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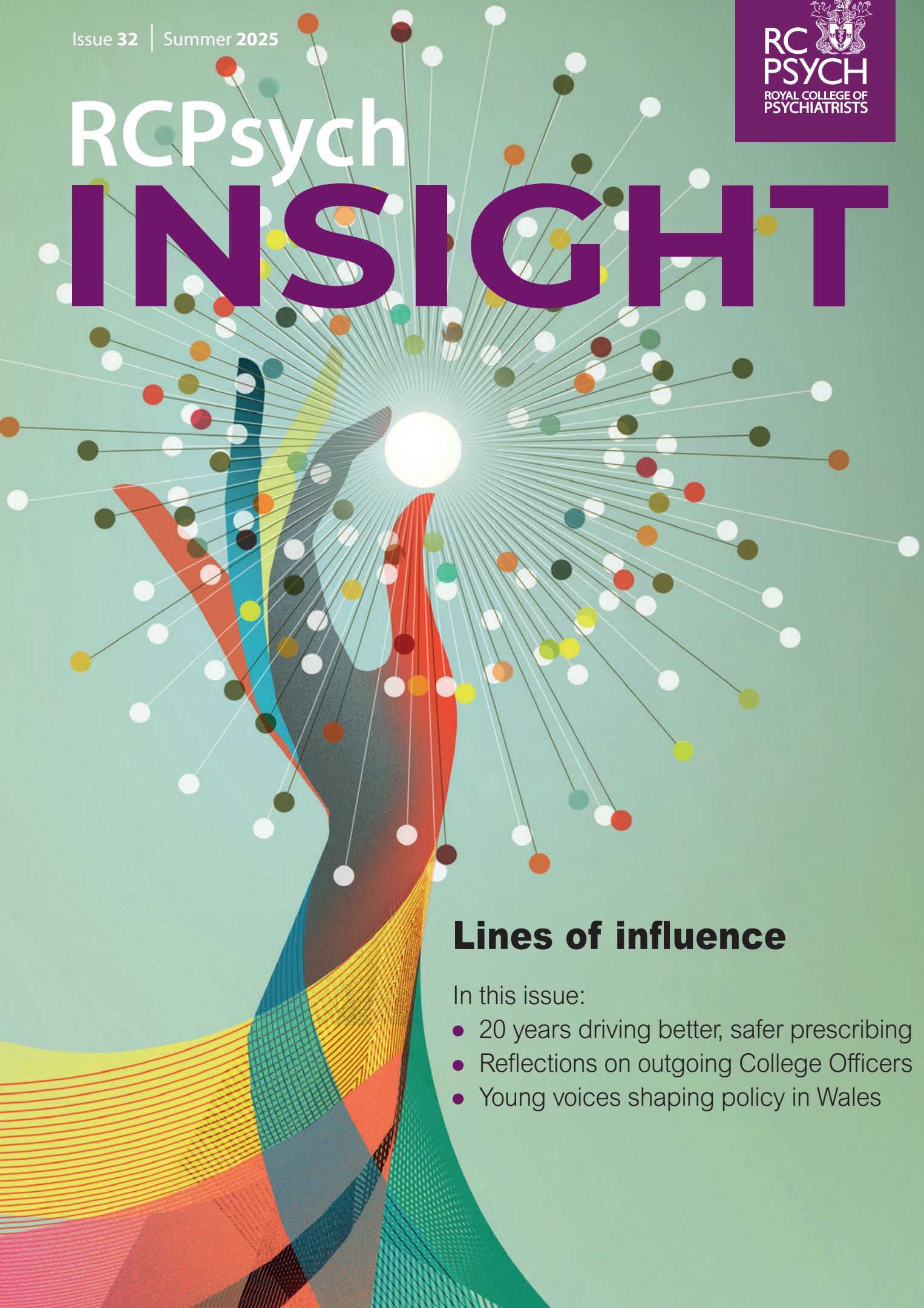
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT



Lines of influence

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- 20 years driving better, safer prescribing
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COLLEGE NEWS IN BRIEF

Guidance on PAs

Following a year-long review, the College has recently published its final report and guidance on Physician Assistants (PAs), offering direction for employers of PAs in psychiatry and wider mental health services. This follows interim guidance released last year and reflects the College's commitment to ensuring PAs work in clinically led, evidence-based roles that support both patient safety and the development of psychiatrists.

The final report, *Guidance on Physician Assistants working in mental health*, stresses the importance of well-defined, properly governed PA roles within multidisciplinary teams. It highlights the need for appropriate training and supervision, with senior psychiatrists, such as consultants or SAS psychiatrists, expected to provide oversight. It also calls on employers to consider the economic impact of PA roles on the wider team and ensure that doctors' training time is protected.

The document was approved by the RCPsych Council and involved extensive consultation across the membership and beyond, including feedback from psychiatrists, employers, sector stakeholders and other medical royal colleges.

Throughout the review, patient safety and high-quality care remained central, with a strong emphasis on supervision, clarity of roles, and ensuring that PAs complement rather than compromise psychiatric training and service delivery.

View the guidance at **www.rcpsych.ac.uk/PAguidance**

New e-portfolio platform

At the start of next year, the College will enter a transitionary period during which it will move away from its current e-portfolio platform, 'Portfolio Online', and onto a new one.

While this might seem like a big change, psychiatric resident doctors and their supervisors need not worry. The main noticeable difference will be a new user interface, which will be just as intuitive as the current one, if not more so.

To ensure that the move is made at a sensible point in every individual's training, it will be carried out in phases starting in February 2026, with full implementation expected in 2027. Regular updates will be sent by email and provided on the College website.

Welcoming new lay trustees

RCPsych has appointed three new lay trustees to its Board of Trustees.

Caroline Rivett, Joseph Morrow CVO CBE and Stuart Bell CBE each bring a wealth of expertise and experience from a variety of sectors, including healthcare, finance, law and technology.

As lay trustees, they will support the College to serve its 21,600 members and promote the voice of psychiatry in the UK and internationally throughout their five-year terms.

Caroline, Joseph and Stuart were formally appointed to the Board at the College's Annual General Meeting, which was held at its International Congress in Newport, Wales on Wednesday, 25 July 2025. They join the College's new Registrar, Professor Owen Bowden-Jones, and Treasurer, Dr Ian Hall, bringing the total number of members to 14.

BJPsych International

BJPsych Bulletin

Open access: Changes without charges

From 2026, the *BJPsych Bulletin* and *BJPsych International* journals will move from their current 'Diamond' open access model – where there are no charges for authors or readers – to a 'Gold' open access model, where the journals can benefit from funding that has been provided by funding bodies and academic institutions for the purpose of supporting open access research.

We know many members publish in these journals without research funding, so we want to reassure you that this change will not create new barriers to publication.

Many authors will find that they are already covered by their institution's overall agreements with our publisher, Cambridge University Press (CUP) or, if they're based in a low- or middle-income country, by the Cambridge Open Equity Initiative. For anyone who is not covered in these ways or funded on the article level, CUP will guarantee waivers in all cases and work is underway to ensure this process is smooth and straightforward.

The journals will remain fully open access for readers, and this change will help to sustain their future. The College will be providing more details nearer the time, but members should feel reassured that there will be no new costs or barriers to publishing.

If you have any comments or concerns in the meantime, please contact **publishing@rcpsych.ac.uk**

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

President's message

Welcome to this summer issue of *Insight*. With the recent hot weather, many of us are feeling the effects – whether in clinics, on wards or during already busy days. It's a reminder of how important it is to pace ourselves and look out for one another.

This issue highlights some examples of the power of collaboration and evidence-based practice in advancing mental healthcare.

We celebrate 20 years of CCQI's Prescribing Observatory for Mental Health (POMH), whose sustained work has driven better, safer prescribing practice through quality improvement programmes.

We also spotlight SleepWell, an NHS initiative, showing how simple, low-cost changes to ward environments and routines can improve sleep, reduce sedative use and support recovery. It's a powerful reminder of the impact of frontline innovation.

