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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT

...on your next RCPsych president

COLLEGE NEWS IN BRIEF

Contents

A royal centenary

This year marks a significant milestone as we celebrate 100 years since being granted our Royal Charter in 1926.

The College's history is complex and encompasses several predecessor organisations and name changes. The granting of the Charter marked the transition from the Medico-Psychological Association to the Royal Medico-Psychological Association, conferring formal rights, powers and privileges, and setting out its objectives, structure and governance. It also elevated the status of psychiatrists among their medical peers.

A coat of arms was granted at the same time, featuring the serpent-entwined rod of Asclepius and the butterflies of Psyche, symbolising the healing of the mind.

In 1971, a Supplemental Charter established the organisation in its current form as the Royal College of Psychiatrists.

To mark the centenary, a modest programme of events and initiatives has been organised, alongside the publication of a commemorative issue of *BJPsych*, reflecting on key papers from each decade of the past century, and a timeline of defining moments and milestones. A commemorative pin badge is also available to purchase.

A special member event was also held on the day of the anniversary itself, 13 March, at the College's London headquarters. Hosted by current President Dr Lade Smith CBE, it featured a panel of six past presidents reflecting on changes within the profession and considering its future.

A key centenary initiative is a mass observation-style project, which aims to capture a snapshot of psychiatry in 2026 by recording members' everyday experiences. Participants are invited to contribute journal entries, videos, or other personal reflections, helping to preserve perspectives that might otherwise be lost.

Upcoming celebrations include a free webinar titled *1926 and All That: Patients, Veterans, Psychiatrists and the Royal Charter.* This will explore the historical context of the Charter, including its implications on professional identity, the findings of the Royal Commission on Lunacy and Mental Disorder and shortcomings in care, and the experiences of First World War veterans, particularly the move towards community care.

For more information about the centenary and updates on the webinar, including the announcement of its date, visit: **www.rcpsych.ac.uk/royalcharter**

New and improved core standards

The College's Centre for Quality Improvement (CCQI), which assists mental health services in assessing and improving the care they provide, has recently published the fifth edition of its core standards.

Used across the College's quality and accreditation networks, these standards promote high-quality, sustainable and equitable mental health care. The newest edition builds on previous work in these areas, placing greater focus on culture and leadership, releasing time to care and enhancing responsiveness to neurodiverse individuals, and promoting personalised, equitable care.

The standards' relevance across all UK nations has also been strengthened, with England-centric language having been removed and feedback integrated from Scotland, Northern Ireland and Wales.

Learn more and read the new standards at: **www.rcpsych.ac.uk/corestandards**

Recognising the impact of menopause

In early March, the College published its first position statement on menopause and mental health, setting out the evidence for the significant impact of menopause on psychological wellbeing. The statement highlights associations with anxiety, depression, cognitive changes, and, in some cases, the onset or exacerbation of serious mental illness.

The statement calls for greater recognition of menopause within psychiatric practice, alongside improved training for psychiatrists and the wider workforce. It also emphasises the need for equitable access to assessment, appropriate treatment (including HRT where indicated), and integrated mental health support, as well as further research to strengthen the evidence base.

A Parliamentary launch event brought together clinicians, policymakers and representatives from relevant organisations, supporting wider engagement on the issue and its implications for service provision.

The event was also attended by various celebrities and influencers in this space, including Honorary College Fellow Davina McCall MBE, who has been active in raising public awareness of menopause and supported the launch on social media.

This work has also contributed to broader public and professional discussion, with coverage across national media, including *LBC, Daily Mail, Independent, Metro, The Jeremy Vine Show* and *The Telegraph*, as well as an in-depth feature in *The Guardian*.

College President Dr Lade Smith CBE discussed the topic on BBC Radio 4's *Woman's Hour*, highlighting the longstanding under-recognition of women's health needs, particularly in relation to menopause.

RCPsych Awards 2026

Nominations are now open for this year's RCPsych Awards. The awards recognise outstanding contributions to the profession, with categories for teams and individuals, including psychiatrists of different grades, experts by experience and medical students. Scan the QR code or visit **www.rcpsych.ac.uk/awards**

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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 spring issue of *Insight* magazine and thank you for your continued dedication and commitment to our profession during what remains a demanding time.

In this issue, we explore some significant developments shaping psychiatry today. This includes the early stages of the Independent Review into mental health conditions, ADHD and autism, which offers an opportunity to better understand the complex drivers of need, identify gaps in care and ensure that future support is grounded in the best available evidence.

Alongside this, we highlight the importance of supporting and sustaining our workforce through initiatives such as the College's Retention Charter and explore some clinical priorities including suicide prevention and improving recognition of conditions such as PMDD.

We also examine the implications of the Mental Health Act 2025 (England and Wales) and what its phased implementation will mean for clinical practice, patient autonomy and service capacity.

Finally, voting is now open to elect my successor. The final decision will be entirely down to you – and your vote really does matter – so I strongly encourage you all to have your say. Voting closes at midday (BST) on 15 April.

Dr Lade Smith CBE

From legislation to implementation

The Mental Health Act 2025 has started to come into force in England and Wales, marking the most significant reform of detention law in decades. While most changes remain some years away, their implications for clinical decision-making, tribunal practice and service capacity are already becoming clear.

A legally significant change took effect on 18 February this year. Restricted patients conditionally discharged into the community may now have conditions imposed that amount to a deprivation of liberty under the Mental Health Act itself, rather than requiring separate authorisation under mental capacity legislation. Although this did not immediately alter day-to-day practice, it marked the first provision of the Mental Health Act 2025.

The Mental Health Act 2025 (England and Wales) received Royal Assent last December after nearly eight years of review and legislative scrutiny. Reform followed the Independent Review chaired by Professor Sir Simon Wessely, commissioned amid rising detention rates, persistent racial disparities and concern that the Mental Health Act 1983 no longer reflected contemporary clinical practice or expectations of patient autonomy.

The Review articulated four guiding principles: choice and autonomy; least restriction; therapeutic benefit; and recognition of the person as an individual. These principles underpin the reforms and will inform the revised Codes of Practice. Many, though not all, of the Review's recommendations were accepted by the UK Government, alongside additional proposals from other sources introduced during the legislative process, throughout which the College also contributed evidence.

The 2025 Act amends rather than replaces the 1983 framework. Its structure, therefore, remains familiar, but key thresholds and safeguards are modified. Implementation will take place in stages.

Codes of Practice

Development of revised Codes of Practice – one for England and one for Wales – is expected over the next two years.

While the Act establishes the statutory framework, it is the Codes that will determine how its provisions are interpreted and applied in day-to-day clinical decision-making. RCPsych will contribute to their development and has emphasised that interpretation must remain clinically grounded.

Conditional discharge and the criminal justice interface

The only provision commenced to date concerns restricted patients conditionally discharged into the community. Previously, neither the Tribunal nor the Secretary of State could impose discharge conditions amounting to a deprivation of liberty. Highly restrictive community arrangements often required parallel authorisation under mental capacity legislation or through the Court of Protection.

