."

Whether it's a prospective or retrospective review, taking part means "you gain a fresh perspective," says Dr Deshpande. "By seeing how others do things, you bring invaluable insights back to your own practice."

To join the IRS, you need to be a consultant with five years' clinical experience. Retired consultants (within three years) are also eligible. Email **IRS@rcpsych.ac.uk** for more information.

Perinatal progress

A collaboration between RCPsych and Egypt's main governmental mental healthcare provider is helping to improve access to specialist care for women who have mental health needs in the perinatal period.

A groundbreaking and intensive training event held in Cairo, Egypt, in October – as part of an ongoing collaboration between RCPsych and the General Secretariat of Mental Health and Addiction Treatment (GSMHAT) of the Egyptian Ministry of Health and Population (MoHP) – has assisted in the development of perinatal mental healthcare training pathways in the country.

Dr Manal El-Maraghy, consultant adult liaison and perinatal psychiatrist at Essex Partnership University NHS Foundation Trust, initiated the work in Egypt, where she was born and grew up, after establishing with the Egyptian MoHP that there was "an appetite" to develop these training pathways. It took 18 months of planning with the Egyptian government, represented by Dr Samar Foad, and clinicians to set up the five-day event, funded by Unicef Egypt. The work was supported by the international working group of the College's perinatal faculty, led by Dr El-Maraghy, as well as RCPsych's International Division, represented by Professor Mohammed Al-Uzri, Presidential Lead for Global Mental Health.

The event's training programme, which Professor Al-Uzri describes as "an excellent example of an output of RCPsych's International Strategy to raise standards of care for patients with mental health problems everywhere," also reflects Egypt's wider Vision 2030 strategy to improve the nation's health. In recent years, this has had a particular focus on women, leading to specialist women's mental health services and pathways being set up by the GSMHAT. Consequently, 17 hospitals have now established women's health outpatient clinics. Many of these have multidisciplinary teams of psychiatrists, psychologists, mental health nurses and social workers.

Building on this nationwide progress in healthcare, the recent training event will help perinatal mental healthcare services to expand their capacity. The organisers recruited psychiatrists working in women's mental health clinics with an interest in developing expertise in perinatal mental health, resulting in a diverse group of 25 attendees – 23 women and two men at various stages of their careers, from newly qualified to management level. The event adopted a 'train the trainer' approach, equipping attendees to share their learning with other colleagues, extending the training's impact.

Dr El-Maraghy was joined in Cairo by two other members of the Perinatal Faculty, Dr Cressida Manning (the faculty's immediate past chair) and Dr Giles Berrisford, who had helped design the programme. Together they co-delivered the training alongside colleagues in Egypt. The training programme was developed based on the needs of Egyptian psychiatrists, who had proactively requested topics such as caring for women with neurodivergence; prescribing during pregnancy and while breastfeeding; and service development and creating care pathways. These topics were reflected in the training programme, as well as others such as preconception care, psychosis, depression, and bipolar disorders.

The increased focus on the mental health needs of women in Egypt, which helped create an appetite for this training programme, reflects an increased attention seen globally, including in the UK. While further research in many areas of this field is still needed worldwide, the UK already has some well-established specialist women's mental health services and has shared its learning with other countries, including Egypt. However, it has been essential to adapt UK service models and pathways to better align with Egypt's specific context and needs.

Dr El-Maraghy explains that similar considerations, specifically around the delivery of perinatal care, were explored during the five-day training event. "It is not about transferring a pathway from the UK to Egypt; it is about understanding people's needs, being sensitive about the local culture, and thinking about other ways healthcare might function differently in the country," she says. For example, the training on medications for different disorders was adapted according to the availability of drugs in Egypt, which, compared with the UK, is restricted because of costs.

The event's attendees were keen to highlight how cultural differences across the country might need to be factored into care delivery, as like in most countries, there is great diversity among Egypt's own population. For example, cultural complexities around women's autonomy were discussed. As Dr El-Maraghy explains: "Some women in Egypt are not used to, or expected to, talk in detail about their issues – particularly with a man – and do not easily accept being examined by one. But also, husbands and fathers will often still have a say on their care." Additionally, some may feel it is important to consult with religious and spiritual healers.

Dr El-Maraghy praises the attendees for discussing such anticipated challenges so openly. She adds: "It is now up to them to shape training pathways by blending their expertise and knowledge of local needs." College representatives will be on hand to mentor and support them beyond the initial period, and assist as pathways begin to take shape. Plans accompanying the development of training include raising awareness of perinatal mental health issues in primary care.

The value of the intensive perinatal training event is also seen in the high-scoring feedback survey responses from the event's attendees. Its vision, outline and outcomes were all summarised at the International Congress on Health, Population and Human Development, held in Cairo in the same week.