At the same time, we highlight our concerns about the complexities surrounding changes to police involvement in mental health call-outs, and are advocating for existing and potential reforms to be implemented safely and effectively for both patients and staff.

This summer has also marked some key moments of transition, as Dr Trudi Seneviratne OBE and Professor John Crichton completed their terms as Registrar and Treasurer, respectively – leaving legacies of leadership, innovation and dedication.

Thank you for all that you do to support patients and psychiatry.

Dr Lade Smith CBE

Getting the balance right

Efforts to scale back police involvement in mental health emergencies are welcomed in principle. But the complexities of implementation have caused concern, and College has been ensuring it remains a key part of the ongoing discussions.

Ask psychiatrists across the UK about the changing role of the police in mental health emergencies, and you'll likely hear the same cautious response.

Dr Alex Thomson, Chair of the College's Faculty of Liaison Psychiatry and working group on mental health and policing, puts it concisely. When asked about recent changes in police response to mental illness-related call outs, he offers just four words.

"The principles are sound," he says – although his intonation leaves no doubt that a "but" is coming. Those "sound principles" are notably encapsulated in the Right Care, Right Person (RCRP) model, originally developed by Humberside Police and now adopted across England and Wales over the past 18 months.

"People don't want over involvement of police in their mental health, but they don't want to be left with no safety net at all"

In England, the approach has been introduced via a formal national partnership agreement between the UK Government, police and the NHS. Whereas, in Wales – where health is a devolved matter but policing and criminal justice are not – there is a statement of intent, with the introduction of RCRP overseen by a national partnership group, which includes the NHS, local government and voluntary organisations alongside the police.

In practice, the model operates similarly in both nations. Police will now only attend mental health-related emergencies if they judge there to be a risk to life, a danger to the public or a crime taking place. This means that formerly routine police tasks, such as welfare checks or searching for patients who have left hospital while detained under the Mental Health Act, are no longer considered police matters. The assumption is they will be picked up by other services.

"The aim is to ensure that where the police are involved in dealing with mental health-related concerns, a healthcare response rather than a law enforcement response is provided wherever appropriate," says Dr Thomson.

This principle in itself gains widespread support. But hesitation and unease soon creep in regarding how this principle has been applied practically.

When the National Police Chiefs' Council in England first announced its plans to roll out RCRP, it estimated it could free up a million hours of police time each year. But with other public services also overstretched, many were left concerned about how the sudden resulting void would be filled.

"The concerns about Right Care, Right Person relate to the risk of police withdrawal from activity at a rate that is quicker than the healthcare service's ability to step in," explains Dr Thomson.

In Wales, the situation feels particularly acute. Ollie John, RCPsych in Wales' national manager, says there was already "constant concern" about the level of workforce coverage available across crisis services in mental health – this has only been compounded since the adoption of RCRP.

"Being able to respond to people in the most appropriate way means you need a properly resourced workforce," he says. "So, before making any changes to the approach, you need to conduct a thorough impact assessment of the existing workforce and its capacity. You need to make sure those alternative services, who will be stepping in, are there."

But even if alternative provision is in place, there is another practical issue: the system itself is poorly integrated. If someone calls 999 due to a mental health emergency and asks for the police, but the call handler determines the matter is, in fact, one for the ambulance instead, they cannot simply transfer the call over. Instead, the caller is advised to hang up and call 999 again and ask for the ambulance service directly.

In an emergency, that is asking a lot of someone. "You can foresee that in a crisis if someone is told they've called the wrong service and they need to redial, there's a risk they won't make the second call," says Dr Thomson.

Sadly, there is already evidence that such risks become reality, and with fatal consequences. In May, the assistant coroner for West Yorkshire issued a Prevention of Future Deaths report concerning a suicide. A member of the public had called 999 expressing concerns about someone's welfare and asked for the police. They were told to hang up and call again to ask for the ambulance service instead. They did this – but they were then told by the ambulance service that they needed to contact the police. Frustrated, the caller ended the call. No attempt was made to get back in touch with the caller and no emergency services were dispatched. It later transpired that the individual who the caller was concerned about died by suicide, leading the coroner to raise serious concerns about RCRP.

This was not an isolated incident. In June, *HSJ (Health Service Journal)* reported that coroners had issued "multiple warnings" about deaths "linked to police refusing to respond to people in mental health crisis".

"It's been really sad and upsetting to see those coroner reports, but some of us with lived experience were worried this might happen," says Em McAllister, the lived experience representative on the College's Liaison Psychiatry Faculty Executive Committee.

"RCRP seems to be selective in its use of lived experience voices to support the notion that people don't want over involvement of police in their mental health. While it's true, they don't want to be left with no safety net at all either, and I think, at the moment, there is a huge lack of clarity about what the appropriate level of police involvement is," she says.

"It feels as though patients are being caught up in a stand-off between services, and there is always going to be an impact on anyone who gets caught up in that."

Across the UK, the College is working to mitigate those risks. In England, RCPsych representatives contributed to drafting and finalising NHS England's RCRP implementation guidance, published late last year. The College is also represented on the national Right Care, Right Person oversight group.

In Northern Ireland, meanwhile, where RCRP is yet to be introduced, RCPsych in Northern Ireland is playing an active role in discussions about its potential adoption.

Dr Julie Anderson, Chair of RCPsych in Northern Ireland, sits on the country's RCRP Silver Oversight group – a multi-agency group responsible for the planning and implementation of the model. "It's a piece of work that the College has very much been welcomed into, and encouraged to participate in, from a really early stage, which is great," she says.

This began with a meeting with the assistant chief constable in charge of

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Continued:
Getting the balance right

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wellbeing within the Police Service of Northern Ireland. “We quickly received quite a compelling argument with regard to why things needed to change and RCRP needed to be implemented,” adds Dr Anderson.

“It was a really positive discussion – and there was a shared understanding of the nuances that must be considered within psychiatry and the police alike.”

Yet despite broad agreement on the need for reform, momentum has stalled.

“I think what’s transpired is, ultimately, a hesitation at a strategic level between health, social work, PSNI, ambulance service and other players within this. This is because the workforce situation in all of those sectors is so dire.”

Over in Scotland, RCRP is not being adopted. But the challenges it seeks to address are very much alive.

“There was a lot of debate with the police service about how we progress, because they have similar concerns about the amount of time that is spent on mental health issues,” says Dr Alastair Cook, who, until recently was Principal Medical Officer at the Scottish Government’s mental health directorate.

Police Scotland has opted for a more cautious stance. “They’ve taken a position that we’re much more comfortable with from a College perspective,” he says, namely that the police’s core duty is to ensure community safety and the wellbeing for the people of Scotland.

Dr Alex Thomson

Dr Cook was a member of the partnership development group that worked up a formal framework for collaboration between services including the police, mental healthcare and ambulance, rather than withdrawing from mental health call-outs. “The overriding principle of that work was what we called the ‘no wrong door’ approach.”

Police Scotland has 24/7 access to mental health clinicians through a dedicated mental health hub, for instance. The framework also seeks to encourage collaboration at a health board or locality level. In some areas, this has already paid dividends. Dr Cook is a consultant psychiatrist in Lanarkshire, where the psychiatric liaison nurse service and the police have worked together to deliver an 80% reduction in police attendances at emergency departments.

It is an example that shows, despite all the challenges, the redesign of police involvement in mental health issues can sometimes yield improved local practices. Often, however, that is dependent on pre-existing local relationships. It is clear that the introduction of the RCRP model itself, or of any model to reduce police involvement in mental health call-outs, does not automatically improve the situation.

Mr John suggests it is therefore crucial that “we have a robust way to monitor the implementation of RCRP”. Em McAllister echoes that call, and emphasises the need for person-centric rather than service-centric measures.

“If you look at the monitoring that does exist for RCRP, it’s all about the various service demands. None of it is about what happened to the people who were caught up in this approach.”

