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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT

Reclaiming our medical identity:
More than prescribers

Contents

COLLEGE NEWS IN BRIEF

Scottish CAMHS targets met, but challenges remain

A rare piece of good news in a system often under strain: For the first time, Scotland's CAMHS have met the national target, with 90.6% of young people seen within 18 weeks of referral. This milestone, revealed in recent Public Health Scotland figures, marks steady progress from 89.1% in the previous quarter and 83.8% a year ago.

But while the numbers look promising at first glance, they don't tell the full story. The overall number of young people still waiting for treatment has grown since the last quarter to 4,362. Referrals remain high, with nearly 9,000 children seeking help in the last three months of 2024. And while 3,812 started treatment, that's 16% fewer than the same period in 2023.

Dr Kandarp Joshi of RCPsych in Scotland welcomed the progress but warned that official figures don't fully account for long waits for autism and ADHD assessments. He urged the Scottish Government to follow through on promises to boost funding, ensuring young people with complex needs aren't left behind.

Professor John Crichton

A hard act to follow

After four years of exceptional service, RCPsych's Honorary Treasurer, Professor John Crichton, will be stepping down from his role at the next AGM on 25 June to take on the role of Executive Director (Medical) at the Mental Welfare Commission for Scotland.

John has made significant contributions to the College over the past eight years, serving as Honorary Treasurer since 2021 and as Chair of RCPsych in Scotland from 2017–21. His dedication and impact will be formally recognised in due course.

In the meantime, the process to find his successor as Honorary Treasurer of the College has already begun. This role is vital and involves responsibility and oversight of the College's financial position, record-keeping, governance and publishing. If you think this could be you, we encourage you to nominate yourself. To find out more about the process, please go to: **www.rcpsych.ac.uk/elections**

Nominate for the RCPsych Awards

From 4 April, members will be able to put forward their nominations for the RCPsych Awards 2025. The awards are an opportunity for the College to celebrate some of the outstanding contributions to the profession, with categories covering teams, individuals and psychiatrists of different grades, as well as experts by experience.

Award winners will be celebrated at a ceremony held in-person at the College's London headquarters in November. Find out more at: **www.rcpsych.ac.uk/awards**

Extending our reach

RCPsych has launched new social media accounts on the rapidly growing platforms Bluesky and Threads – which allow users to share short messages, links, images and videos – to ensure it is reaching as wide an audience as possible as it advocates for the profession.

In addition to the College's other existing channels on X, LinkedIn, Facebook and Instagram, members can follow the new Bluesky and Threads accounts to keep up to date with news and learning opportunities, as well as ways to help the organisation influence decision-makers to improve mental health services across the UK.

You can follow the College's Bluesky account at **@rcpsych.bsky.social** and its Threads account at **@theRCPsych**, and can remind yourself of the College's social media policy on the RCPsych website: **www.rcpsych.ac.uk/about-us/social-media**

Guidance for MSPs

RCPsych in Scotland has launched a new mental health guide for Members of the Scottish Parliament (MSPs) to equip them with vital knowledge about mental health conditions and illnesses. With mental health issues on the rise across the UK, the guide aims to ensure politicians and their staff can better understand different conditions, from common mood disorders to more severe illnesses like schizophrenia.

Importantly, the guide also helps MSPs direct constituents to appropriate support services. Many people reach out to their elected representatives for help, whether they are struggling themselves or caring for someone with a mental health condition. By providing clear, accessible information, the guide empowers MSPs to offer informed assistance and guidance.

This initiative was based on a successful handbook previously developed by RCPsych in Wales for Members of the Senedd (MSs). Professor Alka Ahuja, Chair of RCPsych in Wales, noted that MSs found the resource incredibly useful in their work with the public. Dr Jane Morris, Chair of RCPsych in Scotland anticipates a similarly positive impact. "We hope that the guide will benefit MSPs in Scotland just like it helped politicians in Wales."

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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 is reflected in this spring issue of *RCPsych Insight*, it is clear that the challenges and achievements within our profession continue to shape the landscape of mental healthcare. We highlight critical findings from RCPsych in Northern Ireland's *Time to Bridge the Gaps* report, which starkly illustrates the ongoing crisis in Northern Ireland's mental health services and sets out a clear strategy for recovery. The College is committed to working with policymakers to drive meaningful change.

We also explore the developments of the Mental Health Bill currently progressing through UK Parliament. While the Bill includes some welcome reforms, there are significant concerns about its potential unintended consequences.

Additionally, we reaffirm the importance of psychiatry's holistic approach to care. As psychiatrists, we must resist the narrowing of our role to prescribing medication alone. Our expertise lies in integrating biological, psychological, and social factors to provide truly comprehensive treatment.

Finally, we profile the expansion of Mental Health Watch, our vital data resource that now includes Scotland and Wales. Access to transparent, up-to-date information is crucial in holding decision-makers accountable and improving services.

As we move forward, our focus remains on advocacy, professional development and ensuring that psychiatry continues to be a leading force in mental healthcare. Thank you for your dedication to this vital work.

Dr Lade Smith CBE

Two steps forward, one step back?

With a long overdue reform of mental health legislation in England and Wales in progress, the College has been working hard behind the scenes to get the best possible outcomes for both patients and clinicians.

Last November, with little fanfare, the UK Government introduced its Mental Health Bill into the House of Lords which amends and updates the Mental Health Act 1983 (MHA). On the one hand, the College welcomed the introduction of the Bill and its focus on enhanced patient rights and support of the delivery of relational care, in which clinicians work in greater partnership with patients to ensure that compulsory inpatient admissions focus on therapeutic benefit and safety for all.

However, the College has also been warning of the potential and concerning unintended consequences which may widen existing inequalities, and is emphasising that "there is still work to be done".

When this article went to press, the Bill was progressing through the House of Lords and was about to enter the House of Commons. The College has been working closely with parliamentarians, mental health charities and other professional bodies to support a number of significant amendments to the Bill during its progress through the Lords. But, so far, the UK Government has appeared reluctant to amend the Bill substantially.

The background to reform is a steep rise in the number of detentions this century. Although there was a decline during the pandemic, there have been around 52,500 newly recorded detentions under the MHA in England between 2023 and 2024, a rise of 2.5 per cent. In that same period, Black people were three times more likely than white people to be detained.

To address these problems, Sir Simon Wessely was tasked with leading an Independent Review which was published in 2018. Following this, a draft Bill was published in 2022 that underwent pre-legislative scrutiny by a joint committee of both houses of parliament. After a long delay, a Bill finally made it to Parliament at the end of 2024.

Professor Gareth Owen and Dr Richard Latham are, respectively, the College's special advisor and deputy special advisor on mental health and capacity law for England and Wales. They have both expressed concern about a topic that also dominated debates in the Lords – the position of people with learning disability and autistic people. The Bill would prohibit people being detained for compulsory treatment solely on the basis of learning disability or autism in Part Two of the Act (relating to those not undergoing criminal proceedings).

"The reason for doing this," says Dr Latham, "is because of the scandal of some people with learning disability and autism being detained in hospital for very long periods of time without anything that, in medical terms, amounts to treatment. So, the problem it's attempting to solve is legitimate. But is this the right way to try and solve it?