"I was impressed by the level of engagement from the Egyptian colleagues and the dedication of the RCPsych volunteers from the perinatal faculty in this exchange of knowledge and skills", says Professor Al-Uzri, commenting on the training event's success. "I look forward to strengthening this collaboration and expanding it to include more Egyptian colleagues and RCPsych volunteers for a more sustainable impact."

Dr El-Maraghy has been encouraged by the level of enthusiasm and the groundwork that has been undertaken to support the development of women's mental health services. On a personal note, she found it immensely rewarding when one of the psychiatrists on the course told her that, after attending a talk she had delivered in Dubai five years earlier, she had been inspired to explore her understanding of perinatal mental health further.

Dr El-Maraghy hopes that the approach takien in Egypt might be replicated in other countries that are establishing specialist perinatal services.

"It was a successful, helpful, enlightening event and enriching for me and the other volunteers as we learned a lot from the psychiatrists in Egypt – the world is one big global community," she says. "We see people from the Middle East in the UK, and knowing and understanding what happens in their countries will help us to further and widen our knowledge about equality and diversity in a practical way. We left Cairo feeling refreshed and optimistic."

Therapeutic hope for Co-Sum disorders

People with co-occurring substance use and mental health disorders often struggle to access care that fully addresses their complex needs. A co-produced RCPsych report is in the pipeline that will advise all psychiatrists on best practice for this diverse group.

Co-occuring substance use and mental health (Co-Sum) disorders are common in people attending mental health and substance use services, but this group's complex needs often go unmet. This is not a small patient group; around half of people with a severe mental health illness also have a substance use issue and more than half of people attending substance use services experience a mental health issue.

There is huge variation within this group, from type and severity of substance use to the co-occurring disorder. Common examples include alcohol dependence and depression, or cannabis use and psychosis. Many people with Co-Sum disorders struggle to access appropriate care and have poor outcomes. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in 2016 found that one third of patients treated by mental health services between 2004 and 2014 who died by suicide had a history of substance use disorder, but only 7% were in contact with addiction services.

This gap in services has been recognised in national strategies in Scotland – which is leading the UK in this area – and the UK government's independent review of drugs in 2021.

Consultant addictions psychiatrist Professor Owen Bowden-Jones, chair of RCPsych's working group on Co-Sum disorders, is leading a report that tackles the subject. The group includes experts by experience, representatives from the devolved nations and from addiction, general adult, perinatal, liaison and neuropsychiatry faculties. Previous reports have concluded that services should be person-centred and that clinical management is 'everyone's business'. Rather than repeat these findings, this report will focus on implementation challenges and clinicians' gaps in knowledge.

A common mantra of 'No wrong door' is used for Co-Sum care, meaning that at whichever service someone presents to, they should receive assessment and signposting. The trouble is, says Professor Bowden-Jones, there is often no 'right door' because services may exclude specific co-morbidities. This leaves this vulnerable group confused as to where to find appropriate support.

The strategic disconnect between services is partly due to commissioning and funding structures. Treatment is more joined up in countries with co-commissioned services, but substance use services in England are commissioned by local authorities, meaning services are often asked to focus only on their area. A further problem in England is the deprofessionalisation of substance use services, where staff are often not equipped to assess, diagnose and treat mental health disorders and the presence of psychiatrists is rare.

Similarly, many staff in mental health services report they lack the skills to assess and manage substance use disorders, despite the large proportion of people in their service experiencing these problems. "When someone has both disorders, frontline clinicians can struggle as the service models and care pathways are not established," says Professor Bowden-Jones. And despite the introduction of integrated care systems in England and Wales, this has yet to have a significant impact on this patient group.

And then there is stigma. Working group member and patient representative Rachel Bannister was shocked by the judgment she experienced from members of her healthcare team. She remembers vividly the GP who referred to her as a junky, the service coordinator who would not acknowledge her when providing prescriptions, and the psychiatrist who assumed she would not need support as she was intelligent and resourceful. They made her feel as if the addiction was her fault rather than a symptom of pain and trauma, and these attitudes prevented her from accessing appropriate help. "It was damaging," she says. "It makes you not want to tell anyone about your addiction – as if it's a dirty secret. That's partly why it became so embedded."

Ms Bannister, who is also chair of the charity Mental Health – Time for Action Foundation, was prescribed temazepam when her daughter was an inpatient being treated for an eating disorder hundreds of miles from the family home. She wishes that the trauma of this experience had been acknowledged earlier. If she'd had access to mental health support alongside addiction support, she might have avoided the escalation that required an acute admission.

Stigma is "the elephant in the room," says Professor Bowden-Jones. "People in mental health services sometimes don't see substance use problems in the same way as other mental health issues and this stigma can perpetuate a view that people with addictions are somehow responsible or weak," he says.