Dr Thomson hopes the College may be able to change that. He’s urging members to share stories and experiences of the implementation of the model, particularly where it is felt that a lack of police response led to welfare concerns for patients or for staff.

Ultimately, it comes back to that uneasy balance between principle and practice. “It is important that people with health needs receive a healthcare response without unwarranted police involvement. But it’s also important that patients are appropriately protected and that, in the relatively rare occasions when a patient may be aggressive, that staff are appropriately protected too.”

For now, many argue that achieving that balance remains a work-in-progress.

Making headway

New opportunities have opened up for SAS psychiatrists as a result of commitments made in the College’s SAS strategy. However, the true test of success will be a substantial rise in appointments to these roles and other senior positions.

Speciality and Specialist (SAS) psychiatrists are substantive doctors who make up around a quarter of the UK’s psychiatric workforce. Yet, despite their vital contribution, they remain under-represented in a variety of senior roles, have historically been denied access to many key career opportunities and continue to face a lack of formal recognition and respect – issues that not only impact professional development but also morale, wellbeing and retention. The latest College workforce census found SAS true vacancy rates to be the highest of all psychiatric grades, at 30.3%.

In April 2023, the College took steps to begin to tackle these long-standing disparities by launching its first official policy for SAS psychiatrists – a three-year strategy to support training, leadership, and educational development of SAS psychiatrists, strengthen their involvement with the College and recognise their contribution.

While SAS psychiatrists may not be yet seeing dramatic changes in their day-to-day working lives, Dr Lily Read, Chair of the College’s SAS Committee, is keen to highlight progress that has been made, as well as efforts to lay groundwork for at-scale, longer-term change.

One significant development linked to the strategy has been the 2023 change to College guidance on recognising and approving trainers, which now allows SAS psychiatrists to become clinical and educational supervisors of psychiatric resident doctors – a role previously limited to consultants. Prior to this change, SAS psychiatrists could only supervise foundation and GP resident doctors.

Changing the supervision eligibility criteria, however, was only the first step – full implementation is still a work-in-progress. “Progress made to appoint SAS supervisors has been slow, but we’re working on it,” says Dr Read. “It will happen.” Behind the scenes, the SAS Committee has been actively engaging with the Heads of Psychiatry Schools and Director of Medical Education (DME) networks to promote not only that SAS psychiatrists are now eligible for these roles, but to highlight their value and capability, shift perceptions and monitor how many of the significant number of GMC-recognised SAS trainers are being allocated psychiatric resident doctors to supervise.

Dr Antonino Curatola, a SAS forensic psychiatrist at Aneurin Bevan University Health Board in Wales, is one of the few appointed so far. He is a clinical supervisor for core psychiatric residents, and also teaches medical students, and foundation and psychiatric resident doctors. He describes the shift as a step forward in recognising the contribution SAS psychiatrists can make to training.

“Enabling us to become educators can only improve the profession and patient care,” he says.

Another change aligned with the strategy’s aims is the inclusion of SAS psychiatrists with the MRCPsych in the eligibility criteria for College examiners. Only two have been appointed so far, but there are others taking part in the current recruitment round process. “It’s still a massive step forward,” says Dr Read. “This was almost unthinkable three years ago.”

The College Leadership and Management Fellow Scheme has also been opened up to SAS psychiatrists, with seven successfully securing places in the 2023/24 intake – the first cohort eligible to apply. In addition, early-career SAS psychiatrists can now apply for the Parliamentary Scholars Scheme, providing a new pathway into health policy and advocacy.

Additional efforts made to optimise communication and networking have involved establishing the national Mental Health SAS Tutors’ Network which meets quarterly with the SAS Committee executive. This enables the SAS Committee to engage locally, while providing a channel for local SAS psychiatrists to contribute to national work. Additionally, an SAS e-newsletter, launched at the end of last year, is hoping to build visibility and community by profiling an SAS psychiatrist each quarter, showcasing good practice from across the UK and highlighting resources, opportunities, important updates, and upcoming events.

Another focus has been removing barriers to inclusion in the College. The College’s Presidential Leads for Equity and Equality have reviewed the eligibility criteria for a range of College roles – including the Presidential Scholars Scheme – to ensure they are now explicitly inclusive of SAS psychiatrists, which they previously were not.

Dr Read is also keen to highlight some other pre-existing opportunities: SAS psychiatrists are eligible to access all College credentials. “We now have several SAS psychiatrists who completed the eating disorder credential and the perinatal masterclass,” she says. “Also those who hold the MRCPsych are eligible to apply for College Fellowship and we recently celebrated our first SAS FRCPsych.”

She also highlights that SAS psychiatrists are eligible for nomination across most categories of the RCPsych Awards, and not just the dedicated ‘SAS Doctor of the Year’ category. Having greater visibility in these various roles is one small way to begin the long overdue recognition of SAS colleagues. “Seeing yourself represented is a very good motivator,” she says.

Five years of progress

Dr Trudi Seneviratne reflects on her time as College Registrar, the achievements she's proud of and her hopes for the College's future.

Dr Trudi Seneviratne OBE

Elected College Registrar in early 2020, Dr Trudi Seneviratne OBE brought with her a wealth of experience. She had previously served as Chair of the Perinatal Faculty and had actively being involved in College work since her time as a trainee.

She describes it as a privilege to have taken on the role, having felt she had received a vote of confidence from the membership when she was elected. This confidence was well placed, and her considerable achievements will have a lasting impact on the College, the profession and public health.

The five-year Registrar term is a highly varied role, with a key responsibility of overseeing policy and the College's strategic direction. Under Dr Seneviratne's leadership, the College has upped its focus on public mental health, early interventions and prevention of mental illness at a population level. She spearheaded the creation of the Public Mental Health Implementation Centre (PMHIC), which continues to attract funding to research, understand and prevent early deaths among people with serious mental illness and improve the implementation of evidence-based care. PMHIC also provides training through its recently developed Public Mental Health Leadership Certification, which Dr Seneviratne hopes will inspire more psychiatrists to engage with public health.

The creation of PMHIC aligns with Dr Seneviratne's wider efforts to enhance research skills in psychiatry. "We've aimed to increase the number of psychiatrists with strong research skills outside of academia and among clinicians," she says, "because we want psychiatrists to continue to be curious, ask questions and be involved in new research, innovations and treatment."

"The College desperately needed to shine a light on the mental health of the youngest people in society"

Dr Seneviratne has worked in perinatal mental healthcare for over 30 years. "It is the ultimate place to look after mothers and babies but also to prevent mental illness," she says. "Every day from conception onwards matters – and by looking after the mother you are looking after the developing foetus and the baby. Securing the mental health of the mother has a direct impact on the developing child."

When she began her term as College Registrar, she had already identified a significant gap in College policy in this area and pledged to create a comprehensive framework focusing on the 0–5 age group. This led to the publication of a significant College report, *Infant and Early Childhood Mental Health: the case for action*, which highlights the importance of mental health from pregnancy through the early years. It sets out a clear, evidence-based plan for improving outcomes, with recommendations on workforce development, data collection and cross-government coordination.

"The College desperately needed to shine a light on the mental health of the youngest people in society and how important it is to pick issues up right at the start of life," she says. The report, which was developed with input from a wide range of contributors, including people with lived experience, has since proven to be highly influential.

Other high-profile work Dr Seneviratne has been involved in includes chairing policy round tables on assisted dying/suicide and the Cass Review of Gender Identity Services for Children and Young People. She also played a key role in improving collaboration between coroners and psychiatrists to make the process for producing Prevention of Future Deaths reports more supportive for all involved.

As Registrar, Dr Seneviratne has been committed to giving under-recognised patient groups a voice and increasing the involvement of patients and carers in the College's processes. "It is important to have lived experience represented in the work we do, and I was keen to bring more of those voices into the College committees," she says. "Part of the reason we have had such an amazing expansion of services in perinatal psychiatry was because we joined forces with patients when presenting our case to government."