"At the moment, it is possible for someone with a learning disability or autism to be diverted into hospital at an early stage without criminal charges being brought against them. If you lose this possibility of civil detention, there is a risk that the only route for people receiving hospital treatment is by them being charged. This is because the Bill does not remove learning disability or autism as categories of mental disorder for the purpose of detention under Part Three of the MHA, which covers people who are in prison or facing criminal charges."

There is also a concern that by distinguishing between those who have been caught up in the criminal justice system and those who have not could create a two-tier system. As College President Dr Lade Smith points out, this risks particularly disadvantaging Black men, who are "disproportionately more likely to have contact with mental health services via the police or criminal justice system".

"The UK Government is responding to a lot of these concerns essentially by saying, 'Well, it won't be implemented for up to 10 years'," says Professor Owen. "But that raises the question: is this a good way to make law? The College is warning that this could become 'bad law', by which I mean it could have unintended and unresolved consequences. There are also concerns about how it interacts with the deprivation of liberty safeguards (DOLS) in the Mental Capacity Act, for example," he says."It's just not looking coherent to us."

RCPsych in Wales shares all these concerns but is perhaps more sanguine about how they can deal with them. Although criminal justice is not a devolved matter, health and social care are. Therefore, once the Bill becomes law, says RCPsych in Wales's National Manager, Ollie John, the Welsh Government will have a lot of leeway in how it is implemented. "We will get an enhanced and revised code of practice to make the new Act work in Wales," he says. "We already have mental health legislation in Wales, so the new code will help bridge any gaps."

The Senedd Cymru (Welsh parliament) has to give legislative consent to the provisions of the Bill affecting health and social care services. The Welsh Government has already indicated acceptance of the Bill. Senedd Commitees are due to report on this in April, with a debate in the Senedd expected thereafter. "But, if the Bill is amended in Westminster," adds Dafydd Huw, Policy and Public Affairs Manager for RCPsych in Wales, "that may be pushed back." However, he predicts it's very unlikely that consent will be withheld.

"From RCPsych in Wales's point of view," says Ollie John, "there are still opportunities to strengthen elements of the reform, which may be in the form of complementary legislation. So, in areas like advance choice documents (ACDs), we've got the levers in Wales under our devolved healthcare element to further strengthen that."

ACDs allow people to outline their wishes for future treatment and care while they have capacity, and this is one of the Bill's positive aspects. Research shows them to significantly reduce detentions and to be particularly beneficial to Black people. The Bill states that health bodies would be required to inform patients about them and clinicians would be required to consider using them. However, they are only ultimately to be offered at the discretion of Integrated Care Boards rather than as a right, meaning their use will not be enforced. "We've been advocating for the duty to offer an ACD to be strengthened," says Professor Owen.

He also cites work the College has been doing to support amendments to introduce a Mental Health Commissioner for England, whose primary role, he says, "would be to keep momentum going behind a process of law reform in mental health". Additionally, Professor Owen highlights attempts to change the wording in the sections of the Bill dealing with detention criteria, which, as they stand, he says, "are liable to foster poor reasoning".

Whatever form the final legislation takes, it will have fearsome resource implications. A huge expansion of community services will be required for the learning disability and autism proposals to stand a chance of success. Hundreds more psychiatrists and other mental health professionals will be needed, along with a big expansion of Mental Health Tribunal capacity. Estimates of the extra workforce costs alone have been put as high as £1.9 billion. Whether and when those resources become available will be the ultimate determinants of the reform's success.

You can read more about the College's position and activity relating to the Bill, including amendments proposed by the College, at **www.rcpsych.ac.uk/MHBupdate**

Time for action

A new College report quantifies for the first time the true scale of the crisis faced by mental health services in Northern Ireland and sets out a three-year strategy for recovery.

Dr Julie Anderson, Chair of RCPsych in Northern Ireland

When it comes to convincing those in power to take action, presenting the full extent of a crisis in clear, measurable terms can be a crucial first step. This is exactly what RCPsych in Northern Ireland has done in its groundbreaking report which sets out the reality of the crisis in the country's mental health provision that has been brewing for several years, and sends an urgent message to the government that change is long overdue.

Titled *Time to Bridge the Gaps*, the report doesn't pull its punches. Drawing on figures from the College's 2023 census, to which four of Northern Ireland's five health boards contributed data, it sets out the key statistics in stark terms. Waiting lists are up by almost a third in four years. One in four consultant psychiatrist posts are vacant, an increase of 50% since 2017. More than a quarter of SAS doctor posts are unfilled. And per capita spending on mental health in Northern Ireland is the lowest in the UK by some distance. Yet, as Dr Julie Anderson, Chair of RCPsych in NI, says "mental health need here is approximately 25% higher than in the rest of the UK because of, at least in part, the legacy of the Troubles".

All this means that mental health services in Northern Ireland are in danger of collapsing in on themselves. Understaffing and underfunding are putting psychiatrists and other mental healthcare professionals under huge strain, which, as the *Time to Bridge the Gaps* report points out, "is leading to a decline in job satisfaction and retention. This is unsustainable, and many are leaving the profession or considering early retirement." Add to this the fact that there has been no increase in psychiatry resident doctor (trainee) places in Northern Ireland since 2007, whereas, in the rest of the UK, there have been over 700 more resident doctor places created in the past three years alone.

"They've known what's wrong for years. Now, we're shining a light on it"

Dr Donna Mullen, consultant psychiatrist in addictions, can attest to the impact of these issues on individual professionals. She left a substantive post in South Eastern Health and Social Care Trust in January 2025 to pursue work outside the NHS, and was the fourth consultant psychiatrist to leave addictions services in Northern Ireland within a year. Donna gave a number of reasons why she left the NHS, including her frustration at the lack of funding for the substance use strategy, inadequate resources for the complexity of patients attending addictions services, feeling isolated at work, no specialty doctor or resident doctor support and a lack of opportunity to teach resident doctors.

And it is not as though the Northern Ireland Executive has been unaware of these issues. In 2022 and 2023, the Department of Health (DoH) itself produced two workforce reports that identified shortcomings and made proposals for change. But neither has been funded or implemented.

This situation can't continue, and the College has also been working hard for some years to impress upon the government the need for action, but what was lacking was hard data – something that Dr Anderson's predecessor, Dr Richard Wilson, prioritised. With the publication of *Time to Bridge the Gaps*, it's going to be a lot harder for the politicians to kick difficult decisions into the long grass. "They've known all this for years," says Dr Anderson, "but it hasn't been presented in such a clear way before. Now, we're shining a light on it".

However, Dr Anderson explains that the political system is also a part of the problem. It is one reason why things have got so bad, and it presents a big stumbling block to turning things round. Designed to enable formerly warring parties to work peacefully together, the Northern Ireland Assembly was established in 1998. Since then, it has been suspended six times, for a total of 10 years, when the parties fell out. "The place just stagnates and actually gets worse during those times of suspension," says Dr Anderson, "because nobody makes decisions. Even when the Assembly is functioning, departmental budgets are set annually so long-term decisions are not made."

"We're also in a situation where we have a coalition government," says Emma Allen, RCPsych in NI's manager, "and every decision has to be signed off by all four political parties in the executive. And if there's any new money to be spent, it can't just be signed off by the Minister of Health. It has to be signed off by the Minister of Finance, who belongs to a different party."