The 2025 Act permits deprivation of liberty conditions to be imposed directly under the Act, whether or not the individual has capacity to consent. For forensic services, this has immediate implications. Existing arrangements should be reviewed to ensure the correct statutory basis is relied upon and clearly documented.

The Act also introduces changes at the criminal justice interface. A statutory 28-day time limit is set for the transfer of prisoners requiring hospital treatment. Police cells and prisons are removed from the definition of places of safety under Parts 2 and 3. These measures aim to reduce inappropriate detention environments, but their implementation will depend on the availability of health-based places of safety and secure hospital capacity.

Detention criteria

The Act introduces revised criteria for detention under sections 2 and 3, including explicit reference to 'serious harm' and 'likelihood'. The stated intention of this change is to raise the threshold for detention.

While RCPsych supports strengthening safeguards, it has raised concerns about how the new criteria will be interpreted. 'Serious harm' and 'likelihood' lack fixed clinical definitions. Without careful guidance in the revised Codes of Practice, detention decisions may become framed in defensive or probabilistic terms rather than grounded in clinical formulation.

The College has emphasised that the impact of the revised criteria will depend on how they are interpreted in guidance and applied in tribunal practice.

Advanced Choice Documents (ACDs) and care planning

ACDs allow individuals, while they have capacity, to record preferences about their future care should they later be detained. These may include treatment preferences, communication needs or cultural considerations.

Unlike advance decisions under the Mental Capacity Act, ACDs do not give the patient an absolute right to refuse treatment. However, clinicians must consider the individual's recorded wishes and explain and document any decision not to follow them.

The Act also places Care and Treatment Plans on a statutory footing, intended to be developed collaboratively with the patient and those important to them.

RCPsych has welcomed the emphasis on autonomy while noting practical challenges. For ACDs and care plans to be effective, they must be accessible at the point of detention and embedded within clinical systems.

Learning disability and autism

Perhaps most controversially, the Act removes learning disability and autism as sole grounds for detention under section 3. This aims to reduce inappropriate hospitalisation and promote community-based alternatives.

During the legislative process, RCPsych identified several potential unintended consequences of doing this, including displacement into the criminal justice system, increased reliance on alternative deprivation of liberty frameworks and the risk that some individuals with high-risk behaviours may lack appropriate routes to treatment if community provision is insufficient.

This change may also lead to a shift in clinical practice. Where detention can no longer be based solely on learning disability or autism, greater emphasis may be placed on identifying co-occurring psychiatric disorders, with implications for diagnostic formulation and tribunal evidence.

The College has emphasised that reform must come with investment in community services and careful implementation.

Safeguards and oversight

The Act expands various procedural safeguards. For example, patients detained under section 3 will be referred to the Tribunal earlier than previously (within 28 days). Community Treatment Orders will be subject to tighter scrutiny. The 'nearest relative' role will be replaced by a nominated person, chosen by the patient wherever possible, with similar rights and additional responsibilities. Rights to Independent Mental Health Advocacy are strengthened, and additional safeguards apply to consent to treatment.

These changes enhance autonomy and oversight but increase procedural demands. The College has emphasised that expanded rights require realistic workforce planning and service capacity.

Differences in Wales

In Wales, elements of the Act relating to criminal justice and public protection remain reserved to Westminster, while health service delivery and safeguards within the civil provisions are devolved. Welsh Government policy decisions will therefore be crucial to how reforms are taken forward in Wales.

The Senedd granted Legislative Consent prior to Royal Assent, ensuring that Welsh Ministers retain powers over implementation, including developing the revised Code of Practice for Wales.

Mental health services in Wales already operate within a distinct legislative and policy framework, notably including the Mental Health (Wales) Measure 2010. Reforms will therefore need to align with existing Welsh law, policy and service models and will also be introduced within an integrated system delivered through Local Health Boards, which may shape how changes are operationalised, particularly in relation to community provision. As implementation progresses, RCPsych in Wales continues to engage with the Welsh Government.

Current situation

Only one provision of the Act is currently in force. Implementation of the remaining reforms will be determined by the Department of Health following revisions to the Codes of Practice. RCPsych will continue to scrutinise implementation across England and Wales and engage with the UK and Welsh governments to support reform that is clinically workable and consistent with patient care.

Workforce capacity remains a pressing concern. Research commissioned by the College suggests that expanded tribunal access and enhanced safeguards will require significant additional psychiatric capacity. Government impact assessments, however, project much more modest increases in this capacity, based on an assumption that detention rates will substantially fall. RCPsych does not expect such a reduction given the prevalence of severe mental illness and the climate of heightened concern about risk and public protection. As it stands, the scale and timeline of the workforce capacity increase required remain to be determined.

Learn more

A free College webinar explores the MHA 2025 in more detail: **www.rcpsych.ac.uk/MHAwebinar**

A turning point

Examining some of the complex issues being explored by the Independent Review into Mental Health Conditions, ADHD and Autism in England, with input from one of its vice-chairs Professor Sir Simon Wessely.

It's widely recognised that demand for mental health services has risen in recent years, leaving the NHS struggling to keep up. Many patients face long waits for assessment and treatment, with hundreds of thousands of children and young people waiting over a year for 'meaningful help', such as advice, signposting, evidence-based intervention and consultation. Waiting times for neurodevelopmental assessments, including for autism and ADHD, can be years long. Inconsistent care pathways and delays in access to care leave many people with significant unmet need.

Against this backdrop, the Independent Review into Mental Health Conditions, ADHD and Autism, which was announced last December, is examining the drivers of rising demand for mental healthcare in England and how services should respond, with its findings likely to shape understanding of prevalence, trends and inequalities across mental health conditions and influence future policy and practice.

For some time, there has been considerable debate as to what is causing the increased demand and how it should be interpreted. Suggested factors include a rise in drivers of poor mental health, including socioeconomic pressures and broader social and technological changes; shifting social attitudes and awareness of mental health encouraging more people to seek help; structural factors within healthcare, education and welfare systems that influence demand for assessment and referral pathways to care, as well as demographic changes.

Two months before the review was announced, last October, public debate gained increased prominence when Health and Social Care Secretary Wes Streeting suggested that some mental health and neurodevelopmental conditions may be being overdiagnosed and stated that too many people were being "written off", remarks he later described as "divisive".

Some interpreted the comments as reflecting a wider economic argument linking diagnosis with people leaving or remaining out of work and accessing disability-related benefits. The counter argument is that diagnosis can help people access treatment and support and, in some cases, enable individuals to remain in or return to work. This complex area of how diagnosis, service demand and wider social factors interact is one that the review is examining as it gathers evidence.

RCPsych is committed to engaging with the review process throughout, providing evidence, expertise and opinion to further the College's core aim of ensuring people with mental ill-health can access appropriate care and treatment.

College President Dr Lade Smith CBE says: "The review offers an important opportunity to improve how we support people with mental health conditions. A diagnosis, when made appropriately, should be a gateway to care. With the right treatment and support, people can and do thrive, remain in work and lead fulfilling lives. The system fails when people with a diagnosis, who need appropriate care, cannot get it. It is also important to recognise that the largest treatment gaps remain in severe mental illness, and these must not be overlooked."