Amplifying the patient's voice has also been central to work led on by Dr Seneviratne on bipolar disorder. "Many people with bipolar suffer in silence. They have high rates of suicide and earlier deaths, and diagnosis is not quick enough," she says. At the time she began advocating for change, the average time to diagnosis was 9.5 years. As a strong proponent of a national care pathway, which would end the postcode lottery of care and speed up diagnosis, she set up a round table and formed a collaboration with Bipolar UK. This resulted in a joint position statement calling on the UK Government to improve care for people with bipolar disorder. This ongoing work is making headway and Dr Seneviratne hopes to see a national care pathway embedded into community and mental healthcare services.

Supporting the membership has also been one of the most fulfilling aspects of Dr Senerviratne's time as Registrar. Appointed shortly after the pandemic began, she quickly had to get to grips with the demands of the role as the College – and the world – shifted to remote working. She is proud to have helped guide members through that period and beyond. Since then, she has expanded the College's membership support by introducing a new Associate Registrar for Coaching and Mentoring and extending the focus on wellbeing. Looking ahead, she hopes ongoing work to define and support job plans for psychiatry and to recognise the desire for portfolio careers will ease pressures and reduce the risk of burnout.

Looking to the future, Dr Seneviratne will continue her work as a consultant adult and perinatal psychiatrist at South London & Maudsley NHS Foundation Trust and as Clinical Director of the Perinatal Provider Collaborative of South London Trusts. She runs the mother and baby unit in Royal Bethlem Hospital, where art plays a big part in the provision of holistic care and she is able to have patient reviews outdoors in its stunning grounds that include a bluebell wood and a museum/gallery. Eventually, she would like to spend more time on her own sketching, printmaking and photography and would love to see RCPsych expand its involvement in the arts and have a regular gallery space. By appointing an artist-in-residence and supporting the cultural fringe at Congress, as well as setting up its exhibitions committee, she has certainly helped move the College in this direction.

RCPsych has been a constant in Dr Seneviratne's professional life, and she will still remain involved in its work. She will also continue to be an advisor for the Royal Foundation Centre for Early Childhood, and her work in this area is something she describes as her "personal core business" that will carry on for rest of her life. She also has some research projects under way and she will continue to teach. "We only have one life, and we need to make the most of it," she says and her drive to improve mental healthcare and to champion the profession will continue into the future.

She expresses gratitude to all the members and staff she's worked with, and offers this advice to her successor: "Enjoy the role, listen to the members and take the role of psychiatrists on to the next step."

Dr Seneviratne finished her term of office as College Registrar on 25 June, and her successor is Professor Owen Bowden-Jones.

Creating a culture of continuous improvement

How RCPsych's **Prescribing Observatory for Mental Health** has been driving sustained improvement in the quality and safety of psychotropic medicine use in mental health services for the past two decades.

Prescribing may be routine in psychiatry, but it's far from straightforward. It demands a strong knowledge base in psychopharmacology, an understanding of the evidence base as it evolves, and familiarity with the treatment recommendations in national guidelines. In addition, factors such as system pressures, stretched resources, and clinical uncertainty can lead to variation in prescribing practices. This can result in consequences like delayed treatment, inconsistent side-effect monitoring, care that deviates from best practice recommendations, or missed opportunities to fully inform and involve patients in their care.

Addressing these issues requires dedicated time, focus, and data – and while clinical audits can often be a useful place to start, few services have the capacity to design and complete them on their own, let alone act on the findings.

Recognising the gap between best practice and everyday care – and the challenges services face to close it – the Prescribing Observatory for Mental Health (POMH) was set up in 2005. Its mission is to support the safest, most effective use of medicines in mental healthcare through quality improvement initiatives that include collaborative audits and constructive feedback – all delivered without judgement.

Marking its 20th anniversary this year, POMH is one of the longest-standing projects run by RCPsych's College Centre for Quality Improvement (CCQI), and its offering remains unique among royal medical colleges. It was co-founded by Carol Paton, an honorary research fellow and former chief pharmacist experienced in improving medicines use across mental health services, and Professor Thomas Barnes, an internationally recognised expert in psychopharmacology and schizophrenia research. Before launching POMH, they had both witnessed the positive impact of sharing benchmarked prescribing data with local clinicians and were keen to scale this approach nationwide. Two decades on, they still lead the initiative together as joint-heads.

POMH operates on a membership subscription basis, open to any specialist mental healthcare service across the UK, Crown Dependencies or the Republic of Ireland. Over 60 NHS trusts, health boards, and independent services, including most mental health trusts in England, are POMH members and consistently participate in its quality improvement programmes.

The first stage of each programme is a nationwide audit, designed to evaluate how clinical practice in the participating organisations aligns with evidence-based practice standards in specific prescribing areas, which are often higher risk or complex, such as lithium safety, antipsychotic polypharmacy, or the use of clozapine, sodium valproate, melatonin, or ADHD medication.

The practice standards are usually derived from NICE and/or BAP guidelines, with input from expert clinical advisors. A bespoke data collection tool and guidance are then developed and shared with each participating organisation to help them collect anonymised data about routine clinical care. Once these data have been analysed, each organisation receives a detailed feedback report benchmarking their performance against the standards and against the other participating organisations, whose identities are strictly anonymised.

POMH then supports services to act on the findings – by addressing gaps and enhancing prescribing quality and safety – by offering tailored learning materials and guidance. Follow-up audits, typically 18 to 24 months later, enable services to track their progress.

It is POMH's focus on helping clinicians build practical changes into everyday work that sets it apart from directive models of audit or inspection. Its non-judgemental approach creates a safe space to review prescribing honestly, free from blame or reputational harm. The anonymity of participating organisations is key to this, ensuring confidentiality and promoting open, constructive engagement with the audit process.

"POMH's strength lies in creating a culture of continuous improvement rather than chasing short-term performance targets," says Dr Ify Okocha, Chief Executive of Oxleas NHS Foundation Trust, which has been a member of POMH since its launch.

"Real, lasting change happens step by step, by encouraging clinicians to reflect on their practice and make incremental progress – not by sudden, unsustainable pushes to meet performance targets that fade once the spotlight moves elsewhere," he says. "This way, you get to the root of the problem to try and find the solutions."

Dr Mary Docherty, National Clinical Director for Adult Mental Health at NHS England, can also attest to POMH's impact: "One of its real strengths is how it makes you stop and reflect. When clinicians see the data, they realise where they need to do better and that changes practice."

POMH doesn't just help individual organisations, it influences real-world practice across the board to maximise therapeutic benefit and minimise harms. Dr Docherty underscores its power to make meaningful differences to patients' lives, highlighting two complex prescribing areas.

First, POMH's sustained focus on sodium valproate safety for women of childbearing potential has driven significant clinical and policy changes. Its audits revealed many women were prescribed valproate without full awareness of the serious risks to an unborn child. Through data collection and feedback, POMH highlighted critical gaps in informed consent, contraception discussions and risk communication. This prompted local improvements – such as raising clinician awareness and strengthening safeguards – and influenced national policy. POMH presented its data to regulatory bodies like the Commission on Human Medicines and the MHRA, contributing to the introduction of the formal pregnancy prevention programme for valproate.

"Another crucial issue POMH has tackled," says Dr Docherty, "is one of our most persistent health inequalities: the cardiometabolic risks associated with antipsychotic medication." Its work has helped reduce these risks by boosting awareness and influencing how well services monitor and manage weight, blood glucose and cholesterol nationally.

These are just two examples of POMH's reach, as it has delivered 24 audit-based quality-improvement programmes. Its audit data have also informed several NICE guideline development groups and been cited in treatment guidelines, further influencing national prescribing standards and policies.