Dr Anderson gives a sobering example of how things work in practice. In 2021, a commitment was finally made to build a mother and baby unit, the first ever in Northern Ireland. But its construction has been pushed further and further back and is now set for 2028 at the earliest. Even then, "there's no clear allocated funding to actually then staff it and keep the lights on," says Dr Anderson. "So, while the commitment is a good news story, it doesn't feel like that when you're working in a perinatal community team and, when a mum requires admission, the only option is a general psychiatric ward, separated from her baby."

With so many complex issues fuelling the ongoing crisis, the report not only highlights the problems, but offers solutions. "The document brings together all our work over the years and says, these are our key messages, and these are our strategic priorities."

Three strategic pillars and recommendations are set out in the report: reduce vacancy levels; fix pipeline shortfalls by expanding training places and improving recruitment and retention; and address the needs of specialist services, which trail behind the rest of the UK. The College has identified several key performance indicators to help it to monitor progress.

The reaction to *Time to Bridge the Gaps* has been overwhelmingly positive. Health Minister Mike Nesbitt was present at the launch of the report and the College has introduced it at meetings with the First Minister, the Deputy First Minister, the DoH and other stakeholders.

"We've been doing this work as a College in Northern Ireland for a long time," says Emma Allen, "and we've upped our game. We've got something now that sets things out in black and white. It's time to move into a place of accountability and outcomes-based collaboration."

Time to Bridge the Gaps – RCPsych NI Policy Strategy Briefing 2025–2028 is available at **www.rcpsych.ac.uk/nistrategy**

President,
Dr Lade Smith CBE

Dean,
Professor Subodh Dave

Registrar,
Dr Trudi Seneviratne

Treasurer,
Professor John Crichton

Reclaiming our medical identity

The College Officers stress the need to safeguard the full scope of psychiatric practice, reaffirming its unique ability to integrate biological, psychological and social approaches.

What does 'medical expertise' mean when referring to a psychiatrist? Psychiatry has always integrated biological, psychological, and social factors into patient care. However, there is a growing tendency – both within and outside our profession – to equate 'medical' with 'pharmacological.' This misconception must be challenged.

Prescribing is certainly a key tool, but our training equips us with much more – biological, psychological and social approaches to assessing and treating mental illness. Among multidisciplinary professionals, psychiatrists uniquely have the expertise to synthesise complex psychological, biological and social data to optimise patient outcomes. Co-developing biopsychosocial formulations with patients not only helps create a meaningful narrative for them but also serves as a foundation for personalised care and treatment.

This formulation-based approach is legally supported by mental health legislation across the UK's nations, with provisions that clarify or acknowledge that appropriate medical treatment extends beyond medication to include forms of care such as nursing, psychological interventions and specialist mental health rehabilitation. This affirms what clinicians have always known – that psychiatric treatment is far broader than a medication prescription alone.

With increasing clinical pressures, rising demand, and limited workforce growth, psychiatrists often become the only medication prescribers of the team by default. However, that is very short-sighted. Without expert, formulation-based care plans, our patients are at risk of receiving fragmented and/or inadequate care. Not only is this bad for our patients, but it also risks modelling a solely pharmacological paradigm for our resident doctors.

This can lead to a self-fulfilling prophecy as, when psychiatrists are seen primarily as prescribers, we diminish the breadth of our expertise and lose sight of what truly defines our profession.

We must push back against the forces driving us in this direction, even if it is in small ways, to insist on who we are. When we write court reports, care plans or assessments, we have a duty to consider factors such as a patient's housing, social support and psychological state in addition to their genetic risk factors, physical comorbidities and psychopharmacological history. Our leadership extends across all aspects of care.

We must, of course, be experts in prescribing medications, but if we fail to consider evidence that links psychosocial factors to the potential beneficial impact of those medications, this runs counter to our identity as clinical scientists. What's more, it has real-word consequences – ignoring the wider determinants of mental health outcomes leads to preventable relapses, increases crisis admissions, and, in some cases, forensic involvement. The financial and human costs of such avoidable crises are immense.

Neglecting a holistic approach also diminishes the very essence of what makes psychiatry rewarding. Many enter the field to make a real difference in people's lives and because they are drawn to the complexity of the human experience. If reduced to prescribers alone, we lose out on the fulfilment of forming deeper connections with our patients, understanding their stories, working collaboratively on their recoveries and witnessing the impact of truly personalised care.

A formulation-based, biopsychosocial approach is also the best response to the anti-psychiatry narrative that suggests psychiatrists dehumanise their patients. By demonstrating that psychiatry is about treating the whole person, not just symptoms, we reinforce our role as compassionate, patient-centred clinicians.

In some ways, our field faces an existential challenge. But this is not about pitting the biological, psychological and social against each other; it is about holding on to, or regaining, our position as specialists who bring these nuanced facets together. Otherwise, we not only let our patients down but also weaken the very foundation of psychiatric care.

Psychiatry was one of the first fields to practise precision medicine – an extension of tailoring treatment to the individual. Now, we must take this further. Our years of training enable us to personalise care in ways that no algorithm or guideline can replicate. By reclaiming the full scope of our expertise, we can improve patient outcomes and safeguard the future of our profession.

Let us not fall into the trap of letting our medical identity be reduced to medical prescriptions. Our role is far greater, and, at times, we need to remind both others and ourselves of that fact.

Dr Lade Smith, Professor Subodh Dave, Dr Trudi Seneviratne and Professor John Crichton

Data is power

Mental Health Watch, the College's dedicated website for tracking mental health services, now delivers more frequently updated data reporting and is expanding its remit beyond England to include Scotland and Wales.

How well are mental health services performing in your area? Are staffing levels improving, or is funding falling behind? These questions and more can be answered by Mental Health Watch (MHW), a user-friendly website produced by RCPsych that measures the data that matters for holding decision-makers to account.

When advocating for improvements to mental health services, data is power. Access to reliable, up-to-date figures on funding, staffing and service performance provides the evidence needed to push for change.

MHW makes this information accessible to anyone with an internet connection. Whether you're a psychiatrist, policymaker, researcher, patient, carer or campaigner, it allows you to track mental health service performance over time, not just nationally but also locally and at a trust or health board level. This means greater transparency and stronger evidence for change.

Expanding into Scotland and Wales

When MHW launched in 2019, it focused solely on England, with the aim of helping hold the UK Government accountable for delivering mental health targets set out in the Five Year Forward View for Mental Health and the NHS Long Term Plan. Now, in 2025, MHW has broadened its scope to include Scotland and Wales, offering insights into mental health funding and workforce levels. There are also plans to include Northern Ireland once the necessary data becomes available.

Improved data and data analysis

A recent technical overhaul has made MHW more comprehensive and accessible than before, allowing for greater flexibility in data analysis and near real-time updates – drawing information from multiple sources, such as NHS Digital, Public Health Scotland and StatsWales as each source is published – whether monthly, quarterly, or yearly depending on the data type.

What can I find out using Mental Health Watch?

MHW organises its data into themes.

- **For England:** The website now includes 20 refreshed indicators (metrics) for monitoring services – covering access, care quality, workforce, finance, and leadership. For example, performance against waiting time targets for CYP eating disorders and early intervention in psychosis. The recent addition of sub-ICB and mental health trust-level insights enhances transparency, making it easier to pinpoint where resources are needed most. MHW also now has a new feature allowing you to view tailored content for your area/ICB on a select number of indicators, all neatly provided in a bespoke chart and accompanying summary text.
- **For Scotland and Wales:** MHW has introduced tracking for mental health investment and workforce numbers, with plans to increase the number of indicators over time.