Clinical psychologist Professor Peter Fonagy is chairing the review, with former RCPsych President Professor Sir Simon Wessely and Professor of Paediatric Neurodisability Gillian Baird as vice-chairs.

Speaking in his capacity as vice-chair of the review, Sir Simon explains that its initially broad remit has since been refined. It is now focusing on common mental health conditions, such as anxiety and depression, where recorded diagnoses and service demand have increased over the past two decades, particularly among young people, and ADHD and autism, both of which have also seen a steep rise in referrals.

Sir Simon points to the 2013 revision of diagnostic criteria that brought several previously distinct conditions under the umbrella of autism spectrum disorder, creating a broader diagnostic category, as an example of how definitions, and with them demand, have evolved over time, meaning that more people may have been brought into services who might not previously have been identified. Changes in societal awareness may also have fed into this.

"There is no doubt that awareness has dramatically increased. Likewise, acceptance and understanding in the general population have also changed for the better," he says.

At the same time, the review is considering whether this shift could have implications for those with more severe needs if services become stretched. "Some people are still being left behind and there are concerns that those most severely affected don't always receive the care and support they need."

Other areas under consideration include what diagnoses should lead to in terms of care and support, as well as how they are made to begin with and who makes them. The latter leads to issues of inequity, given the increasing reliance on private assessments – those able to pay can often access assessment more quickly, raising concerns about fairness where access is influenced not only by need, but by the ability to navigate, or bypass, a complex system.

College Registrar Professor Owen Bowden-Jones CBE is contributing to a specific area of the review and reporting on ADHD medication as an independent expert. He highlights the need to consider prioritisation in the context of long waiting lists. "Given the scale of demand, we need to ensure that those with the most severe symptoms can access timely treatments. But this must be balanced carefully to ensure that no one who would benefit from assessment and treatment misses out."

Another reason to strike this balance carefully is to ensure that certain diagnoses are not framed as more legitimate than others, which would risk minimising or stigmatising those affected.

The potential risks and benefits of people "medicalising" their distress are also being put under the spotlight. Sir Simon gives the example of people expecting to be prescribed antidepressants for transient periods of stress or anxiety. "We also have to ask whether everything we are now seeing necessarily requires a clinical response," he says.

At its core, understanding the drivers of prevalence and service demands needs to be about improving outcomes. While there are significant differences of opinion about the reasons behind rising demand, there is broad agreement that the current system is not working as it should for many people.

This may be feeding into wider outcomes, particularly for young people. The review is therefore exploring the increase in those not in education, employment or training (NEETs), and the relationship between economic inactivity and mental health. "We have known for generations that prolonged economic inactivity can have a profound impact on mental health," says Sir Simon. "We need to reverse this, otherwise too many young people will have a poor start in life."

The College has emphasised that whatever the findings of the review, improving access to care will require sustained investment in the mental health workforce, alongside better training and clearer pathways to assessment and treatment. Ensuring that diagnoses are based on high-quality, comprehensive assessments, and that they lead to timely, evidence-based support, remains the ultimate aim.

There has been understandable interest and apprehension as to how the review will develop. Clinicians, patient groups and policymakers are keen to know the conclusions it will reach and how these might shape future services. For psychiatrists in particular, the findings are likely to have significant implications for clinical practice.

Psychiatry is well represented within the review's working group, which includes psychiatric specialists in autism and ADHD alongside psychologists, educators, social care professionals and people with lived experience.

Understanding the experiences of all clinicians, not just specialists, is an important part of building a full picture. To support this, the College has sought input from members across the four nations of the UK to ensure a representative evidence base, recognising that the review's findings in England are likely to have wider implications.

Sir Simon acknowledges the scale of the task at hand and the need for realistic recommendations. "There are complexities," he says, "and it will be hard to reach a simple consensus. We need to get the balance right and make positive, sometimes brave, suggestions. Not ones that are simply aspirational."

Drawing on his experience leading the 2018 Independent Review of the Mental Health Act, he is aware of the limits of what such work can achieve. "No single review could ever be expected to resolve all of the challenges facing mental health services," he says. But in a system under increasing pressure, there is a clear opportunity to make meaningful progress, both in how diagnosis is understood and how care is delivered.

Nurturing our workforce

The College's Retention Charter aims to assist in improving how psychiatrists are supported at work and enable employing bodies to better retain and nurture their psychiatric workforce.

As part of its work to strengthen support for the psychiatric workforce, the College recently published its Retention Charter. Launched in the second half of 2025, the charter provides a framework for employing bodies to improve how they care for their psychiatrists so they feel safe, valued and able to achieve their full potential – supporting workforce retention and patient care.

Workforce shortages and retention difficulties remain a major challenge for mental health services across the UK, contributing to mounting service pressures and reports of staff burnout and moral injury. According to the 2023 RCPsych Workforce Census, 28.6% of consultant posts, 30.3% of SAS psychiatrist posts, and 37.7% of locally employed doctor or Clinical Fellow posts across participating NHS organisations are vacant or filled by locum psychiatrists.

"For years now, people have been talking about the factors that affect psychiatrists' decision to remain in the profession. However, these had not been brought together in a systematic way," says RCPsych's Presidential Lead for Retention and Wellbeing Dr Ananta Dave, highlighting the charter's potential to address these issues. "Not only does the charter break these factors down, but it also provides targeted guidance on what employing bodies can do about them."

Dr Dave, who led the charter's development, explains that it groups key retention factors into four domains so that employers can consider them in a structured way in the context of their own organisations, starting with a self-assessment exercise. It also provides recommended aims and actions for making improvements, alongside good-practice examples.

To determine the key factors to focus on, the College drew on a wide range of sources, including its own surveys, research from the GMC and the NHS, surveys from NHS employers and providers and from trade and defence unions, as well as surveys and studies examining retention in other medical specialties.

"From this evidence, we can see that there are many factors that influence a person's decision to continue in a profession or a specialty," says Dr Dave. "This can include their workplace culture, support available for personal and professional development, the flexibility of their job plans, whether or not they feel valued, and how employers address issues like workload pressures, complaints, discrimination and bullying."

Dr Dave also emphasises that workforce shortages themselves can exacerbate retention issues. "If psychiatrists struggle to maintain standards of care due to a lack of capacity, this can have a huge impact on their experience of work. It can cause distress and moral injury, eventually causing them to want to leave the organisation, the country or the profession," she says. Improving retention would likely have the opposite effect, highlighting the importance of maintaining a sustainable workforce and of tools such as the charter.

The charter's domains cover 'creating a culture of belonging'; 'supporting the mental and physical health of psychiatrists'; 'aiding in their career planning' and 'developing medical leadership'.