With a lot of failings being systemic, it can seem difficult for individual psychiatrists to make a difference. The report will therefore include practical advice on simple interventions, such as screening tools that help audit the problem or brief interventions, such as the FRAMES model. "Screening, assessment and brief intervention could be easily adopted without significant cost, although these should ideally be paired with larger service-level changes and improved pathways," says Professor Bowden-Jones.

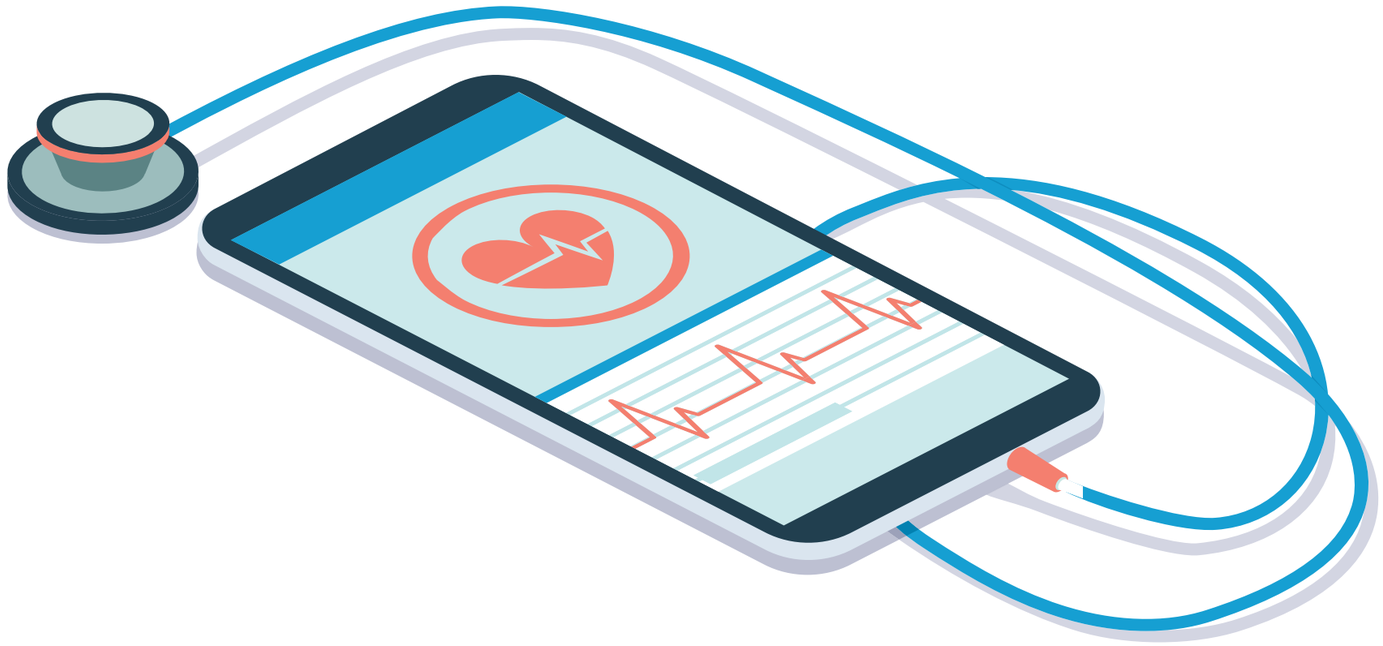
"We want to upskill all frontline clinicians to feel competent and confident in assessing, managing and developing treatment plans for people with Co-Sum disorders," he says. The report will have sections on the most common co-morbidities such as alcohol and mood disorders; cannabis and acute and chronic mental health problems; sedatives and PTSD; and methamphetamine and psychosis. It will also discuss vulnerable populations including homeless people, women in the perinatal period and people with neurodivergence.

Ms Bannister reflects on how small things can make a profound difference. When she was finally referred to a dual diagnosis service, a psychiatrist looked her in the eye and said: "You just need a hand to hold to see you through this." This kindness was so important. During the acute phase of her addiction, she said that only two clinicians enabled her "to not feel the indignity of shame". This, and the acknowledgement of her trauma, began to turn things around. She highlights the importance of continuity of care and the therapeutic relationship, but emphasises the often-underestimated power of small acts of humanity.

"Even with brief interventions, you can make that person feel safe and understood; you can listen and be kind. While this is obvious, it can be lost under pressure. Body language, how you look at a patient, how you listen and respond, and the language you use are so important," she says.

Ms Bannister and Melinda King, another expert by experience, have put together a powerful foreword for the co-produced report, calling for clinicians to look beyond addiction to underlying trauma. It quotes addiction specialist Dr Gabor Maté – "The question is not why the addiction, but why the pain" – and stresses the importance of therapeutic hope that people can get better with the right treatment. Increasingly, this will involve a trauma-informed approach. The trauma that often drives addiction should be acknowledged in treatment plans, says Professor Bowden-Jones.