While MHW does not currently cover Northern Ireland, it aims to do so once the necessary data becomes available.

How do I use Mental Health Watch?

1. Go to **mentalhealthwatch.rcpsych.ac.uk**
2. **Decide what you want to know** – Whether it's staffing levels, hospital admissions, or funding, for example.
3. **Find and compare data** – View data by NHS trust, health board, Integrated Care Board (ICB) or sub-ICB and compare the performance of several organisations at a time.
4. **Understand what it means** – Each indicator explains why the data matters for mental health policy and service improvement.
5. **Spread the word** – Share your findings on social media, in a report or with policymakers to drive change.

Turning data into action

MHW is a data source, but it can also be a campaigning resource. By providing clear, comparative data, it enables anyone to track trends, hold politicians to account and advocate for better mental health services. As the website evolves, its potential to shape policy and enhance mental healthcare across the UK continues to grow.

Influencing the plan

RCPsych's response to the UK Government's initial consultation for its 10-year plan for NHS services in England aims to make sure mental health is firmly on the agenda.

The UK Government launched *Change NHS* last October as part of its engagement process for a 10-year health plan to shape the future of England's NHS services. At its core, the plan centres on three key 'shifts': moving more care from hospitals into communities, making better use of technology, and prioritising prevention. However, mental healthcare is not explicitly addressed within these proposals, raising concerns that it could be overlooked without deliberate and proactive action being taken.

As part of *Change NHS's* engagement process, organisations, individuals, experts, NHS staff and patients were invited to respond and share their priorities and concerns. Given this opportunity, RCPsych responded in a way that made sure mental health was brought into the conversation, reinforcing its broader advocacy efforts.

"It's an opportunity to tackle long-standing challenges that we have in mental healthcare"

Following extensive engagement with faculties, divisions, officers, patient and carer representatives, and members, the College submitted a comprehensive 5,000-word response, making full use of the word limit to highlight its long-standing policy priorities and reflect more specific proposals from the engagement work. Striking a balance between support and caution, the response welcomed positive changes but also emphasised the need for mental health to be prioritised and explored solutions that respected the parameters of the plan.

Dr Jon Van Niekerk, Chair of RCPsych's Faculty of General Adult Psychiatry, says: "It's an opportunity to tackle long-standing challenges that we have in mental healthcare, and our submission was bold." Focusing on early interventions, integrated care and workforce investment, the response also explored challenges and possible policies for each proposed shift.

RCPsych's response to the plan's first key shift, the move to community care, included issues affecting urgent and emergency care and inpatient service capacity. Dr Van Niekerk says capacity – or rather the lack of it – is a key issue as one in 10 adult mental health beds is occupied by someone who is clinically fit for discharge but has nowhere to go because of the lack of resources in community mental health and social care. A solution to this would require meaningful integrated care, with investment in supported housing, social care and community care.

This is supported by Dr Elaine Lockhart, Chair of RCPsych's Faculty of Child and Adolescent Psychiatry. She emphasises that it is essential that young people who need inpatient care are able to access local provision, as being placed far from home can be hugely detrimental to their health. In response to some of these issues, the College has recommended intelligent commissioning to ensure bed distribution matches local need.

Dr Van Niekerk stresses the need to find better ways to predict mental healthcare needs as the current system puts undue stress on acute care and fails to care for "the missing middle" – those with serious mental illness who fall below the threshold for referral to secondary care.

This is also seen in children's care says Dr Lockhart: "We don't have enough support in the community for children who are struggling but may not have a clinical condition and we also need more capacity within specialist services to provide direct care and work across services."

The College has suggested piloting the placement of psychiatrists in primary care settings which could greatly improve timely access to psychiatric care and begin to reach those in the middle, providing effective contact at an early stage.

The plan's second shift is the improved use of technology. It is clear that the use of digital and artificial intelligence tools can reduce the admin burden. Examples of this in mental health include reducing ADHD assessment waiting lists from five years to 12 months through the use of digital screening tools, as well as reducing the time taken to complete autism assessments by using AI tools to perform tasks such as data collation and response analysis. However, the College has advised that investment in day-to-day IT infrastructure be prioritised, particularly when IT issues are a huge source of daily stress for NHS staff. The College also recommends having a single user-friendly portal for patients that is empowering but not a replacement for face-to-face care. Dr Lockhart points out the safeguarding aspects of using technology with children – and the importance of having a therapeutic relationship before moving care online.

In response to the plan's third shift, prevention, the recommendations from the College centre on early interventions. "Almost half of all mental illness begins before the age of 14, yet support often comes far too late. If we can invest in prevention, it will not only save money but also save a lot of suffering," says Dr Van Niekerk.

Effective prevention requires a long-term vision. A College report on this topic, *CR238: Infant and early childhood mental health: the case for action*, makes recommendations to sustainably address the public mental health implementation gap for under 5s and their families. And its findings indicate the need for investment in truly integrated services that support children and young people with mental health needs "rather than in siloed systems," says Dr Lockhart.

Within its responses to the three shifts, the College has made its position clear that long-lasting change should be supported by investment in mental health services for people from birth onwards – achieving prevention using early intervention and high-quality, meaningfully integrated services. At the moment, mental health only gets 10% of NHS funding in England but it contributes to 20% of disease burden. "You might not be able to eliminate the disease burden but investment in mental health will help to reduce it," says Dr Van Niekerk.

And rather than fire-fighting by focusing on short-term measures to reduce A&E pressures, investment in children's services will help reduce the pressures on A&E and acute services in physical health in 20 or 30 years' time, says Dr Lockhart. Spending in early years can prevent a lot of short-, medium- and long-term difficulties, and we can identify who is more likely to be struggling as children are hugely affected by their social conditions, poverty and adverse childhood experiences, she says.

The College has also emphasised the need for investment in the mental health estate to ensure safe and therapeutic environments for patients and staff. Dr Lockhart highlights the particular importance of this for children and young people with neurodevelopmental disorders who are over-represented in inpatient care.

Workforce issues are also covered and will need attention if any plan for the NHS is to work. While the government's plans to expand the mental health workforce are welcomed, Dr Van Niekerk says: "Expansion is not enough; retention is crucial." The College has called for ringfencing of funding for mental health support for NHS staff, and for an investment in staff development and training to help make the NHS a more desirable and sustainable option.

The College's response covers a lot of ground, and this article highlights only a few key aspects. It also complements the College's ongoing advocacy efforts as it works towards achieving its priorities. There have already been follow-up meetings about the plan, and this is certainly not the end of the College's involvment. With the final plan set to be published in June, Dr Van Niekerk says: "It is vitally important that we are involved in the implementation because the devil will be in the detail."

Learning from each other

A partnership between RCPsych and the Ghana College of Physicians and Surgeons is demonstrating the value of bidirectional learning.

Cross-cultural collaboration isn't just about sharing knowledge – it's about learning from each other, bridging cultural divides and transforming practices on both sides. A collaboration between RCPsych and the Ghana College of Physicians and Surgeons has been achieving precisely this, enhancing sub-specialty training while creating a lasting impact on mental healthcare in Ghana. The project recently completed its second phase, culminating in face-to-face learning sessions in Ghana, which focused on four specialties: child and adolescent, old age, addictions and forensics.