Domain 2 for example, focuses on the mental and physical health of psychiatrists. One of the central recommendations under this domain is for organisations to 'promote staff health and wellbeing and provide support, at an early stage, for those experiencing work-related stress, burnout, or ill health'. The charter puts forward a number of recommended actions that would support this, including ringfencing funding for staff health and wellbeing initiatives, establishing regular reviews of caseloads, and regularly seeking feedback from staff on barriers to support.

The charter also includes a set of 'maturity matrices' that organisations can use to assess whether they are at a 'foundation', 'intermediate' or 'mature' level, and then track progress over time. This system is not intended to place pressure on employers or function as a tick-box exercise, but to help them measure meaningful progress.

"We want the work to feel aspirational yet approachable," says Dr Dave. "There is no pressure to adopt the charter and there is no single way to implement it. Organisations have the freedom to work through it at their own pace."

With this in mind, the College has also published a self-assessment tool and guide to help employers identify areas they are already doing well in, and others which might need more development, enabling them to determine what to prioritise when first starting out. There is also an interactive online hub that houses all information employing bodies would need to get started with the charter, including a 'how to' guide, to make it easier to navigate.

When developing the charter, the College prioritised representing the full diversity of the workforce, ensuring it is relevant to psychiatrists across grades, roles and backgrounds. This includes those at the beginning and later stages of their careers, as well as SAS psychiatrists, international medical graduates (IMGs), locally employed doctors, LGBTQ+ clinicians, those with disability, those with significant caring responsibilities, and those from minority ethnic backgrounds.

Inclusivity is embedded throughout the charter, including in its recommended actions. For example, one calls for enhanced support for early-career psychiatrists, those between career stages, those returning to work after a break and IMGs. Another promotes targeted support for groups who may face particular challenges navigating their careers, such as new parents, less-than-full-time psychiatrists and those in the independent sector.

"One of our profession's strengths lies in the diversity of our clinicians, and the different insights and perspectives this provides," says Dr Dave. "It is therefore crucial that when we think of retention, we are not using a 'one-size-fits-all' approach and are considering the needs of many different groups of people to achieve equity in retention practices."

To raise awareness of the charter and what it can do for employing bodies, the College launched it at a conference attended by medical directors in July 2025. Dr Dave has also been travelling across the UK to meet with medical directors and other senior leaders, as well as colleagues in RCPsych divisions, to discuss how the charter can support their organisations.

To build on this work and establish a strong evidence base around retention practices and the use of the charter, the College will also continue to work with its members to develop tools for evaluating impact. At the request of the Association of Medical Royal Colleges, RCPsych also developed a version of the charter for all clinicians to extend its potential benefits to the medical profession more widely, which was published recently.

This work is part of the College's wider focus on retention, including its Thrive in Psychiatry campaign that launched last year, which aims to raise awareness of the challenges psychiatrists face and promote ways that organisations can better support clinicians throughout their careers.

Learn more

The Retention Charter and its online hub:
www.rcpsych.ac.uk/retentioncharter

The Thrive in Psychiatry campaign:
www.rcpsych.acuk/thrive

Meet your **presidential candidates**

Three candidates – Dr Regi Tharian Alexander, Professor Subodh Dave and Professor Robert Howard – are standing to take over from Dr Lade Smith CBE in June as the College's 19th president.

Here on this page, each candidate presents a shortened version of their presidential statement outlining their priorities and vision for the College.

As part of the election process, members have been invited to submit questions to all three candidates, which are being answered on a Q&A webpage. The College also hosted a presidential hustings event, where each candidate set out how they would lead as president and responded to questions live.

Full candidate statements, video introductions, Q&A responses and a recording of the hustings are available on the 'President election' section of the College website: www.rcpsych.ac.uk/president-election

Have your say

Voting in the presidential election is now open to all Members, Fellows, Specialist Associates and Honorary Fellows (who have previously held one of these grades) and closes at midday (BST) on Wednesday 15 April.

Information on how to vote is included on the election emails being sent directly to you by our partner, Civica Election Services. If you're eligible to vote but haven't received the ballot email, or are having any issues voting, please visit: www.rcpsych.ac.uk/voting

Voting is also open for positions across the devolved nations, English and international divisions, faculties, special interest groups, the Psychiatric Resident Doctors' Committee, and for the elected member of the College's Council. These also close at midday (BST) on 15 April.

To find out more and check your voting eligibility for each of these roles role, visit: www.rcpsych.ac.uk/elections

Dr Regi Tharian Alexander

Consultant Psychiatrist, Hertfordshire Partnership University NHS Foundation Trust

Our College's core purpose is clear and enduring. We set high medical standards in psychiatry and support psychiatrists to meet them.

One College with one mission, we must balance the needs of all four UK nations fairly while championing our core purpose internationally.

To do this effectively, we need a College that enthuses its members, a College that is a natural home for them.

As President, I will prioritise three areas to deliver this.

First, protecting psychiatry as a medical specialty.

I will champion the distinct expertise of psychiatrists and their unique medical identity. Speaking up against attempts to dilute these standards, I will work collaboratively for constructive solutions. Patient safety demands that.

Second, fixing recruitment, retention, and career progression.

We fill core training posts but lose doctors later.

With over half our workforce now women, fair career progression is an imperative.

I will push for fairer entry routes, stronger training pathways, and expanded routes to specialist registration including CESR.

We can prioritise UK graduates while delivering justice for international graduates already here.

Third, making the College a practical ally.

Psychiatrists today face overwhelming pressures and moral injury.

I will focus on practical support: better employer partnerships, affordable CPD, smarter use of technology, expert advice for clinical scenarios, and more autonomy for faculties and divisions.

Building on the unique relationship of trust that we have with patients and their families, we can, together, shape Psychiatry as a medical specialty rooted in evidence, treatment, and outcomes.

regialexander.com

Regi Tharian Alexander | LinkedIn

Professor Subodh Dave

Consultant Psychiatrist, Derbyshire Healthcare Foundation Trust; Professor of Psychiatry, University of Greater Manchester; Dean, Royal College of Psychiatrists

The journey from an underprivileged Mumbai community to becoming a doctor was shaped by my parents' aspiration and ambition. It instilled my belief in confident, compassionate and aspirational medical leadership, and is why I am running for President.

Psychiatry and Psychiatrists are under siege, with rising demand and complexity in overstretched, underfunded systems. We need strong medical leadership that places Psychiatry at the heart of healthcare, using our unique biopsychosocial expertise to deliver person-centred care.

I have five priorities.

1. **Enhance the influence and impact of psychiatrists** at team, organisational and policy levels, ensuring frontline expertise shapes service design and delivery.
2. **Use the College's influence to drive optimal patient outcomes** through safe, consistent implementation of evidence-based treatments like clozapine, lithium and ECT to narrow the mortality gap for patients with severe mental illness.
3. **Ensure our workforce is sufficiently staffed, diverse and supported to thrive.** Scapegoating and fear inhibit good psychiatric practice. I'll build on my record of support for Doctors in Distress to foster relational Psychiatry.
4. **Promote primary, secondary and tertiary prevention** and public mental health across the life course.
5. **Lead cutting-edge innovation** in applied research, digital technology and funding to improve psychiatrists' working lives.