It is hoped the report will lead to significant improvements. "Given the number of people with Co-Sum disorders, improving care for this group should be a priority. They are some of the most vulnerable people attending our services, with some of the poorest clinical outcomes. We should and can do more about it," he says.



Computing risks and benefits

Digital technology offers huge potential in mental healthcare, but must be used ethically with patient consent and proper support. When implemented well, it can complement traditional approaches, without seeking to replace clinician interaction.

Dr Paul Bradley was an early convert to the use of digital technology in healthcare. His interest dates back to his teenage years, during which he coded small software solutions for the GP surgery at which his father was a doctor and his mother was practice manager. Even at this age, his aim was to find ways in which technology could support the provision of excellent patient care.

Now, as chief clinical information officer for his trust alongside his role as a consultant learning disability psychiatrist, he pursues that aim for all the patients receiving treatment in his organisation and those that support and care for them.

"Technology should be an optional wraparound to augment services"

"I've always thought of digital technology as an amplifier," explains Dr Bradley, who is the College's specialist advisor on mental health informatics, as well as a member of its flourishing Digital Psychiatry Special Interest Group. "One-on-one care will always remain at the heart of psychiatry," he says. "But now, through the introduction of new technology, I can also spend time on initiatives that will benefit a large number of patients right across the service, helping to give them timely access to the right intervention."

The use of digital technology has rapidly accelerated in recent years, including in healthcare. The reasons for this are multifaceted. One is that computing power has increased while also becoming cheaper, and so more readily available. It has become easier for healthcare organisations to employ digital tools – although, thanks to outdated infrastructure and devices, it is not always easy for individual clinicians to reliably access them. While these advanced technology solutions offer substantial potential, we also need to invest in the day-to-day infrastructure that underpins their use, otherwise the benefits will never be fully achieved.

The pandemic and associated lockdowns served to further increase dependence on such technology. With virtual consultations and support becoming the norm overnight, suddenly there was a clear and widespread demonstration of the possible uses and merits of digital tools in mental healthcare. Of course, this also threw up the potential risks of not using them appropriately. Someone being coerced in their home environment, for example, needs to receive care in a safe place if they are to benefit from treatment.

"There's a lot of potential in the apps and systems that are out there, whether we're talking about providing basic appointment information, or getting into the territory of chatbots or online libraries, or even into full-blown AI therapy," says Dr Bradley.

The last of those has been a near-endless generator of recent headlines, even though it is not necessarily a new phenomenon. The very first artificial intelligence chatbot – launched as far back as 1966 – was expressly designed to emulate a psychotherapist. Eliza, as she was dubbed, is still available online. She is, however, noticeably less capable at productive conversations than her more famous descendants: the likes of ChatGPT, launched to the public in late 2022, or Google's Gemini.

It is these more recent AI tools that have led to extensive public discourse about the role of computers in society. And while ethical considerations have always been present in using digital technology in healthcare settings – keeping information safe and private has been relevant from the outset – such questions feel deeper and more urgent when the availability and capability of technology has progressed so rapidly.

"Digital technology can be misused or poorly implemented," says Dr Bradley, "and that comes with risks that are amplified because of the reach of these kinds of more recent tools."

Dr Abdi Sanati is Chair of the College's Professional Practice and Ethics Committee, as well as the former chair of the Philosophy and Psychiatry Special Interest Group, and so such risks are ones on which he has frequently reflected. His view is that any technology must be proven to support better patient care – through scientific trials – before it is used.

"It must make our work more efficacious," he argues. "Any technology that makes work less efficacious will, by definition, be unethical. You cannot afford to lose time, work or resources to something, particularly in this day and age when pressures on services are so extreme."

Dr Bradley agrees. "'Releasing time to care' is a good phrase to describe what technology aims to do. However, in reality a certain amount of people's time is bound up because of poorly implemented and poorly configured digital systems."

This, he says, speaks to the need for implementation to be properly resourced. This includes not only appropriate funding – which would preferably be equitable to that seen for digitisation of physical healthcare services – but appropriate clinical involvement.

Patient engagement is crucial. "The more that technology is going to be used by people with mental health conditions, the more important it is to include their voice, their views and their active participation," says Dr Bradley.

"There's a very broad spectrum of how people feel – in every way and direction you can imagine. Some will be very keen on technology and some will be absolutely reluctant and avoidant, and understandably so." And some people, will not have sufficient, or perhaps any, access.

Informed consent is fundamental to any ethical use of patient-facing technology, as Dr Sanati highlights. Patients must fully understand how any digital tools will be used in their care and, importantly, be genuinely able to withhold or withdraw consent. Where patients are vulnerable – as is often the case in mental healthcare – it is a process over which particular care must be taken.