"It was a real learning experience for us to see what true collaboration meant," says Dr Shivanthi Sathanandan, one of the project's two College co-leads for addictions psychiatry. "It wasn't about preparing lots of lectures – it was about being open to a learning experience from both sides." Together with her fellow co-lead, Dr Anna Walder, they travelled to Ghana to take part in person. "We could talk about the UK experience, but actually we needed to ask what would be more useful in Ghana. We were there to learn together and see how our shared experiences can help each other," she says.

The project's two-way or 'bidirectional' learning approach created dynamic collaborative sessions during which trainees could challenge the trainers. For example, during the addictions psychiatry sessions, important discussions emerged around the value of harm minimisation and what this could look like in the Ghanaian context. Dr Sathanandan says these discussions highlighted the principle of 'local evidence for local interventions' – particularly given the culturally specific nature of addictions and drug use.

"We were able to bring complex cases to the group"

The addictions co-leads visited Ghana with Dr Hasanen Al-Taiar from the Forensic Faculty, who delivered the training in this area (taking forward the work of the project's two co-leads for forensics, Dr Stephen Attard and Dr Bradley Hillier). Together they were able to build on feedback given to a first team who had started a few weeks earlier.

Part of that first team delivering in-person sessions was Dr Ama Addo, who has 18 years' experience of teaching in Ghana and who was the project lead for child and adolescent psychiatry. To get the most value out of collaborative and cross-cultural training like this, she says it is vital that "learning objectives come from local trainees rather than outsiders imposing what they think trainees should learn".

She advises making sure everyone is aware of each other's expectations and responsibilities early on. There can be communication difficulties on both sides and establishing the best way to communicate can help – for example, in this project's case, it was sometimes necessary to use WhatsApp rather than email. "The planning takes longer than you would assume and having key local people who can help with the organisation is vital," she says.

Dr Addo stresses the need to be flexible and imaginative, describing changing an initial lecture-heavy timetable to one that would allow more active and case-based learning. "I don't think people learn much from just being lectured at," she says. Working alongside Dr Addo in Ghana was Dr Mani Krishnan, the project's College lead for old age psychiatry. Recorded online modules and Q&A sessions were followed by the in-person sessions with some joint sessions between each specialty.

Dr Pearl Adu-Nyako is a senior resident in child and adolescent psychiatry at the hospital in Kumasi, where the training took place. She is one of Ghana's few senior residents in the specialty and is responsible for large numbers of patients in varied settings. She is also involved in education and advocates for patients and the profession in the media and with commissioners. Such a multifaceted role is not unusual for Ghanaian psychiatrists.

Working alongside Dr Addo, she participated in the training, selecting cases for discussion, modifying the schedule and addressing logistical challenges. The success of the training would not have been possible without her hard work and the sacrifices she and the entire team of senior residents made led by the head of their department at Komfo Anokye Teaching Hospital.

"The bidirectional nature of the programme allowed a lot more room for learning," she says. "The sessions would have been purely theoretical otherwise. We were able to bring complex cases to the group and have practical discussions about treatment challenges and how we could provide culturally appropriate interventions with the resources we had," she says. And hearing details of some UK cases strengthened her understanding of the biopsychosocial approach and the need for creative and diverse ways to support patients.

For Dr Adu-Nyako, the programme has been transformative and she has also noticed the difference in her colleagues – particularly in the way they engage with families. She is keen for the partnership to continue so the country can build capacity in the specialties and she is enthusiastic about taking up further opportunities. "Any effort that would help Ghanaians prioritise child and adolescent mental health is critical. Further collaborations could help improve outcomes for Ghanaian children," she says.

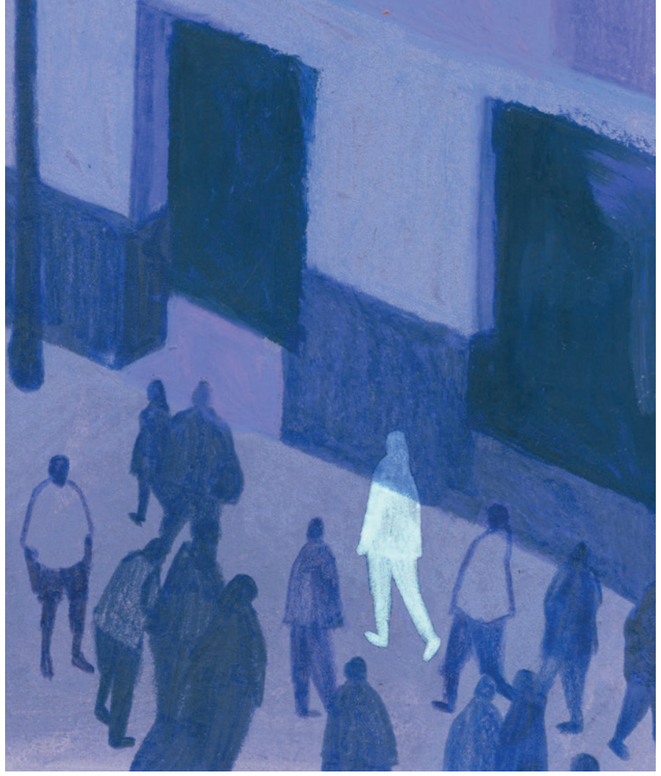
Dr Sathanandan also found the experience transformative: "It was exhilarating not to have the answers – we asked the residents, 'What do you think? You are the experts.' It made me reconsider the nature of teaching in the UK and it has motivated me to look through our data and work closely with our commissioner as a way to progress the specialty." It also made her reflect on the psychiatrist's role in the wider system. "Seeing how important the connections with the wider mental health team are in Ghana inspired me to work on those connections in the UK."

While the project's online training was valuable, Dr Addo emphasises the importance of the in-person training and the additional benefits it offered, including giving attendees protected academic training time and making it less likely for technical issues, like unreliable WiFi, to interfere with sessions. She also highlights how it allowed for a greater level of human connection, explaining: "It was much easier to have a dialogue when teaching people face-to-face, to build relationships and have meaningful Q&As."

Dr Sathanandan took a lot away from her experience in Ghana. "We have such a Eurocentric view of medicine, but we truly are part of a global community. You can't take psychiatry away from philosophical, cultural and socioeconomic concerns. In Ghana, we constantly thought about what would and wouldn't work, questioning why things would be done. It made us think how we could come back and collaborate with our patients and have meaningful coproduction."

Dr Addo highlights the value of the multilayered nature of the learning – trainers, trainees and colleagues all learning from each other. She uses the example of joint sessions at which English and Welsh, Scottish and Ghanaian mental health legislation were explored. "It is a good model for trainees to see experienced professionals collaborating," she says.

For other psychiatrists who want to be involved in a similar project, Dr Addo says: "It is a very positive experience if you like teaching and spending time with enthusiastic psychiatrists early in their careers. But you must be intellectually curious and have a degree of humility to be willing to learn from each other."



Illustrations by Jodie Howard

When reality feels unreal

An exploration of the day-to-day experiences of patients with depersonalisation-derealisation disorder, featuring insights from the authors of an RCPsych eLearning CPD module, who are raising awareness of this complex and often-overlooked condition.

Depersonalisation-derealisation disorder (DDD) is complex and under-recognised, yet is thought to affect 1% of the population – the same prevalence as obsessive-compulsive disorder or schizophrenia. People with DDD experience extreme dissociation, questioning their sense of self (depersonalisation) and the world around them (derealisation). Despite this, their ability to distinguish between reality and their altered perception remains intact, differentiating DDD from psychotic disorders.