Alongside some of its quality improvement programmes, POMH has developed some practical prescribing tools. Its 'Ready Reckoner' supports safe antipsychotic prescribing by helping clinicians calculate combined antipsychotic doses and compare them with BNF limits, aiding dose rationalisation and reducing the risk of high dosage. Meanwhile, its Patient-Held Lithium Pack, developed with the NPSA and National Reporting and Learning System, encourages shared clinician–patient responsibility with vital information, including test schedules, side-effect alerts, and toxicity advice. This widely adopted tool has been credited for significantly improving lithium monitoring, reducing prescribing errors and boosting patient safety.

In addition to helping organisations improve, POMH has looked inwards to enhance its own offering. Its customised reports for members have recently been enhanced and now include brief, practical 'lightbulb' suggestions of how to address areas where local practice has fallen short. And its recent 'Sharing Best Practice' initiative showcases successful local responses to audit findings, promoting cross-organisational learning and innovation.

Critically, POMH receives no support from the pharmaceutical industry, preserving its integrity and avoiding conflicts of interest. Funded entirely by its members, its consistently high membership speaks to its impact.

As mental health services face growing demand, POMH's role may be increasingly vital. While levels of engagement with, and dissemination of, POMH's tailored reports will naturally vary between participating services, the sustained improvements seen across many quality improvement programmes reflect the strong commitment of members to effect real change. "It's an outstanding programme," says Dr Okocha. "I'd like to see all mental healthcare providers not only join but engage as much as possible."

Now in its 20th year, POMH continues to build a legacy defined by steady, thoughtful change. Perhaps its most important achievement is cultural: promoting prescribing not just as a technical task, but rather as a core aspect of care that deserves attention and support.

"The rigorous work POMH is doing is making a real difference to patients' lives," says Dr Docherty. "The skill and expertise within it, along with its commitment to evidence-based improvement, make it a really important part of the mental healthcare quality and safety ecosystem."

Find out more about POMH at:
www.rcpsych.ac.uk/POMH

POMH
PRESCRIBING OBSERVATORY FOR MENTAL HEALTH
BETTER USE OF MEDICINES
20 YEARS

Counting the cost

The landmark **HEARD study** reveals the human and financial toll of fragmented, insufficient care for people hospitalised with severe mental health conditions – and calls for a national strategy to break the cycle.

(Illustration by Ikon Images/Marie Montocchio)

People with some of the most complex mental health needs have long been underserved by mental health services, often finding themselves caught in cycles of hospital admissions, sent out of area, or reliant on community support that is disjointed, insufficient or difficult to access.

The recently published Health Economics And Relational Disorder (HEARD) study, led by Principal Investigator Dr Felicitas Rost and consultant psychiatrist Dr Sue Mizen, set out to better understand the scale of this issue. The product of years of detailed analysis, the study examined both the clinical outcomes for this vulnerable group of patients and the financial cost of their care, and investigated the impact of a specialist community-based psychotherapeutic service developed by Dr Mizen more than a decade ago.

For Dr Mizen, the need for a different approach became quickly apparent to her not long after she took up her first consultant post at Charing Cross Hospital in London. "Within the first year, it became really obvious that if things didn't change, I was going to spend the rest of my working life telling people that I would help them if I had the resources, but that, sadly, I didn't," she says.

Determined to find a better way forward, she began investigating how mental health resources were being allocated. What she found was that a small minority of patients accounted for a huge proportion of the funding. These individuals had often been hospitalised with complex mental health conditions and often had multiple comorbid conditions and/or clinical characteristics – such as personality disorder, eating disorders, medically unexplained physical symptoms, substance use, neurodivergence and significant lifetime trauma.

"There is a group of individuals who fall through the net, and the costs of that, both psychological and financial are enormous"

It was a similar story when she moved on to a new role in Devon Partnership NHS Trust – patients with the most complex needs had a significant presence in services, but were not receiving care that addressed their specific needs.

"Many were spending extended time in hospital, both in local mental health services and elective out-of-area placements, without receiving any targeted treatment for their disorder," says Dr Mizen. And for those receiving therapy in the community, what was available was far from sufficient to manage the level of risk, instability or co-morbidities these patients presented with. "They were being offered something generic that wasn't actually going to improve their wellbeing."

Many also frequently visited physical health services at a huge cost. For example, in one small-scale review of 55 individuals who regularly attended A&E with medically unexplained symptoms, the costs were staggering. "Based on national tariff costs, we calculated their lifetime service use cost to be £6.4 million," says Dr Mizen. "And when I subsequently met and interviewed each of those 55 individuals, 47 of them met the diagnostic criteria for personality disorder."

Armed with robust data, Dr Mizen developed a business case for a new approach. By focusing on the costs associated with hospitalisation, across both physical and mental health services, she secured £1.5 million in funding from commissioners in Devon to set up an intensive psychotherapy service. Specifically designed for people with the most complex needs and at highest risk of hospital admission, the Devon Specialist Personality Disorder Service (SPDS) became fully operational in 2012.

Now, more than a decade on, the HEARD study has formally evaluated its impact and is strengthening the case for wider adoption of this service model. To undertake this research, the Talking Therapies Task Force (TTTF) was set up. This collaboration, chaired by Dr Mizen, brings together six psychotherapy and counselling bodies to advocate for therapies for patients with the most complex needs. The College's medical psychotherapy faculty, of which Dr Mizen is a past chair, was a founding member and the College Centre for Quality Improvement is also now a partner.

Principal HEARD Investigator Dr Rost, who is a senior lecturer in psychology and psychotherapy at the Open University, as well as a practising psychotherapist, explains that the study determined the number of patients with the most complex mental health needs using services and the financial cost of their 'standard' care in Devon and London. It also asked a key question: whether the Devon SPSD was reducing hospital admissions and emergency service use – and therefore costs – after patients had used the service compared with before.

Answering these questions involved analysing de-identified clinical and local authority data from close to 30,000 patients – over 4,700 from Devon and the rest from London. All had a Health of the Nation Outcome cluster score of 7 ("enduring non-psychotic disorders") or 8 ("non-psychotic chaotic and challenging disorders") and specific diagnostic codes associated with individuals with the most complex personality disorders.

The study identified the service use pattern of the whole group – including A&E activity, inpatient admission, community mental health activity, social care activity and primary care visits. The total annual cost amounted to £24.8 million in Devon and £60.8 million in London.

Dr Rost explains that within these figures, a small group of individuals stood out. These were high-cost outliers, defined for the purposes of the study as people whose care costs exceeded three standard deviations from the group average. They accounted for a disproportionately large share of spending – mirroring the pattern Dr Mizen had previously identified.

"We found that in both Devon and London the proportion of people with severe mental illness who had the most complex needs, was small," says Dr Rost. "In Devon, it was just 1.8% of the cohort so only about 85 people, and in London 1.1%, so about 270 people."

Yet despite their small numbers, this group accounted for a huge percentage of the total cost – nearly a third of the total in Devon, and almost a quarter in London. "Around two thirds was being spent on local mental health inpatient care or out-of-area placements," she says." The health economic analysis confirmed this translates to a national annual cost of £615–920 million."

Crucially, despite these high levels of service use, a survey of this patient group and their carers confirmed their clinical outcomes remained poor.

In contrast, the Devon SPDS offers local psychotherapeutic care alongside practical support, such as outreach and supported housing. Patients under the service's recovery pathway take part in a psychodynamic psychotherapy programme four days a week for a year, and two years of individual and group outpatient psychodynamic therapy. The service is designed to cater to the full range of risk and comorbidities present in the group.

The HEARD study confirms that people who received care through this service have experienced a significant reduction in the number and length of hospital admissions. Their use of emergency services fell too: at the outset, 98% of patients in the study group sought help from these services; after therapy, it fell to less than half. On top of this, previous research had shown that in its first eight years, the service not only paid for itself but made a 15% cost saving on out-of-area placements alone. This is before considering the savings on in-county inpatient admissions identified in the HEARD study.

The service's impact isn't only seen in the numbers. Many patients and families interviewed for the study spoke about how they preferred being in supported housing than in hospital, and that the psychotherapeutic day programme gave them a sense of belonging. They also felt the therapy had been a source of meaningful help, addressing what was going on for them mentally rather than focusing on symptoms.