Digital technology must never be a substitute for interaction with clinicians; it is an additional tool. It should also not be thrust upon people in a blanket way. "Patients should not be given a Hobson's choice, i.e. no genuine alternative, and it is important that any technology is scientifically proven to make patient care better," he says.

It is a point being increasingly emphasised by national and even international organisations. The EU set out its European ethical principles for digital health in January 2022, designed to "place digital health within a framework of humanist values" that includes informed consent. Prior to this, in Scotland, third sector organisations created a set of five human rights principles for digital health and social care. Among them are the principles of "people at the centre", "digital as a choice" and "access and control of digital data".

Following concerns around how some physical monitoring video technology has been introduced in the past, the College is calling for a clear framework that delivers the best of digital technology and protects all of us against its potential negative impacts. This is particularly crucial as new healthcare services and strategies evolve, such as the NHS 10-year plan, which is expected to place greater emphasis on digital technology.

For Dr Bradley, the greatest benefit from patient-facing technology in mental healthcare will be if it is used as "an optional wraparound to augment services". But, as with many aspects of healthcare, if done well "it cannot be one size fits all".

The College's Digital SIG explores technology in clinical practice, research insights, educational opportunities and community building. To find out more, or join, go to: **www.rcpsych.ac.uk/dpsig**

Members of the North Kent MHLD team with award presenter Dr Trudi Seneviratne

Awards season

Looking back at the work of individuals and teams recently celebrated at the RCPsych Awards.

The annual RCPsych Awards returned to the College's London headquarters this November, bringing with it the opportunity to reflect on and celebrate exceptional work in psychiatry from the past year and beyond. The event recognises the accomplishments of teams and individuals, and its categories cover psychiatrists of different grades and non-medical professionals working in the field.

There are also dedicated categories focusing on the work of trainees, including the Core Psychiatric Trainee of the Year Award, which this year went to Dr Kate Womersley. Praising her promotion of safe, effective and equitable healthcare as both a leader and academic, the judges described Dr Womersley as a "warm, empathetic clinician with a strong streak of social justice in her".

Honouring professionals across all career stages, this year's winners also included Janet Treasure, Professor of Psychiatry at King's College London, who received the Lifetime Achievement Award for her work as a clinician, educator, researcher and academic. Regarded as a leading figure in the specialty of eating disorders, she was an early proponent of the involvement of families as partners in care and developed and tested interventions with this approach. Also an advocate for the value of co-production, she co-produced treatments and services for eating disorders with experts by experience, as well as several academic and self-help texts on the subject.

In a short film played at the ceremony, Professor Treasure's colleagues and associates spoke about the significant influence she has had on the profession, as well as on their own lives and careers. Carer representative Veronica Kamerling commented that her contributions towards eating disorders has "created optimism that recovery is possible".

Another well-established psychiatrist recognised at the ceremony was Dr Asif Bachlani, who received the Psychiatrist of the Year Award. The judges referred to him as a "curious, innovative clinician" and a "stigma fighter", and his nominator wrote at length about his work to address inequalities, promote leadership skills and advance data literacy, an area in which he is recognised as a national expert.

His many achievements include establishing a successful neuro-developmental service, implementing digital technologies to improve patient care, and helping to increase diversity and gender equality within the executive committee of the College's General Adult Faculty. He continues to lead the data literacy programme for the College to improve patient outcomes and upskill all grades of psychiatrists on data and digital literacy to reduce health inequalities and improve population health.

Also demonstrating great innovation were the team winners of the Psychiatric Communicator of the Year Award, whose impressive public education programme was co-produced by RCPsych in Wales, Technology Enabled Care (TEC) Cymru and, most importantly, young people. Named 'Cynefin', a Welsh word which evokes a personal sense of belonging that might relate to one's relationship to their community, the programme facilitates engagement with topical issues in a variety of ways, including through school debates and interactive workshops. Cynefin has enabled young people to inform government policy in Wales, such as by helping to shape a Senedd cross-party group on climate and wellbeing, which, now established, is co-chaired by young people as well as a politician. The programme has also helped to create opportunities for young people interested in research or clinical careers in mental health.

Many other teams were commended at the awards, including the multidisciplinary North Kent Mental Health of Learning Disabilities Team (MHLD), who won the title of Psychiatric Team of the Year: Intellectual Disability. They were praised for being quality driven, having strong leadership and great teamwork, and for their use of resources.

At the RCPsych Awards ceremony, the President's Medals were also presented, which extend the College's gratitude to eight recipients who have made significant contributions to key areas relating to psychiatry, including policy and education. The winners of these medals, as well as the winners and nominees of this year's RCPsych Awards, exemplify psychiatry and mental health care at its very best.