Symptoms are subjective and unobservable – often masked by numbness. People with DDD may be terrified of what they experience and may struggle to even describe it. However, common themes include feeling as if the world is behind a veil or perceiving themselves as robotic. The most typical symptoms are a sense of unreality and disconnection from thoughts, memories, and surroundings.

DDD is a distinct condition, but symptoms can be experienced as part of other mental health conditions, such as panic, PTSD, anxiety and depression, schizophrenia or psychosis, and physical illness such as migraine and epilepsy. It is also often experienced alongside other mental health conditions.

Consultant clinical psychologist Dr Elaine Hunter has researched depersonalisation since the 1990s. For years, she led the only specialist NHS DDD clinic and now runs an independent specialist practice.

Her interest grew from her PhD in childhood trauma, during which she realised some children were dissociating spontaneously as a form of psychological protection. She says that the symptoms of dissociation are an "innate mechanism we can all experience" – but only in a transient way, for example when tired or jet lagged. But with DDD, those feelings persist causing distress or impairment.

A useful way to understand DDD is as a psychological buffering system, where parts of the mind or body temporarily disconnect. The lack of internal feedback can manifest as emotional and physical numbing, alongside feelings of unreality and disembodiment.

Many patients recall a trigger, such as childhood trauma, panic, or bad experiences with recreational drugs. A common theme is anxiety. "It is often a precipitating and perpetuating factor, but it is important that DDD is not dismissed as 'just anxiety' as this makes people disengage with services," says Dr Hunter. It may have a sudden or gradual onset and it can be episodic or chronic, with certain factors – such as stress, crowds, bright lights – worsening symptoms. Most people with the disorder will experience it constantly, albeit with fluctuating levels of severity.

Gwen Webb first developed symptoms in her late teens following adverse childhood experiences. "It felt like the most extreme Groundhog Day mixed with depression," she says. "Every day blended into the next. I was missing chunks of time and it became so severe that I couldn't recognise myself in the mirror. My logical brain could identify it was my face, but it felt like I was looking at another person." When she googled her symptoms, she had a "penny-drop moment," relieved to finally have words to describe what she was experiencing.

It took her four years to get a formal diagnosis, despite bringing a description of the disorder, the Dissociative Experience Scale and Cambridge Depersonalisation Scale (which can be used to assess severity) and an illustration showing how she felt to her initial appointment in adult mental health services. The result was a referral for an autism assessment and she was discharged with no support for her distressing symptoms.

Many wait even longer – over seven years – before receiving a diagnosis. Accessing treatment is another challenge, as DDD is rarely covered in general psychiatric training, leaving people reliant on individual clinicians' knowledge.

Dr Hunter and neuropsychiatrist Professor Anthony David have produced an RCPsych CPD module on DDD and accompanying CPD podcast to help address this knowledge gap and equip psychiatrists with the skills to recognise and treat the disorder.

The two worked together in the research team at the depersonalisation unit at the Institute of Psychiatry in the 1990s and the DDD specialist unit at the Maudsley Hospital. Their commitment to DDD research continues, having just completed a successful NIHR-funded feasibility study on a cognitive-behavioural therapy (CBT) treatment model for the disorder. "We hope that clinical trial evidence will convince the NHS and NICE to make it part of the offer that's available throughout the NHS – only then are we are going to reach the people that need it," says Professor David. But first, they need to secure more funding.

Long waits for treatment can be isolating. Work and relationships suffer, and many struggle behind a 'mask of normality'. "I laugh and smile – outward signals of joy – but it is not a felt thing," says Gwen. "Positivity comes in split seconds but disappears quickly."

One of the main treatments for DDD is CBT. Other talking therapies may help, as can mindfulness ("the antithesis of depersonalisation," says Dr Hunter). Schema therapy, EMDR for PTSD and trauma-focused CBT can also be used. Sometimes, patients benefit from treating comorbidities before tackling DDD.

Pharmacological treatments have also had a positive effect. Lamotrigine, which is used for epilepsy and bipolar disorder and blocks the glutamate system, combined with an SSRI has had some success, and rTMS has had "guardedly positive" results for some people. However, none of these have the backing of clinical trial evidence.

An individualised approach to care is needed as some therapies won't be suitable for everyone. Gwen personally found EMDR too intense, and that mindfulness "didn't even touch the surface," but she has become an expert in her own condition and uses a lot of coping strategies. She gets peer support and volunteers with the DDD charity Unreal, and is also involved in research. Friendships she has made with others with DDD have been invaluable and she recommends that psychiatrists signpost patients to Unreal as it has helped her and many others. While Gwen has had long-term chronic DDD, she is keen to highlight that recovery is possible and the majority of people do get better.

It is clear that more training and awareness is needed for clinicians at all levels. To find out more, Gwen recommends talking to people with lived experience, being curious about the condition and reading more about it so that the words used to describe the condition are familiar. On a similar note, Professor David advises that clinicians ask their patients the right questions as many will be afraid to describe their symptoms.

He is also keen to encourage more psychiatrists to get involved with DDD research which will in turn improve care: "It is a fascinating condition because it asks questions about the normal sense of self that we take for granted. It could help psychiatrists understand a lot about other conditions too."

Find out more

- RCPsych's CPD module and podcast: To access both, search 'DDD' at **elearninghub.rcpsych.ac.uk**
- Patient support: **unrealcharity.com**
- *Overcoming Depersonalisation and Feelings of Unreality*, a book co-authored by Dr Hunter, Prof David and two others.

Professor Russell Razzaque

Bringing compassion to the forefront

A new, innovative training programme aims to equip psychiatrists and other mental health professionals with advanced tools for compassionate and relational care.

"I want to bring the relational dimension back into the heart of the way we work," says Professor Russell Razzaque, the College's Presidential Lead for Compassionate and Relational Care. "Historically, psychiatry has rested on two pillars: technical and relational. But, in recent decades, the relational pillar has withered."

Aiming to help redress this imbalance, he created a new residential course, the Compassionate and Relational Learning Programme, to set a new standard in mental healthcare by fostering a culture of compassion and empathy, and firmly reprioritising relational care.

Produced by the College's NCCMH, the course sits on solid foundations. Firstly, there is growing evidence for, and recognition of, the central role that the therapeutic relationship plays in psychiatric patient outcomes, as well as an expanding body of research supporting the strong link between childhood trauma and severe mental illness in adulthood, highlighting the importance of trauma-informed care.

Secondly, there is demonstrable demand. The results of a members' survey conducted by Professor Razzaque in 2018, for example, showed a strong desire for better therapeutic relationships with patients. "There's a huge appetite for this," he says. "Many realise that relational skills are fundamental to our work and there is a deficiency in how services currently operate."

Each module lasts two days, with three held per year over a three-year period. Attendees can attend individual modules or complete all nine for a certification. This year's sessions will take place at Fitzwilliam College, the University of Cambridge, starting with the first module on April 23–24. Bookings include accommodation in student halls and all meals.

A key aspect of the course's design is to equip clinicians with practical tools that can be implemented immediately including how to integrate compassionate and relational care into conversations around prescribing. A strong clinician–patient alliance can improve adherence to regimens and influence patient expectations.

The first module (dialogical practice) aims to equip attendees with techniques inspired by 'open dialogue', an approach that takes a social network perspective and encourages practitioners to build a therapeutic relationship not just with the patient, but also the people around them. This can help to ensure a patient's support network is able to really engage and support them in their care.