As Dean, I translated ideas into action, launching national educational initiatives to improve patient care.

As President, I will bring my marathoner's determination and tenacity to help psychiatry reclaim its leadership role and secure better outcomes for our patients and communities. Together, let's **include, innovate and implement**.

www.subodh-dave.com

X: @subodhdave1

LinkedIn: Subodh Dave

Instagram: subodh4president

Professor Robert Howard

Professor of Old Age Psychiatry and Honorary Consultant Psychiatrist, University College London and North London Foundation Trust

I'm standing for President to improve and defend what really matters to members - our standards, services, colleagues and the help we can give our patients. In my career, I have learned that evidence and clarity of argument improve things for patients and colleagues, both as a clinical academic and, when as Dean, I led recovery of our postgraduate training systems after MTAS and started Choose Psychiatry.

Our workforce crisis and budgetary considerations drive an agenda of substitution which threatens patient safety and multidisciplinary training. We must immediately define the scope of work for PAs and oppose dangerous substitution of psychiatrists. Building and protecting our workforce will be at the heart of my Presidency. A Psychiatry-specific assessment for CT1 entry, College accreditation of Trust HR systems, repairing connections between residents and consultants, creating novel additional training capacity, supporting training and career development of SAS colleagues and making annual job planning a robust College-led negotiation, are all among my Manifesto promises detailed at **profrobhoward.com**.

Please visit the website, read my proposals and use the links to learn more about me.

We cannot allow feelings of helplessness to stop us working to make the experience of being a psychiatrist better. I'm not just asking for your vote. I want you to look again at your individual feelings of ownership of what should be *your* Royal College and your willingness to listen and engage with a programme of change to improve the areas that matter most in your life as a psychiatrist.

Navigating publishing pitfalls

RCPsych's Publishing Team offers practical advice on submitting to the College's portfolio of journals, highlighting common oversights that can reduce a paper's chances of being accepted.

The College manages five academic journals that publish a wide range of mental health research and commentary, from cutting-edge studies and systematic reviews to educational resources, opinion and debate.

Across the College's portfolio, and academic publishing more broadly, far more papers are rejected than accepted. While rejection is a normal part of academic life, many early decisions hinge on issues that are avoidable.

Understanding how these decisions are made can demystify the process and help authors approach submissions more strategically, giving their work the best possible chance of success. The following tips highlight how to avoid some of the most common pitfalls.

1. Choose the right journal

One very common reason for rejection is poor fit. A paper may be methodologically sound and clinically relevant, but if it does not align with a journal's scope, tone or typical scale of research, it is unlikely to progress.

Fit goes beyond subject matter. It includes the framing of the research question, level of analysis, methodology and intended audience.

You can often judge the kind of papers that a journal is likely to accept by looking at what it has previously published. If similar subject areas or research methods have not appeared in the journal before, then it is probably not the right place to publish your research. Every paper has a home – it just may not be the first journal you try.

2. Get the basics right

In a high-volume system, first impressions carry enormous weight. Before a manuscript reaches the editor-in-chief or a handling editor, it undergoes an initial screening by journal staff to ensure all the required elements are present. Editors assess not only the subject matter but the overall standard of presentation. If basic elements, like abstracts, declarations and tables, are missing or badly formatted, or the article is too long or has too many references, it may not progress.

This is not to be punitive. Such oversights can signal larger problems: if the basics seem rushed or incomplete, editors may question whether similar care has been taken with the methods, analysis or interpretation.

Each College journal has a 'Preparing your materials' section within the author instructions on its website, which sets out what is expected of submissions. Checking your manuscript against this guidance is therefore essential.

3. Clearly define your research question

A well-defined research question is the foundation of a robust paper. It should be immediately clear to your reader what your research is trying to do, and how you are trying to do it. A clear research question also helps structure the paper – guiding how the aims, methods, and results all fit together.

4. Don't overinterpret your data

Overinterpretation of findings is another frequent and avoidable reason for rejection. Confusing correlation with causation is an obvious example. Editors may reject your paper on this basis alone, as this kind of basic error or overstatement can undermine trust in a submission as a whole, even when the underlying study is sound.

Don't be tempted to overstate the significance of your findings. You do not have to try to force a scientific breakthrough with every paper – it is sufficient to contribute to the field.

5. Write clearly

Your paper should be clear and readable. A strong paper does not need to sound complex to be impressive. In fact, ideas that are clearly expressed are easier to evaluate and are more persuasive.

Proofread your paper carefully, and even ask a colleague to review it as well. You might consider using AI tools to check your spelling, grammar and punctuation, improve readability, and check you've adhered to the journal's guidelines. (If AI tools are used during manuscript preparation, however, the College requires that their use is declared.)

6. Use reporting guidelines

Most study designs now have associated reporting guidelines designed to improve transparency and rigour. These frameworks outline the information needed for readers to assess a study's validity. For example, systematic reviews are expected to follow PRISMA guidance. These guidelines are collated by the Equator Network and are readily accessible. They can serve as practical checklists during manuscript preparation and consulting them early can prevent avoidable criticism during peer review.

7. Don't plagiarise – even your own work

Plagiarism remains a serious concern in academic publishing. Authors should not present others' work as their own. However, self-plagiarism is also an issue: authors should not reuse material they have published elsewhere; this includes reproducing or closely paraphrasing their own work. Submissions should present new and original material. If it is necessary to refer to your own work, it should be fully referenced.

8. Get involved in publishing

Peer reviewing, participating in journal clubs and taking on trainee editor roles can all help build understanding of how editorial decisions are made and what journals are looking for.

Peer reviewing:
Gaining experience as a reviewer can help improve critical appraisal skills and often improves one's own writing. Seeing how manuscripts are assessed can also make the process feel less opaque.

BJPsych Advances has published two helpful articles by Neel Halder on the peer review process – 'Peer reviewing made easy' (2011) and 'Peer reviewing made easier' (2021). These provide practical guidance on how to structure and write constructive peer reviews. Further resources can be found within each journal's peer review information pages.

Journal clubs:
These focus on appraising a recent article from a journal. *BJPsych* Journal Club, for example, is an open-access online event that aims to train the next generation of writers, reviewers and editors. Recordings are available via *BJPsych's* Magnify blog.

9. Recommend reviewers

Many journals invite authors to suggest potential peer reviewers when submitting manuscripts. Appropriate recommendations can help the process run more smoothly, although all suggestions are subject to conflict-of-interest checks and additional reviewers are selected independently by editors.

Authors and reviewers should not have any contact during the peer review process, or before a final decision has been made, without the journal's permission.

10. Take processes seriously, not personally

It can be easy to take rejected submissions or peer review comments to heart. You will have invested a lot of time and energy into your paper, which might make it difficult to consider where and how it could be improved.

Rejected manuscripts offer an opportunity to reflect on what might not have hit the mark. Peer review is a collaborative process between the authors and reviewers aiming to make a paper as robust as possible. Supportive but rigorous review – which the *BJPsych* journals pride themselves on – will only improve your work.