If you'd like to nominate a team or individual for 2025's RCPsych Awards, you can sign up to be notified as soon as nominations open. Visit: ***www.rcpsych.ac.uk/awards***

Nothing about us without us

How RCPsych's forthcoming disability guidance, informed by lived experience, sets a blueprint for inclusive mental health workplaces where all staff can reach their potential.

To address a critical gap – disability inclusion in psychiatry – RCPsych formed a Task and Finish Group in 2022. Comprising disabled psychiatrists, the group has developed practical guidance, set to be published in January 2025, to help mental health services foster inclusive workplaces.

"This is about inclusion," says Dr Mhairi Hepburn, a consultant psychiatrist with bipolar disorder and ADHD. "This is about involving us in properly co-produced work." Dr Hepburn, who is also RCPsych in Scotland's Equity Champion, joined the group after noticing the RCPsych Equality Action Plan overlooked disabled psychiatrists.

The Equality Act 2010 defines disability as a physical or mental health condition with a substantial and long-term impact on one's ability to do normal day-to-day activities. In 2022/23, nearly one in four people in the UK reported having a disability, including those with neurodivergent diagnoses like autism, ADHD, and dyslexia.

"I don't consider ADHD to be an illness," Dr Hepburn explains. "There's no deficit of attention. My attention is directed in different ways from most people's. However, it is very much a disability because I'm disabled by society. I'm disabled by the barriers that are put in place by a world that caters to neurotypical people."

The social model of disability frames disability as a problem caused by societal barriers rather than problems or deficits within individuals. Removing these barriers is central to the group's recommendations, which highlight reasonable adjustments like flexible hours, remote work, accessible facilities, and parking. Despite legal obligations, nearly a quarter of employers fail to provide them.

"A lot of people don't tell their employer about their disabilities," says Dr Hepburn. "Or if they do, they just tell their line manager. The decision-makers at the top don't know how many disabled employees they have within their departments."

"There's lots of extra work for disabled employees, like getting reasonable adjustments organised and spending considerable time explaining what we need," she adds. "I describe it as having a part-time job on top of a full-time job."

Dr Suparna Sukumaran, a consultant child and adolescent psychiatrist and one of the group's leads on physical disabilities, can attest to this. After the effects of a stroke forced her to leave paediatrics training, Dr Sukumaran switched to psychiatry, pursuing her interest in neurodevelopmental conditions. As a trainee, she would visit workplaces to assess their physical accessibility, meet colleagues and discuss what assistance she might need, like carrying equipment or opening heavy doors.

She highlights that some individuals may find the 'medical model' of impairment acceptable, as it frames support as a practical response to specific challenges rather than a form of dependence, but this is not always the case.

Other challenges can look very different, and can include chasing Access to Work funding, enduring microaggressions, and facing assumptions about competence. "There are often quite discriminatory comments about people with neurodivergent conditions," Dr Hepburn shares. "And then they say, 'Oh no, we didn't mean *you*.'"

"Very occasionally, my patients would say, 'How can you look after people when you're not well?'" Dr Sukumaran adds. "Well, I'm not ill. I'm slow at doing certain things."

Still, Dr Sukumaran, who is also an RCPsych Equity Champion, has found that her visible disability often helps her connect with children with neurodevelopmental conditions. "I'm actually speaking from experience of having a disability, albeit a different one, and I can say what it's like, that it doesn't stop you, and you can still do very well in life."

While reasonable adjustments are legally mandated, the group encourages employers to go beyond minimum requirements. Their recommendations include appointing disability inclusion leaders, training managers, and establishing employee networks.

The benefits of disability inclusion also extend beyond disabled employees. Practices like scheduled breaks and flexible rotas help to improve workplace wellbeing for everyone.

Dr Hepburn sees the guidance as a model for other specialties and professions. "We've really been listened to. It's proper co-production." And, to those seeking to be better allies, she offers a simple reminder: "Nothing about us without us."

Tribute to Dr Onikepe Ijete

RCPsych's forthcoming disability guidance is dedicated to Dr Onikepe Ijete, a driving force and member of the Task and Finish group, who sadly passed away in late 2023. She is remembered for her endless energy and enthusiasm, and her ability to quietly but effectively push for change.

Professor Sir David Goldberg at his home in London in 2018 (Photograph: Alicia Canter)

A compassionate pioneer

Remembering the life and work of Professor Sir David Goldberg (1934–2024).

Professor Sir David Goldberg was a groundbreaking figure in modern psychiatry whose work helped transform mental health services globally. A proponent of integrating mental healthcare into primary care, his career saw him publish distinguished epidemiological research, develop influential tools and frameworks, and train and mentor countless psychiatrists and other health professionals. In addition to his sharp intellect, he was known for his humility, warmth and wit.

Born in 1934 in Hampstead Heath, north London, David entered a world on the brink of upheaval, with the Second World War looming. He was raised with his brother and sister by parents Paul Goldberg and Ruby (née Brandes), descendants of Jewish immigrants from Germany. After the war broke out, the family took in a cousin who escaped Nazi Germany via the Kindertransport.