"We know that involving friends and relatives in care reduces the suicide risk by up to 90%. And there are things clinicians can do immediately to begin working in this way," Professor Razzaque says.

Making patients feel safe is another crucial factor as it can be an important step in an individual's recovery, as well as a prerequisite to ensuring clinicians are able to build a meaningful connection with patients.

"Trauma-informed care means creating a safe space for patients where they feel heard, says Professor Razzaque. "This isn't a given – patients won't automatically feel safe. In fact, the opposite is more likely to occur due to the inherent nature of the dynamic involved." Therefore, creating a sense of safety "involves skill and effort on the clinician's part," he says, "because you need to mitigate against the default position".

As part of developing the programme, Professor Razzaque collaborated with other compassionate and relational care experts, as well as lived experience contributors. The result is a syllabus designed not only for psychiatrists, but other practising clinicians and senior mental health professionals across the multidisciplinary spectrum.

With significant numbers of NHS staff reporting struggles with their own mental health, this programme's content is even more pertinent, as a relational approach to care is beneficial to clinicians too.

"Nurturing these skills can help us be more compassionate with ourselves," says Professor Razzaque. "It also makes the job a lot more rewarding. We see improvements and recovery happening because of us and our relationship with our patients."

Modules 1–3 of the programme take place this year in Cambridge on 23–24 April, 4–5 September and 15–16 December respectively. To find out more and book your place, go to: **www.rcpsych.ac.uk/crclp**

Dr Margaret Gani

Championing equity

A network of Equity Champions has been appointed across the College to ensure that equity in mental healthcare isn't just an abstract concept, but a reality.

Liaison psychiartist Dr Margaret Gani has spent a lot of time considering what the term 'equity' in mental healthcare truly means in practice. "This has meant trying to understand what it means to the people I work with and care for," she says. "For someone who is stuck in hospital and can't be discharged because the necessary arrangements haven't been put in place, equity might mean something very different than for the person who feels discriminated against for their sexuality or their race."

Dr Gani became the Equity Champion for the College's Liaison Faculty in September, joining a newly established network of Equity Champions tasked with advancing the College's Fairness for All strategy. This network brings together representatives from the College's 13 faculties, three devolved councils and eight English divisions, as well as SAS and resident doctors. Each Champion has been co-opted into their respective executive committees, allowing them to drive meaningful change by advocating for equity-driven initiatives, tracking progress, and collaborating closely with leadership to foster inclusive practices.

Initially, Dr Gani had some reservations about putting herself forward. "Equity is extremely important," she says, "but it doesn't always have the best reputation." When done badly, it can seem performative or forced. But as a liaison psychiatrist focused on preventative mental health, she realised that tackling health inequalities was already central to her work. So, she wanted to expand on this and apply. Now, she is dedicated to bridging the gaps that prevent people from accessing the care they need. "Equity is about ensuring that, regardless of personal characteristics, people have access to resources and services to make their lives better in ways that are appropriate to them," she says.

The network is overseen by the Joint Presidential Leads for Equity and Equality, Dr Amrit Sachar and Dr Raj Mohan, and the Joint Leads for Women and Mental Health, Dr Cath Durkin and Dr Philippa Greenfield. It aims to build and improve upon the work of its predecessor, the Equality Champions network.

"We took valuable lessons from our previous Equality Champions network," explains Dr Sachar. "One key issue was a lack of clarity around the role. This time, we've provided detailed job descriptions, clearer guidance, and more support." The new framework includes quarterly network meetings, a WhatsApp group for sharing ideas, and monthly online drop-in sessions with one of the Presidential Leads.

"I've done quite a few of the drop-in sessions," says Dr Sachar, "and I really love doing them. We encourage people to ask questions and to let us know if they're struggling to get to grips with how the College works or what the role entails."

To make a difference in the long term, "this equity work needs to be embedded in all elements of the College's remit," she says. "The first thing we've asked the Champions to do is get equity as a standing agenda item in their executive committees. And then, we want them to bring an equity perspective to all the other agenda items."

For Dr Gani, equity work resonates personally, as well as professionally. Living with severe endometriosis, she knows first-hand how disparities in healthcare access can affect outcomes. "As a doctor, I've probably had better access to supportive psychotherapy than many women with the same condition," she says. That's one of the reasons she's particularly passionate about the intersection of women's physical and mental health, and is looking to work on a College project in this area.

"At the end of my time as an Equity Champion," she says, "if I can say, as a result of the initiatives I've been involved in, there are some women somewhere in the UK who have better, more equitable access to preventative mental health support, I would consider it an amazing success."

Become a champion!

Four Equity Champion posts are currently available – in the Addictions Faculty and in the Trent, South Western and South Eastern divisions. To find out more or apply, please contact Ruth Adams, Head of EDI Strategy, at **ruth.adams@rcpsych.ac.uk**

A Welsh dragon sculpture located outside of the ICC Wales building

Congress comes to Wales

This summer, Wales will host RCPsych's annual International Congress for the first time in over 20 years. In addition to a diverse programme of talks and sessions, the event offers delegates new opportunities to connect with nature, as well as each other.

"**Croeso** (Welcome) to Wales, a nation known for passion, resilience, and creativity, values that will resonate throughout your time at the Congress," says Chair of RCPsych in Wales Professor Alka Ahuja speaking to future delegates of RCPsych's International Congress 2025.

Offering a refreshing change of pace from the city-based locations of Congresses past, the event will take place from Monday 23 to Thursday 26 June at the International Convention Centre (ICC) Wales in Newport, the grounds of which are nestled within ancient woodland.

As in previous years, delegates can look forward to an extensive schedule of talks and sessions featuring world-class academics and clinicians, experts by experience and opinion leaders from the social and political spheres. It will also offer several networking opportunities, including cultural fringe activities and a series of lunches, breakfasts and wellbeing sessions. The popular ePoster hub will also return, at which delegates can browse through hundreds of digital posters showcasing groundbreaking research and innovations.

The grounds of the ICC Wales are home to a variety of green spaces, offering delegates plenty of opportunity to immerse themselves in nature – from scenic walking and running trails to tranquil woodland areas called 'ponder pods', and an indoor 'living lounge' where plants grow along the walls. Such spaces have been built into the event's fringe programme and will be used for activities like the 5km Congress run and mindfulness sessions.

Looking ahead to the event, Professor Ahuja highlights the Welsh word 'hwyl' which captures a blend of energy, enthusiasm and spirited enjoyment. "This is something we hope you will experience during Congress," she says.

Highlighted sessions:

- **The past, present and future of disease-modifying drugs for dementia: A comprehensive update**
  In light of the emergence of the first drugs able to modify the disease course of dementia (specifically Alzheimer's disease) and the controversy surrounding them, as well as other ongoing developments in the field, this session will discuss the history and current situation regarding disease-modifying drugs for dementia.
  Both clinicians and people with lived experience will be featured, exploring current challenges and opportunities, while reflecting on likely changes in the near future. Time is also allocated for discussion and the exchange of ideas.

- **A 21st century renaissance – emerging from the 'dark ages' in bipolar disorder**
  This session will explore critical gaps hindering understanding and treatment of bipolar disorder, while highlighting promising new avenues for progress. It will ask how advances in neuroscience, psychopathology, precision psychiatry, lived experience and data science can help to improve outcomes and usher in a 'renaissance' for bipolar disorder.
  Topics explored will include more efficient use of language for outcomes research, emerging themes within the neuroscience underlying bipolar and key gaps in care.