The study's findings are all summarised in a health economic report from the Centre for Mental Health, commissioned by TTTF and launched in the House of Lords in April 2025, alongside recommendations to the UK Government to develop a national strategy for these hospitalised patients. The hope is that this evidence will encourage other areas to pilot the Devon approach. Advocates say it is an example of the power of clinician-led service redesign, and of quantifying the impact of inadequate provision.

For Dr Rost, the message is clear: "The strength of the HEARD study is that it makes a health economic argument. We really need to start pointing out that there is a group of individuals who fall through the net, and there are consequences of that. There are costs, both psychological and financial – and those costs are enormous."

Learning from example

The **Friendship Bench**, Zimbabwe's pioneering community mental health programme, is helping to shed light on the nature of the therapeutic alliance and its influence on treatment outcomes.

Dr Sam Gnanapragasam (top left) with Friendship Bench research colleagues

The Friendship Bench is a world-renowned community mental health programme developed in Zimbabwe offering free counselling, therapy and support to people with common mental health conditions such as anxiety and depression. Delivering interventions in several different formats, it provides treatment to over 280,000 people in the country each year. But its name comes from the first method of care that it offered: therapy sessions on wooden benches in safe, accessible community spaces conducted by local volunteers – primarily older women, known in their communities as *gogos,* meaning 'grandmothers' in local languages such as Shona and Ndebele.

The founder of the Friendship Bench, Professor Dixon Chibanda is one of about 18 psychiatrists in a country with a population of around 17 million people. During a TED talk that he presented on the programme, he explained how he and his colleagues came to develop the innovative therapy model. After re-thinking his initial impulse to take a "western, biomedical" approach that relied more heavily on psychologists and psychiatrists, he realised the best way to improve local access to care was to use an approach that is not only culturally relevant, but that works within the country's available means: "It dawned on me that actually one of the most reliable resources we have in Africa is grandmothers. Grandmothers are in every community, and they don't leave their communities. So, I thought how about training grandmothers in evidence-based talk therapy, which they can deliver on a bench."

And this is exactly how the programme developed, with grandmothers undertaking an eight-day intensive training programme in problem-solving therapy, during which they learn to deliver a screening tool and put together SMART action plans, followed by a 30-day clinic internship. The approach has demonstrated high levels of efficacy, including in a randomised controlled trial published in *The Journal of the American Medical Association.*

"It's a really powerful and inspiring example of a locally driven solution, developed by experts from the country in which it's being implemented, that has been effectively scaled up," says Dr Sam Gnanapragasam, a psychiatric resident doctor at South London and Maudsley NHS Foundation Trust. Currently, he is in Zimbabwe studying the Friendship Bench for his PhD in African Health Research, which is funded by the Wellcome Trust. He has formed a research team that includes Professor Chibanda, who has been acting as one of his supervisors.

The Friendship Bench's innovative approach to therapy delivery makes it an ideal basis for Dr Gnanapragasam's research project. His work examines the extent to which the therapeutic alliance contributes to positive depression outcomes achieved through task-shifted psychological interventions (i.e. those in which aspects of care are delegated from highly specialised professionals, such as doctors and nurses, to those with less specialist training). Through interviews with Friendship Bench care providers and recipients, he has found that the role of grandmothers as care providers can reveal a lot about the nature of the therapeutic alliance and how cultural factors can help to strengthen or weaken it.

"*Gogos* already have significant cultural capital in Zimbabwe. They are recognised members of the community who come from the same background as the care recipients, and who are seen as respectable figures you can go to for advice," he explains. "This is quite different from the dynamic we associate with psychological therapies in the UK for example, where you typically don't know your practitioner prior to your first session."

"As a result, a level of trust often exists before the Friendship Bench's talk therapy begins, and care recipients can be more willing to speak openly and feel understood. However, at the same time, if the care provider is a well-known member of the community, this can sometimes lead to concerns about confidentiality."

"It can therefore be even more important to establish a safe space and reassure care recipients that the sessions are entirely confidential. But once they feel confident in this, a strong therapeutic alliance can be established."

The crucial role of the therapeutic alliance is supported by existing evidence that identifies it as one of the most consistent predicators of outcomes in psychological treatments. Even in the context of prescribing medication, research has shown that psychosocial and relational factors have a significant influence on pharmacological outcomes.

However, as most of the research in this area has been conducted in high-income countries, it is not clear exactly how this translates to low- and middle-income countries, particularly in cases where treatment is delivered by non-specialists. Dr Gnanapragasam hopes that his project will help to fill in the gaps, and potentially provide cross-cultural learnings that would be helpful for high-income countries as well.

His research has already helped to reinforce how important it is for measurement tools to be adapted to accommodate different cultural backgrounds. "The original plan was to take a gold standard therapeutic measurement tool that is used around the world, do some straightforward translation and plug it into a big quantitative study in which we would track therapeutic alliance across the sessions and match that with treatment outcomes," he says.

"But we soon realised during interviews that the concept of therapeutic alliance in the Zimbabwean context may be too different from how it is presented in the existing tool, and that using it without doing any adaptation may mean we do not capture any meaningful results. And so, we needed to take a step back, rethink the approach and adapt the measurement tools that we had," he says. "The value of accommodating these kinds of cultural factors in care – and learning how to do so effectively – cannot be understated."

He goes on to explain that he is utilising a 'reverse' or 'back translation' approach in his research, in which existing effective treatments are examined, and the factors that may be driving change – the therapeutic alliance in this case – are identified and studied to shine a light on how to improve care. While back translation is standard practice in many areas of healthcare, including medication development, it is still relatively novel in the realm of psychological interventions in the global mental health space.

In recent years, however, the Wellcome Trust has begun to break ground by supporting research that uses a back translation approach to examine interventions across the spectrum of mental healthcare. They have categorised a number of factors, ranging from circadian rhythms to peer support, as key influencers of mental health, which they refer to as 'active ingredients'.

"The promise of this kind of research is that we can learn more about how and why certain interventions are working, and indeed why some people do not benefit, so we can make them more effective for an even greater number of people," says Dr Gnanapragasam.

He hopes that once his research project is completed in 2027, his findings about the therapeutic alliance will not only be useful to the Friendship Bench programme itself, but that they will also aid in the development and improvement of other mental health interventions.

He is incredibly grateful to the Friendship Bench for allowing him to learn from their success, as well as his own research team, Zimbabwean collaborators and his supervisors including Professor Chibanda and Professor Melanie Abas. He praises his research assistant, Ms Lovender Kuanka who has a background in social work and has worked in Zimbabwean secondary mental health institutions. She has carried out many of the interviews, communicating with study participants in their local language of Shona. "She has been able to bring forward an in-depth cultural and contextual health systems understanding, while I contribute a psychiatric and research lens," he says. "I think we've really learnt a lot from each other."

He adds that he would recommend doing a PhD abroad to anyone and particularly highlights the African Health Research (CREATE), funded by the Wellcome Trust, and Health Priorities in the Global South schemes. "Even outside of the research and its related impact, it feels very tangible in terms of what we'll be bringing back: The relationships we've built, and all the learning about how teams are operating in different countries."

(Illustration by Maggie Chiang)

SleepWell for recovery

Sleep deprivation is common on mental health wards, but **SleepWell**, an innovative multimodal NHS programme, is showing how better sleep environments, culture change and tailored care can transform patient recovery.

While it might be assumed that hospitals provide a positive atmosphere for recovery, the reality is that many inpatients suffer from sleep deprivation – partly because of the culture, practices and environment of wards. Patients often spend their days indoors with little exposure to natural daylight, and at night it can be overly bright and noisy – conditions that are not conducive to restful sleep. Add in high levels of undiagnosed sleep apnoea, overprescribed sleep medication and illness-related sleep issues, and it is no surprise that sleep disturbance is prevalent on mental health wards. This is a factor that can delay recovery.