In 1943, Ruby and the children were evacuated to Oxfordshire. Although distanced from the direct conflict, the family often faced prejudice, and many locals treated them as outsiders. David began to question why people he had never met – whether from Oxfordshire or Germany – would wish him harm. These early experiences may have contributed to his curiosity about human behaviour.

David developed a keen interest in his father's post-war work as a civil servant managing government training centres and rehabilitation units for returning soldiers. Psychologists would visit his father at the family home, and David often listened in to their work discussions around the dinner table.

At school, he listed psychiatry and biophysics as his top career choices, long before he knew much about either. Inspired by Oliver Zangwill's *An Introduction to Modern Psychology*, he decided to pursue psychology. However, his father only agreed on the condition that he study medicine as well. As his father was the one paying, David conceded. It was a decision he didn't regret.

David began his university studies at Hertford College, Oxford, in 1952, before completing clinical training at St Thomas' Hospital in London. Specialising in psychiatry at the Maudsley starting in 1963, David trained under prominent figures such as Professor Aubrey Lewis – whose presence at the institution drew him to train there – and Professor Michael Shepherd.

David published two widely adopted research tools that have advanced the ability to assess mental health in diverse contexts – the Clinical Interview Schedule in 1970, and the General Health Questionnaire (GHQ) in 1972. Widely used in low- and middle-income countries, a tailored version of the GHQ has allowed practitioners to screen for mental health conditions without requiring specialist training, bringing care to underserved communities.

At the University of Manchester, where he became a senior lecturer in 1969 and professor in 1972, David was responsible for teaching around 300 medical students and around 50 junior psychiatrists each year.

All the while, his interest in primary care psychiatry was a developing theme, and after a year as a visiting professor in the States, he was fuelled by more observations of mental disorders being missed in primary care. His research on this topic continued upon his return to Manchester in the form of a collaboration with colleague Professor Peter Huxley. In 1980, the pair developed the Goldberg–Huxley model, also known as the filter model, which outlined the stages of the pathway to psychiatric care, highlighting that the majority of mental health care takes place in primary care settings rather than specialist environments.

This work influenced mental health policy, underscoring the need for GPs to be equipped to manage psychiatric disorders. David introduced weekly GP training sessions, focusing on practical diagnostic skills and interview techniques.

Reflecting on this, Professor Dinesh Bhugra, a former RCPsych President and close personal friend, says: "David was an extraordinary thinker who recognised the importance of primary care psychiatry early on and brought it into focus. His work bridged mental and physical health, changing how we view patient care."

His influence also extended globally. As a long-term consultant to the World Health Organization, a role he continued into retirement, he contributed to revisions of the International Classification of Diseases (ICD), ensuring its frameworks reflected cultural differences. "He frequently travelled to give talks and share knowledge, which was deeply important to him," says Professor Bhugra.

He also created a master's programme aimed at international trainees wanting to study in the UK. Often, he went above and beyond, helping them find accommodation and navigate practical challenges like opening bank accounts.

Through his teachings and research, David explored the social determinants of mental health. He recognised that poverty, education, and social conditions profoundly shaped psychological wellbeing, and he advocated for holistic approaches that considered patients' lives beyond their symptoms.

In the UK, mental healthcare was increasingly delivered in the community, due in part to the Mental Health Act 1959. David encouraged students to consider how services in their countries could improve, and many later influenced policy in nations like India and Pakistan.

Among like-minded others, David played a role in advocating for psychiatric training standards to be raised. During the 1960s, as plans were under way for the Royal Medico-Psychological Association to transition into the Royal College of Psychiatrists, a group of trainees vehemently opposed proposals for a stand-alone membership examination. They were adamant that the plans for the new College should instead prioritise ensuring high standards of specialist training across all locations under its remit, with the exam secondary to that. David supported the trainees, facilitating a letter to *The Guardian*, which amplified their shared concerns. The trainees' advocacy efforts contributed to reforms that made training and standard-setting central to the new College, something that continues to this day.

David's written works are another important element of his legacy. Among the books he authored and co-authored, the seminal *The Detection of Psychiatric Illness by Questionnaire*, remains foundational to psychiatric research and practice. This is all in addition to his research papers, of which he published over 300.

In recognition of his services to medicine, David was knighted in 1997, and, in 2009, he received RCPsych's first-ever Lifetime Achievement Award, honouring a career dedicated to alleviating suffering and advancing mental health services. The David Goldberg Centre, part of King's College London, was established in his name after his retirement in 2000 and continues his work by advancing research and training future generations of psychiatrists.