Respond in full to every point that your reviewers raise, but avoid making additional changes unless requested. If you do disagree with a comment, explain your reasoning clearly and professionally, and the editor will make a final decision.

Further advice

The International Committee of Medical Journal Editors (ICMJE) has helpful guidelines for what should be included in a manuscript submission on their website. All of the College journals also have more information for prospective authors on their respective websites.

By choosing the right journal, presenting your work clearly and paying close attention to detail, authors give their submissions the best possible chance of success.

Editorial roles in a journal: *Who's Who?*

Editor-in-Chief (or EIC): Leads the editorial board, screens new submissions and assigns them to handling editors, while also setting the journal's overall strategic direction.

Handling Editor or Section Editor: A subject expert on the editorial board who manages the paper through the review process and selects appropriate peer reviewers.

Managing Editor: The journal's administrator who oversees the day-to-day management of all submissions and editorial processes, with assistance from support staff.

The Fellowship's current cohort (left to right): Pettiann Bhoorasingh, Iyinoluwa Popoola and Elsie Ampomah

Shaping the next generation

The College is inviting applications for the next Aggrey Burke Fellowship, a programme designed to support Black medical students and improve representation in psychiatry.

Black people remain the least represented ethnic group within psychiatry – particularly those of Caribbean heritage. One way that RCPsych has sought to help address this is through the Aggrey Burke Fellowship, a two-year programme designed to support Black medical students in exploring and pursuing a career in the specialty. It was launched in 2023 as part of the College's Equality Action Plan.

Open to Black medical students at UK universities, the fellowship offers mentorship from senior psychiatrists, a CPD fund, access to the College's e-learning hub and a fully funded place at the College's International Congress. Three places are available in each cohort, and applications are now open for the next group of fellows, who will begin the programme in September.

The fellowship is named in honour of Dr Aggrey Burke, the first Black consultant psychiatrist appointed by the NHS, who died last December aged 82. Born in Jamaica, he spent much of his career researching racism and mental illness, and highlighting inequalities. At the programme's launch, he expressed his hope that it would help the next generation "to take steps in their careers that I could only have dreamed of when I was starting out".

The first cohort of fellows – Daniel Olaniyan, Oluwamayomikun Ajayi and Isabelle Gallier-Birt – completed the programme last year and describe it as a highly positive experience. Daniel says applying to take part was "one of the best decisions I've made".

All three highlighted the value of mentorship and the opportunity to connect with and build relationships with senior and inspiring figures in psychiatry, including College President Dr Lade Smith, who co-conceived the scheme.

During their time on the programme, the inaugural fellows contributed to College initiatives, including a Black History Month podcast discussing their experiences as medical students. They are currently undertaking research exploring perceptions of psychiatry among Black medical students and the barriers they may face.

Increasing the diversity of the psychiatric workforce is also just as important for improving patients' experiences of care, particularly those from historically disadvantaged communities who may feel they will not be fully heard or understood.

The current fellowship cohort – Iyinoluwa Popoola, Pettiann Bhoorasingh and Elsie Ampomah – joined the programme last year. For Iyinoluwa, the fellowship sends an important message: "It shows younger Black medical students that this is something that they can do, and that the College does want them and has made a space for them," she says.

For Pettiann, addressing health inequalities was a key motivation to apply. "I'm of Jamaican heritage," she says, "so I've seen a lot, even within my own family, of the taboo and stigma and cultural misunderstandings when it comes to mental health."

Mentors are central to the fellowship, offering guidance and support throughout the programme and for Elsie this was a huge draw. "I applied because of the opportunities the fellowship presented," she says, "the main one being mentorship."

Consultant child psychiatrist Dr Ifeoma Ameke mentored one of the first cohort and says she felt "honoured and privileged" to take part. As a Black female psychiatrist, she feels grateful for Dr Aggrey Burke's work to expose racial and gender discrimination in medical school admissions – something that was evident to her when applying to medical school in the late 1980s.

Through the programme, Dr Ameke built a strong mentoring relationship with her mentee Daniel. Both based in Bristol and sharing Nigerian heritage, the pair also connected through Daniel's strong interest in her specialty. Together they explored the challenges faced by Black medical students today and the opportunities the fellowship offers.

"It was a privilege to walk alongside my mentee and guide and support him over two years" she says, adding that he, like the other fellows, is "an outstanding role model for young Black students interested in medicine and psychiatry".

Applications now open

Medical students: Applications for the 2026–28 cohort close on **27 April.** For information and to how apply, visit **www.rcpsych.ac.uk/abf**

Mentors: Senior Black psychiatrists interested in mentoring should email **careers@rcpsych.ac.uk** with their location and specialty by **30 June**.

Closing the gaps in suicide prevention

As the Suicide Prevention Consortium's four-year programme draws to a close, its final report sets out a clear message to services: there must be 'no wrong door' to care and support must be genuinely person-centred.

When someone seeks help for suicidal distress, the first response they encounter can determine what happens next. Policy has long emphasised compassion, continuity and holistic care. But, in practice, people still encounter rigid thresholds, siloed services and exclusion.

Over the past four years, the Suicide Prevention Consortium has examined this gap between principle and reality. Its final report, *Suicide prevention principles: from policy to practice*, argues that two core principles must underpin suicide-related care: there must be no wrong door to accessing support, and care must be person-centred.

The Consortium brings together Samaritans; the National Suicide Prevention Alliance (NSPA); the Support After Suicide Partnership (SASP); WithYou; and people with lived experience. NSPA and SASP have been hosted by the National Collaborating Centre for Mental Health within the Royal College of Psychiatrists since last year.

'No wrong door' means that when someone presents with suicidal thoughts, self-harm, suicide attempt(s) or suicide bereavement, their distress is addressed at that point of contact rather than deferred because it falls outside a service's remit.

People with co-occurring needs are particularly vulnerable to being redirected. Those presenting with suicidality alongside alcohol or drug use may be excluded from mental health services, while substance use services may feel unable to manage suicide risk. The result is not neutral. It increases clinical risk.

A no-wrong-door approach does not mean every service delivers every intervention. What it does mean is shared clinical ownership of risk, parallel responses to need and pathways that connect people across services rather than leaving them in limbo. It also requires scrutiny of eligibility criteria and commissioning arrangements to ensure people with complex needs are not at risk of being excluded.

The report also highlights that postvention (support for people bereaved by suicide) is a fundamental component of prevention. Suicide bereavement is associated with elevated risk of mental ill-health and suicidality, yet bereaved individuals often encounter the same fragmented pathways as those in acute crisis.

As Michelle Stebbings, Executive Lead at SASP, puts it: "You can't say you're preventing suicide and ignore people who've been bereaved."

Person-centred care, meanwhile, is not simply about individualised formulation. It requires collaborative decision-making, cultural sensitivity and the ability to tolerate conversations about suicidality without shutting them down. One of the report's lived experience contributors describes good care in these terms:

"My psychologist in particular is great at sitting with my suicidality and giving it space, and acknowledging and understanding its presence, and the role it has in my life. She doesn't shut conversations down. […] I am grateful she is able to hold her worries and prioritise what would be more helpful for me."