SleepWell is an award-winning sleep improvement package for inpatients that is helping to turn this around. Based on the wealth of evidence that supports the vital role sleep has in maintaining physical and mental health, the initiative began with a 2018 pilot on seven wards at the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. The pilot was conducted by consultant neurologist Dr Kirstie Anderson from the Newcastle sleep service, in collaboration with a group of psychiatry and nursing leads. Since then, SleepWell has been rolled out across the trust, leading to improved patient wellbeing and a reduction in the use of sleep medications, and has received strong support from both staff and patients. Ongoing studies are evaluating its impact on length of stay and healthcare costs.

The programme combines assessment and modification of the physical environment and the culture of each ward, as well as screening for sleep disorders such as obstructive sleep apnoea. A sleep lead for each ward and estates managers are involved from the beginning, and hospital areas are modified that negatively affect sleep quality – such as squeaky doors, loud machines and a lack of blackout blinds. It is not a one-size-fits-all approach and it does not involve costly renovations.

Patients are encouraged to follow consistent daytime routines that support their circadian rhythms – the body's internal 24-hour cycles that regulate various processes, including the sleep–wake cycle. This is achieved by creating opportunities for greater exposure to daylight and access to more physical activity during the day (both of which act like natural sleeping tablets, says Dr Anderson), as well as lower levels of caffeine consumption. Wind-down periods are also in place, which involve noise levels and lighting being lowered to signal that night is approaching. Night staff wear soft-soled shoes and are reminded to speak at lower levels.

There is also education for staff about using other methods to improve sleep, such as cognitive behavioural therapy for insomnia (CBTi), before prescribing sleep medication, which can quickly create tolerance and dependence. As a result, prescription levels have reduced dramatically – in the pilot, for example, they went down by 41%.

The programme uses the STOPBANG tool to screen for sleep apnoea upon admission. Sleep apnoea, which is estimated to affect 20–30% of mental health patients, destroys the restorative quality of sleep by repeatedly jolting people briefly awake throughout the night. In cases of severe obstructive sleep apnoea, this can occur every 20 to 30 seconds. Most people are unaware they have the condition, but it can contribute to treatment resistance in those with mental health disorders.

All staff are trained on the importance of sleep and are supported to improve their own sleep habits. This includes being given access to CBTi, when appropriate, which is also offered to patients on some wards. Ward staff can often be hardy shift workers who may have disrupted circadian rhythms, says Dr Anderson, but "you have to value your own sleep to value your patients' sleep". Ongoing education for all staff has been key to the programme's safe and effective implementation.

When Dr Anderson was asked by consultant psychiatrist Dr Stuart Watson to help investigate sleep disorders on the trust's mental health wards almost 10 years ago, it was the trust's policy to conduct checks on patients throughout the night at least once an hour. These observations can profoundly disrupt the 90-minute sleep cycles that we all need for healthy sleep. It is normal for people to wake briefly during NREM and REM cycles, but more frequent sleep disturbance increases pain and stress levels, and causes significant agitation in anyone – whether or not they have a mental illness.

"We objectively measured the sleep, noise and light levels on four of the trust's adult acute wards and saw significant sleep disturbance for patients," says Dr Anderson. "Disrupting sleep has a big impact on memory, suicidal and psychotic ideation, anxiety and depression, as well as physical health – contributing to increased cancer risk and slower wound healing. Our attitude shouldn't be, 'It would be nice to sleep well'. Sleep should be recognised as essential to recovery."

Regular daytime engagement by nursing staff is vital for safe, supportive care. However, there is no evidence that overnight timed checks reduce harm. Before the pilot study, there were instances of patients going on weekend leave and then returning to hourly checks on the ward, which lacked therapeutic rationale and, at times, strained the patient–staff relationship.

Consultant psychiatrist Dr Patrick Keown, who was involved in the programme's design and implementation, says: "While we didn't set out to create a trauma-informed package, one of our findings was that patients reported that night-time checks can trigger memories of earlier traumatic experiences, so they felt safer when they had a protected sleep period without disturbances."

As part of SleepWell, each patient now undergoes an individual risk assessment to determine if having protected sleep hours is appropriate for them, which takes place after they've been on the ward for at least 72 hours. For adults, having protected sleep hours means not being disturbed from 12–6am, and for young people – who need more sleep – from 12–8am. This decision is made collaboratively by the multidisciplinary team, the patient, and their carer(s) as part of their individualised sleep care plan.

Protected sleep hours will not be suitable for everyone, but they are typically implemented for around 50% of patients, allowing them to avoid sleep disturbance and support their recovery. Nurses still monitor and respond to changes in mental or physical health and can increase the frequency of observations at any time, as needed. Without the constraints of a blanket observation policy, they are freed up to attend to patients with greater needs.

Dr Keown describes some initial challenges in building staff confidence around using the SleepWell programme. "It was important to get it officially approved in order to make staff feel supported and confident that the trust thought it is a safe way to proceed." The pilot was a rapid success and gained momentum through word of mouth. The trust board formally approved the changes to the engagement and observation policy, and the programme was rolled out ward-by-ward, leading to a trust-wide change of culture regarding the importance of sleep.

Dr Keown says that patient feedback has been positive, particularly from patients with previous experience of the wards. "Patients said they got better more quickly and felt a lot better at night. One patient, who previously had been sleeping in different parts of the ward, began sleeping in his bed when we stopped night-time observations," he says.

From the pilot onwards, the safety of the programme has been monitored carefully and there are monthly nurse-led meetings to share good practice and discuss any incidents. Four years of data show no increase in deaths associated with SleepWell and support its ongoing safety.

SleepWell has the backing of the College, and President Dr Lade Smith has been "incredibly supportive" say Dr Keown and Dr Anderson. They are both keen to share their learning and see the programme replicated at other mental healthcare providers, bringing the therapeutic benefits of better sleep to more inpatients across the UK. Dr Keown encourages psychiatrists to raise the topic at mental healthcare provider meetings and emphasises the importance of a multidisciplinary approach being taken.

In the meantime, small changes could start to shift ward culture. "Even 20 minutes of exposure to daylight outside – particularly in the morning – can help reset the body clock," he says. "Try to have group activities outside in courtyards and ensure patients have more active days, calmer evenings and quieter nights."

A new chapter ahead

Having recently stepped down as College Treasurer, Professor John Crichton reflects on his time in post – overseeing digital transformation, championing sustainability, and expanding the College's international reach – while continuing his long-standing public health campaigning for safer kitchen knives.

After four productive years, Professor John Crichton has much to reflect on from his time in post as Treasurer. The role has responsibility and oversight for the College's financial health, governance, recordkeeping and publishing – something he took on in 2021 during the turbulent times of the pandemic, with financial pressures likely to be looming ahead. Despite the challenges, he was able to drive progress by championing causes close to his heart – notably the drive towards net zero, expanding the College's international reach and establishing a 'digital fund'.

Before assuming this role, he was the Chair of RCPsych in Scotland and was keen to continue contributing to the College. "There were things I believed passionately in that I wanted to pursue – such as the international role of the College – and being Treasurer allows you to have influence across the board as there is little you can do without the right finance in place," he says.

He is proud of the College's commitment to achieving net zero by 2040 and has led by example – holding all Treasurer's meetings online and discouraging unnecessary air travel. "Before COVID, it wasn't unusual for people to fly up to Edinburgh from London for a 2-hour meeting and then fly back again. Online meetings save a huge amount of time and carbon," he says. The shift to virtual meetings has also helped the College expand its international reach, allowing members to take part in meetings from anywhere in the world. "It binds us all closer together," he says.