Despite the extent of his accomplishments, David remained unpretentious and humble. In his homelife, he shared over five decades of marriage with Ilfra (née Pink), a distinguished gastroenterologist. David credited all his professional achievements to her, who he described as his "basis of stability and happiness". Married in 1966, they raised four children – Paul, Charlotte, Kate, and Emma – and were together until Ilfra's death in 2017.

David passed away in September aged 90, having developed Alzheimer's a few years earlier. In tribute to him, his Oxford college, Hertford, flew its flag at half-mast during the week of his passing.

His children remember him as a resourceful and loving father with a "wartime mentality" who viewed challenges as surmountable. His daughter Kate recalls how he preferred to build furniture rather than buy it, and how he engaged in debates about literature that inspired her to become an English teacher. "He was kind, generous, and always reading," she says.

Professor Sir David Goldberg once said he didn't want to be remembered, but his impact on psychiatry – marked by compassion and innovation – continues to influence patients, colleagues, and trainees worldwide. In addition to his four children, he is survived by nine grandchildren.

Let Wisdom Guide

RCPsych Treasurer Professor John Crichton discusses the symbolism behind the College's Coat of Arms, exploring its historical and mythological influences and how it represents the role of psychiatrists.

"**While** you may be very familiar with the College's Coat of Arms, you might not know the extent to which it represents who we are as a community of psychiatrists. The relevance of this heraldic emblem, which will celebrate its 100th birthday in 2026, might at first glance not be obvious, but upon closer inspection it reveals a wealth of symbolism. It is a gift from an earlier generation and, despite being nearly a century old, remains relevant today.

At the centre of the design, we see the serpent-entwined Staff of Aesculapius, the Greek God of Medicine and Healing. This image is known across many parts of the world as a symbol of healthcare and medical practice and, here on our Coat of Arms, the snake and staff signify our role as doctors. We then have two additional snakes, which feature prominently as the supporters either side of the central shield. Some suggest the significance of the Aesculapian snakes – which are nonvenomous – may lie in their usefulness in keeping vermin at bay in ancient temples of healing. Equally, their periodic shedding of their skin to reveal a new, continuous piece of skin, free of blemishes and scars, may also have led to the creature's appeal as a symbol of healing.

While it is the staff that identifies us as doctors, it is the four butterflies surrounding it that identify us specifically as psychiatrists. The symbolic importance of the butterfly is rooted in Greek mythology and the story of Psyche, a mortal woman known for her beauty who later became the Goddess of the Soul. In ancient Greek, 'psyche' means both 'soul' and 'butterfly,' connecting the two in a symbolic relationship. Psyche's story revolves around transformation, struggle and eventual transcendence, and provides a metaphor for the therapeutic journey.

At the top of the Coat of Arms, it is perhaps surprising to see an ancient Egyptian hieroglyph forming the crest upon the helm. This symbol is the ankh, a T-shaped cross with a loop on top, which often appeared in ancient Egyptian culture and represented life. In art, it symbolised life or life-giving substances, such as air or water; in medicine, it was believed to possess healing powers, and medical practitioners carried an ankh with them as a symbol of expertise.

This ancient Egyptian influence on the College emblem likely reflects the discovery of King Tutankhamun's burial in the early 1920s and the subsequent popularity of all things Egyptian, meaning such symbology was part of the cultural zeitgeist during the time preceding the emblem's creation. Notably, the word 'ankh' forms the middle part of Tutankhamun's name.

There is one more Egyptian element on the Coat of Arms, as the ankh is cradled by two black wings of an Egyptian Kite. This is the symbol for Isis, the Egyptian Goddess of Healing. With her wings outstretched, she embodies the caring force that protects life and guides the soul through physical and spiritual realms. The combination of the ankh and Isis's wings highlights the balance between life and protection. Like a bird of prey mantling over a catch, these wings may symbolise the protection of patients while they recover and are vulnerable.

Although Isis's wings are typically depicted as black, including on our emblem, they have occasionally been shown in rainbow colours, an appropriate alternative given the use of rainbows to celebrate healthcare workers during the pandemic and the College's commitment to equity, diversity and inclusion.

The final notable element of our Coat of Arms is the College motto: 'Let Wisdom Guide', seen in some versions of the design. In biblical literature, wisdom is often personified as a female figure. She is known as *Sophia* in the Greek tradition and *Hokmah* in Hebrew. She serves as a source of practical knowledge and a moral compass, emphasising ethical conduct and thoughtful living, and she embodies an understanding of human nature and the complexities of life.

Referring to her as Sophie, a derivation of Sophia, I sometimes will ask a group of trainee psychiatrists: "Have you met Sophie yet?" to encourage them to think differently about their patients or a clinical dilemma. Sophie may represent the patient seen on call, those whose treatment responses are presented in a meta-analysis, or the patient seen in psychotherapy. Our patients are our greatest educators and in them we find guiding wisdom."