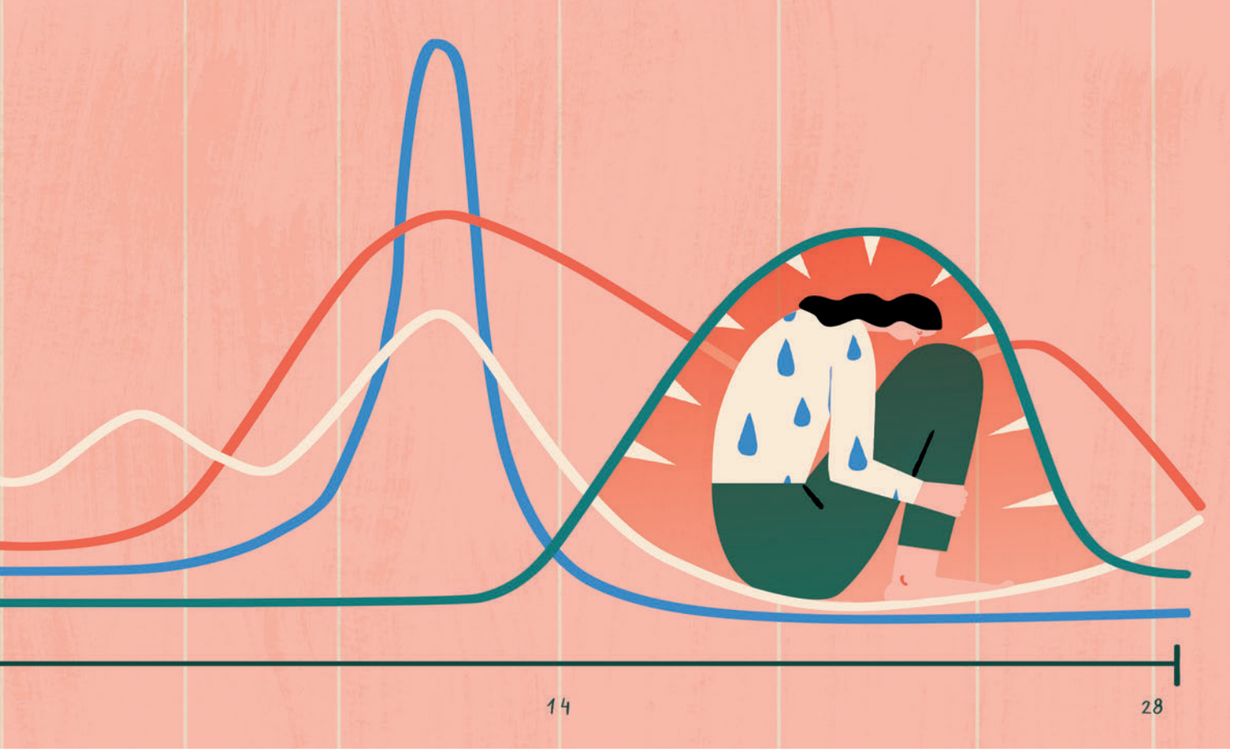
The Consortium's findings align with the College's 2025 *Co-occurring Substance Use and Mental Health Disorders (CoSUM)* report, which highlights poor coordination between mental health and substance use services as contributing to poorer outcomes for people with co-occurring conditions, including elevated suicide risk. Both underscore that rigid separations between mental health, substance use and suicide-related care create gaps that require integrated, collaborative pathways to address.

For psychiatrists, the implications are practical. Suicidality should be held within assessments even when the presenting problem appears to be substance use, housing instability or physical illness. Local thresholds that exclude people with co-occurring needs should be questioned. Suicide bereavement should be recognised as a clinically relevant exposure. In leadership roles, psychiatrists have a responsibility to shape integrated pathways rather than defend silos.

Although commissioned in England, the report and the challenges it describes are recognisable across the UK. It does not propose a new theory of suicide prevention. It calls for consistency between what psychiatry already knows and what services deliver showing how these principles can be embedded across systems and sectors.

Read the report

Suicide prevention principles: from policy to practice can be accessed from the resources section of **supportaftersuicide.org.uk**



(Illustration: Laura Liedo)

Understanding PMDD

Premenstrual dysphoric disorder comes with highly debilitating symptoms yet takes an average of 12 years to diagnose. It could be identified much sooner if menstrual health became part of mental health screening for women.

Premenstrual dysphoric disorder (PMDD) is a severe condition linked to hormonal fluctuations during the menstrual cycle that is often under-recognised in psychiatric practice. Characterised by acute distress and functional impairment, it affects 1.6% to 5% of women and other people assigned female at birth who menstruate.

The onset of symptoms may occur during or after reproductive or hormonal changes associated with pregnancy, miscarriage, perimenopause and the menopausal transition, but can also occur without an obvious trigger and fluctuate in response to other stressors. Common symptoms include irritability, low mood, anger, anxiety, fatigue, poor concentration and pain, and occur during the luteal phase, which starts at ovulation and ends at the onset of menstruation.

PMDD is distinct from premenstrual syndrome (PMS) in its intensity and impact. It has a significant association with self-harm and suicidality, with evidence suggesting lifetime active ideation in around 72% of those affected. Patients may present in crisis and symptoms can be misattributed to psychiatric disorders, such as bipolar or emotionally unstable personality disorder. At the same time, comorbidity is common: around 70% of people with PMDD will have another psychiatric diagnosis across their life course.

The leading aetiological theory suggests PMDD reflects an abnormal response to falling progesterone during the luteal phase, although other pathways, including those involving oestrogen signalling, may also play a role. People with PMDD also appear more sensitive to synthetic progestogens, such as those found in hormonal contraceptives, to which responses vary. Although they are sometimes used to manage PMDD, they can worsen symptoms in some individuals. Premenstrual exacerbation of other conditions is common but poorly understood and can make formulation more complex.

PMDD is relatively easy to diagnose by tracking symptoms over two menstrual cycles using the Daily Record of Severity of Problems to confirm a luteal-phase pattern. However, the average time to diagnose PMDD is 12 years, during which the individual will see an average of six healthcare professionals.

Greater awareness is needed in both primary and secondary care, and among the public. But this delay in diagnosis may also reflect PMDD's positioning within healthcare. As it is classified as a depressive disorder in the DSM-5, it can fall between psychiatric and gynaecological services. Although a multidisciplinary approach is recommended by the Royal College of Obstetricians and Gynaecologists, in practice this can often remain elusive.

Professional discomfort may be another factor contributing to missed or delayed recognition. Expert by experience Emily Elson notes how this can differ between specialties. "Psychiatrists can feel uncomfortable asking about periods and gynaecologists don't like asking about mental health," she says. "What you find is two taboo subjects together and you get a black hole of stigma and shame."