- **The silent epidemic: Understanding the hidden impact of domestic and sexual violence on the brain**
  This session will increase awareness of the neuropsychiatric sequelae for women victims/survivors of domestic and sexual violence, and equip clinicians with practical guidance on identification and response to women with brain injury.
  Topics covered will include the Institute for Addressing Strangulation's new intercollegiate guidance for health systems on the response to Non-Fatal Strangulation, charity Brainkind's research on brain injury amongst victims/survivors of domestic abuse, and clinical manifestations of brain injury in women.

- **Modernising the Mental Health Act 1983**
  This session will discuss proposed reforms of the Mental Health Act, intended to give people who are detained greater choice and autonomy and enhanced rights and support, and to ensure dignity and respect throughout treatment.
  The current and past three Presidents of RCPsych, who have all been involved in the development of the legislation, will deliver the sessions, covering key areas including reasons for the reforms, how they were decided on, and what they will mean for psychiatrists in England and Wales. Challenges and controversies around the changes will also be highlighted.

- **But I'm not an academic: getting started in psychiatric research**
  Getting started in academic psychiatry can seem daunting, but it is something all psychiatrists can do. With a focus on those who have not been through a formal academic training programme, this session will stress that there are opportunities available at all stages of a psychiatric career. From getting started with local research projects as a core trainee, through to learning how to obtain funding for your research idea, session attendees will learn how to ignite their research journeys.

Confirmed keynote speakers

- Dr Lade Smith CBE, President
- Baroness Luciana Berger, House of Lords
- Professor Rebecca McKetin, National Drug and Alcohol Research Centre, University of New South Wales
- Professor Simon Gilbody, University of York
- Professor Norman Sartorius, Association for the Improvement of Mental Health Programmes
- Professor Ian Kelleher, University of Edinburgh
- Dr Marchelle Farrell, author and medical psychotherapist
- Professor Marianne Van Den Bree, Division of Psychological Medicine and Clinical Neurosciences, Cardiff University
- Professor Mary Cannon, RCSI University of Medicine and Health Sciences
- Professor John Cryan, University College Cork
- Professor Linda Gask, University of Manchester
- Professor Rob Poole, Centre for Mental Health and Society, Bangor University
- Professor Philip Shaw, King's Maudsley Partnership for Children and Young People
- Professor Dixon Chibanda, London School of Hygiene and Tropical Medicine and University of Zimbabwe
- Dr Theresa Miskimen Rivera, President Elect of the American Psychiatric Association

Shaping the Congress programme

The programme for every Congress is put together by the International Congress Organising Committee, a body made up of two smaller groups: the Executive Committee, who have overall responsibility for planning, and the Advisory Board, who advise and steer the Executive Committee.

If any members are interested in getting involved in the planning process, they can do so by joining the Advisory Board. Five positions are made available on the board each year, and members will be notified by email when applications open for them in September.

As part of the event's development, all members of the Organising Committee meet twice a year to review all submitted proposals. Despite receiving around 200 proposals each year, they will together ensure each submission is reviewed by at least 15 of its members and given an average score.

The smaller Executive Committee will then review some of the submissions in greater detail before deciding what will be on the final programme. It is primarily the higher scoring submissions that are reviewed again, but others are also included to ensure there is overall balance within the programme.

Go to **www.rcpsych.ac.uk/congress/organising-committee** to find out more.

Book your place

International Congress 2025 is taking place from 23–26 June at the ICC Wales in Newport.

For more information scan the QR code above or go to: www.rcpsych.ac.uk/events/congress

Audience members reacting to a Health:Pitch performance

Opening up the heart through opera

By taking operatic performances into health and social care settings, the charity Health:Pitch uses music and storytelling to break through isolation, deepen connections, rekindle joy and allow intense emotions to be shared in some of the most challenging situations.

"**Singing** filled the room, elevating the whole atmosphere. Residents started to smile, move their hands to the rhythm and sing along, as did their relatives and the staff." This is how Dr Jo O'Reilly, Chair of RCPsych's Medical Psychotherapy Faculty, recalls the transformative effect of an opera singer's performance at a care home.

Moments like this are created by Health:Pitch, a charity Jo passionately supports. "Music has a way of unlocking something within us all," she says, "often revealing feelings we struggle to articulate or never knew were there."

Founded by former intensive care physiotherapist Camilla Vickers, the charity develops intimate, playfully operatic storytelling experiences and brings them into hospitals, care homes, mental health settings and conferences, adapting to different audiences and staff groups as they go. Carefully designed with minimal props to allow easy set-up, these 50-minute performances leave a lasting impact – helping audiences rediscover joy and connection, whether living with dementia or struggling with their mental health.

For Camilla, the inspiration was deeply personal and borne out of a traumatic period of her life. While living in Italy, she learned that her mother was terminally ill in South Africa. She relocated them both to her home in rural Wiltshire, where she could provide round-the-clock care. During this otherwise painful time, her set of Italian opera singer friends would come and visit. When rehearsing for concerts during their stay, their singing brought some levity and captured emotions Camilla could not express.

"I had lost trust in the world," says Camilla, "but music's beauty broke through the hopelessness." Intrigued by opera's potential to help those in distress, she explored the growing body of research on the role that the arts can play in preventing illness, promoting wellbeing and supporting recovery, sparking the creation of Health:Pitch.

Since 2017, the charity has developed six productions, weaving music and storytelling together, performed by a small group of skilled artists. They have reached audiences in the UK and abroad, including RCPsych's General Adult Faculty conference in Belfast last October. Each production incorporates elements of novelty, surprise, humour and playfulness, as well as participation and meaningful connection.

Despite their playful nature, the performances do not shy away from difficult topics. "We explore things people avoid talking about," Camilla explains. Themes of isolation, helplessness and death take centre stage in accessible and moving ways. "The creative arts tackle life's deepest pains and joys, such as love, betrayal and loss," adds Jo. "It's surprising they're not used more in healthcare to help us express ourselves, process things and connect."

One performance sparked an unexpected moment of connection for a withdrawn elderly man. When he requested a favourite aria, it led to a rare, cherished conversation with his daughter. "She later described it as getting a glimpse of her once-sociable father with a twinkle in his eye, who she thought she'd lost forever," Jo recalls.

These moments highlight music's power to foster connection among everyone present – patients, families, caregivers and staff alike. "It brings you closer to those around you," says Jo. It is this sense of shared experience that is at Health:Pitch's core.

Even the performers experience transformation. One of whom, Health:Pitch's Musical Lead and internationally acclaimed opera singer Francesca Lanza, was initially sceptical. She describes her involvement as life-changing. "I used to focus only on my voice and technique," she says. "But this work made me see the effect my voice has on people." Profound emotional reactions from audiences have deepened her connection to the music and those who listen to it.

A popular and often-performed aria, *Mon cœur s'ouvre à ta voix*, literally translates as 'My heart opens itself to your voice'. "That," says Camilla, "captures exactly what we see time and time again watching our audience members respond and engage."

With a growing body of research highlighting the role that the arts can play in health and wellbeing, Health:Pitch is proving just how significant that integration can be – bringing music, storytelling and connection to some of the places they are needed most.

Find out more at ***www.healthpitch.org***