During his tenure, Professor Crichton played a pivotal role in shaping how the College responds to global humanitarian crises. At the outset of the war in Ukraine, RCPsych contacted the Ukrainian Psychiatric Association to offer support, and they requested that the College's patient information resource on trauma be translated into Ukrainian. After facilitating this, the College undertook a broader appraisal of how it should respond to such crises and developed – with instrumental input from Professor Crichton – an emergency response delivery plan to be implemented when College leadership determines it can make a meaningful contribution to relief efforts. RCPsych also committed to reaching out to other international psychiatry organisations during times of crisis to offer translations of patient information as quickly as possible. Since 2022, the College has translated its materials to support those impacted by crises in Pakistan, Turkey, Syria, Libya, Palestine, Israel, Morocco, Lebanon and Iran.

"The College is family. It is there for psychiatrists until the day they die"

Another notable legacy of Professor Crichton's term is the creation of the College's digital fund. Inspired by the building fund that enabled a past renovation of the College's London headquarters, the digital fund sets aside resources to ensure IT systems remain fit for purpose. "Every IT system has a life span," he says. "By creating a digital fund, we ringfence funds to ensure we have the money and plans in place to refresh the digital systems that our members rely on."

His longstanding commitment to public health has also shaped much of his work. He explains that part of the appeal of taking on a role at the College was to become more effective at media engagement and influencing public health policy – particularly in the area of homicide prevention. He became involved in the campaign for safer knives more than 15 years ago after a patient killed her three young children with a kitchen knife the day before a custody hearing. The case affected him greatly and he took a sabbatical, "partly to recover", and researched homicide inquiries in England and Wales. "Again and again, kitchen knives would be involved, which led me to promote round-tipped kitchen knives as a public health measure to reduce the impact of knife violence."

This is something is he still heavily involved with now – and on the day he was interviewed for this article, he had travelled down from Edinburgh to London (by train, of course) to promote the 'Let's be Blunt" campaign in UK Parliament alongside Leanne Lucas who survived the 2024 Stockport attack. (For those who want to switch to safer knives, he recommends the Viners range, saying "I guarantee that they will still cut your onions".)

Another aspect of Professor Crichton's role as Treasurer was to oversee the College's heritage assets and rare book collection. To this, he brought a genuine enthusiasm for the wealth of information and resources held by the College and an eagerness to make it all more accessible and engaging. He was delighted by a recent project focused on the College's collection of portraits of past RCPsych presidents, gathering insights by interviewing both sitters and the artists. Their reflections are now available on the website, and QR codes next to the portraits at the London HQ also provide easy access, like in a museum. He loves the way additions such as these can capture people's curiosity and improve engagement with the history of psychiatry and the College. He hopes there can be an expansion of this kind of work to include voice recordings or podcasts. "Who wouldn't want to be able to go back in time to hear a podcast from Sigmund Freud on the superego and the id?" he says. "It would be fantastic! This is the kind of viable archive that we are building up right now."

Professor John Crichton

His eye for innovation and digital transformation also extended to the College's publications – transitioning the journals' content onto an app to retain a journal-like reading experience while reducing the costs that come with physical publications and saving on carbon. By changing the policy from members needing to opt out of receiving paper copies to one where they need to opt in instead, there was a dramatic change. "We turned the stats on their head," he says. Previously, 15% had opted out of paper copies and now about 15% opt in. This has saved us 300 tonnes of carbon every year in production and distribution."

Reflecting on life as Treasurer, he compares it to chairing a multidisciplinary team meeting, bringing together the skills of all the people in the team. "If anything, I have accomplished as Treasurer has had a degree of success," he says, "it is down to the members and staff team who support me – they take ideas and make them reality while steering me away from less wise courses of action and mistakes,"

Asked if he had any advice for his successor, he offered: "Don't be a hawk when someone asks for a fee reduction." He is proud that the College has an automatic reduction for resident doctors who work less than full time, people who are on extended sick leave and those on parental leave during his time in office. He has had a policy of being sympathetic to people who explain their circumstances and request a fee reduction and hopes future Treasurers will follow suit.

Professor Crichton now takes up a senior role for the Mental Welfare Commission in Scotland, the human rights watchdog for people detained under the Mental Health Act, which also means giving up his job as a consultant forensic psychiatrist at the Royal Edinburgh Hospital, where he has worked for 27 years.

While he will not be taking up another RCPsych role, he says: "The College is family. It is there for psychiatrists until the day they die. Many of my passions and projects have had continuity since way before I was Treasurer and I hope they will continue way beyond my role."

Professor Crichton officially stepped down from his role as Treasurer on 25 June, and his successor is Dr Ian Hall.

Pupils from Llysfaen Primary School in Cardiff with Jane Dodds MS

Giving young people a voice

A College-led initiative is enabling children and young people in Wales to play a meaningful role in influencing government policy on mental health, public education and community engagement.

Cynefin – pronounced *kuh-nev-in* – is a Welsh word with no direct English translation, conveying a sense of place, belonging and connectedness to the world. It's also the name of a youth-led public education programme developed by RCPsych in Wales that encourages school pupils to discuss their experiences and views on issues that affect their mental health and wellbeing, and inform decision-making in the National Parliament of Wales (the Senedd).

The origins of the programme go back to December 2015 when RCPsych in Wales organised a debate featuring four eminent psychiatrists in front of an audience of secondary school students. While it was well-received, "the young people thought they had equally good skills and would rather be doing it themselves," says Professor Alka Ahuja, Chair of RCPsych in Wales and the programme's lead.

So, Cynefin quickly evolved into a series of student-led debates, with the young people also choosing the format and topics. "The debates have now become something the whole school gets involved with," says Professor Ahuja. "Often one school will host all the cluster schools in the area. It's become like a national cultural event."

Recognising the increasing number of younger children presenting in clinics on mental health grounds, the programme team decided to extend Cynefin to primary schools in 2016. "We involved the 10- and 11-year-olds," says Professor Ahuja, "and they were amazing."

As the programme grew, it expanded to include many other forms of self-expression, as well as debating. "We were mindful that not everybody feels comfortable standing up and talking about things," says Professor Ahuja. So, activities such as drawing, painting, model-making, writing, animation and rapping are now part of it – additions that were particularly welcomed by pupils with autism and other special educational needs.

Cynefin now engages over 5,000 participants across schools and communities, exploring issues such as loneliness, body image and financial stress. It has also worked with the National Children's Laureate, who led workshops capturing themes that were later animated and shared on social media to amplify the young people's contributions.

From the outset, Cynefin has piqued political interest. The Welsh Government formally recognised its influence on the development of the Welsh schools' curriculum, citing it at as an example of best practice in engaging young people. And, notably, RCPsych in Wales co-hosted a well-received debate on climate change featuring 12 youth climate ambassadors for Wales, which led to the formation of a cross-party group on the subject in the Senedd in 2023. The group is co-chaired by a member of the Senedd and one of the youth climate ambassadors – something that may be unique in Europe. "As far as I know, it is the only group that is co-chaired by a young person," says Professor Ahuja. "It's been very empowering."

In February, a group of pupils from Llysfaen Primary School in Cardiff involved in the programme were invited to the Senedd to present their views on topics important to them and take part in a debate on smartphone policy in schools. "The young people did not hold back," says Professor Ahuja, and their views directly influenced the final policy.

Also attending was Jane Dodds MS, Leader of the Welsh Liberal Democrats and Chair of the Senedd's Cross-Party Group on Children and Families. "What struck me most was the confidence, clarity and compassion with which these young people spoke," she says. "Hearing directly from the pupils about their experiences and views on such important topics – including the impact of social media, the challenges of transitioning from primary to secondary education and the pressures of exams – was both powerful and thought-provoking. We must continue to support and expand programmes like this if we are serious about building a democratic society that truly listens to, values and learns from its young people."

There's far more to Cynefin than the space here allows – from its ongoing work with teachers, to its mental health research award for sixth form students, to its recently launched, co-produced toolkit to help more schools to benefit from its approach. But for Professor Ahuja, one aspect jumps out: the Cynefin summer schools for secondary school students considering a medical or mental health-related career. "I always get emotional when I talk about this," she says. "We've got one former attendee studying medicine at Cardiff, and another at Oxford. It's my proud mummy moment."