Consultant psychiatrist Dr Sophie Behrman runs a menopause and menstrual mental health clinic. She believes reluctance among clinicians to explore hormonal aspects of mental health may partly reflect efforts to avoid outdated ideas linking women's mental illness to the womb, such as the historic concept of the 'hysterical' woman. But she argues that asking about menstrual health should become routine in psychiatric assessments.

"Ask about periods and normalise that conversation," she says. "Understanding illness in the context of menstrual cycles is important and makes PMDD much easier to identify." This is particularly important for people with severe mental illness, whose physical health is often neglected.

For Ms Elson, it took years to identify the link between her hormones and her mental health. An eating disorder during her teens and 20s complicated the picture as her periods were irregular and the pattern was obscured. "It took over my whole life," she says. "I had around ten days a month when I could function more independently… the remainder of the month I struggled a lot with my mood and engaged in destructive behaviours, such as self-harm and putting my life at risk."

The first time she had the courage to suggest her symptoms were linked to hormones, it was dismissed by a psychiatrist. Eventually, it was her GP who recognised the link. Because she was already engaged with mental health services, Ms Elson had already tried several recommended interventions, such as lifestyle changes, talking therapies, SSRIs and oral contraceptives.

Following her diagnosis, she spent two years trialling different combinations of oestrogen and progesterone HRT, alongside taking GnRH agonists to induce a chemical menopause. Her symptoms only improved when she had a 'progesterone holiday', mimicking the hormonal effects of surgical intervention in the form of a hysterectomy with bilateral salpingo-oophorectomy. "Never in my adult life had I known you can have that level of calm, stability and functioning," she says.

This informed her decision aged 29 to undergo the surgery itself – an option offered as a last resort in extreme cases. She says it was both "the easiest and hardest decision of my life. It was between my fertility and my life, so it wasn't really a choice."

Before her surgery, she spent almost a year on a psychiatric ward. Now, she lives independently and works as a professional lead for lived experience practice in the NHS. However, she says it took over five years to get the balance of HRT right and she is keen to see greater awareness of the "car crash of hormones" that can accompany surgical menopause.

Although this surgery removes the biological source of the hormonal fluctuations that drive PMDD, it does not remove the body's *response* to the hormonal fluctuations that are often experienced while adjusting to surgical menopause and navigating HRT. Because of this, Ms Elson stresses that patients should still receive mental health support under these circumstances.

In her case, she was also coping with trauma and grief from years of illness, multiple overdoses, inpatient admissions, broken relationships, the loss of fertility and the time lost while undiagnosed for PMDD when she was psychiatrically medicated but focusing on the wrong core issue. Ongoing support, therefore, was crucial.

Symptoms being dismissed or minimised is another barrier to diagnosis. Expert by experience Dimple Khatiri, a clinical pharmacist and trainee advanced clinical practitioner, reports hearing many people with PMDD describe experiences of "medical gaslighting" in which "women don't feel listened to or taken seriously".

In her case, it took over 10 years to get a diagnosis. She had avoided telling her GP she felt suicidal every month and convinced herself that her symptoms were caused by a toxic relationship and childhood trauma, both of which are associated with PMDD.

It was only after experiencing an intense urge to crash her car on the motorway that she sought help. Even then, she did not disclose the severity of her symptoms. She was given antidepressants, which helped to some extent, but she remained undiagnosed. Four years ago, she began seeing a therapist who suggested that what she had dismissed as PMS might actually be PMDD.

Today, Ms Khatiri manages her PMDD with a combination of therapy, SSRIs, healthy eating, supplements and avoiding ultra-processed foods. Her SSRIs are taken throughout the month, but they can also be prescribed on a luteal-phase basis.

Receiving the diagnosis and the validation that her symptoms are part of a recognised disorder has been crucial, alongside a flexible, person-centred approach to treatment.

Finding the right intervention(s) can take time, as effectiveness often has to be assessed across menstrual cycles. There is a strong evidence base for CBT, although access on the NHS remains limited.

To support clinicians in recognising and managing PMDD, the College has developed two learning resources featuring all three contributors to this article. Emily Elson and Dr Sophie Behrman (with colleague Professor Arianna Di Florio) contributed to an eLearning module, while a CPD podcast features Dr Behrman in conversation with Dimple Khatiri.

Recognising PMDD can ultimately be lifesaving, given its association with suicidality. Paying attention to the interaction between menstrual and mental health can also reveal other hormonally influenced patterns of illness.

Ms Elson's message to psychiatrists is simple: "Asking about periods might unlock an important piece of information. You already ask difficult questions. Add one more in."

Learning resources:

The PMDD CPD podcast (30 mins) and eLearning module (60 mins) are both avaliable from **elearninghub.rcpsych.ac.uk**

Information and support:

- International Association for Premenstrual Disorders
- The PMDD project
- The Me v PMDD app

Gold dust

Award-winning carer contributor Dr Rekha Lodhia explains what it truly takes to put lived experience at the heart of research, practice, and care – and why the insight it brings should be valued like gold dust.

Dr Rekha Lodhia

When Dr Rekha Lodhia won the Carer Contributor of the Year award at the 2025 RCPsych Awards, it was more than a career milestone. "It was closure for everything we've been through with my dad," she says.

From the age of five, Rekha was a carer for her father, who lived with severe mental illness. She and her siblings navigated a family life shaped by crisis, confusion and a healthcare system that felt opaque and distant. "No other young carers should have to have had the journey that I've had," she says. Her work is a testament to this conviction.

Today, Rekha is an Honorary Lived Experience Researcher at Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). She also chairs their Lived Experience Action Research (LEAR) Group and holds a PhD from Loughborough University on promoting walking for health.

For her, approaching lived experience coproduction in a manner that she finds "constructive" means being able to contribute meaningfully without feeling compelled to bare everything. "Lots of my colleagues can really share their story quite widely. It's absolutely hats off to them. But I can't do that. There's just too much at stake for me."

Pressure to disclose, she explains, creates an unnecessary barrier to involvement in lived experience work. "I'm not a victim," she says firmly. "I'm somebody that comes with this amazing, unique expertise that I can provide in a constructive space." What unlocks that expertise, she argues, is reciprocity. "I can only do that if you show me your vulnerability."

"I know that I'm helping future generations, but I'm also helping myself"

Working as an expert-by-experience lead on a BSMHFT Quality Improvement (QI) project for example, gave Rekha the opportunity to engage in co-production on her own terms. The QI project, two years in the making, draws on the Patient and Carer Race Equality Framework (PCREF) to address culture-based health inequalities in mental health services at BSMHFT.

For Rekha, good co-production starts with diversity of perspective. "It's like our hands. Our fingers are all different shapes and sizes, and that's what makes our hands so perfect." The QI team, which included psychologists, consultant psychiatrists and early-career clinicians, reflected that principle. When colleagues opened up, Rekha found real understanding and action followed quickly. "It made me feel comfortable enough to share a lot of my lived experience from being a child carer."

She also values the QI framework's built-in feedback loops, something she identifies as a persistent gap in lived experience work more broadly. "Often in lived experience work, people are asked to share their experiences and insights, but don't get feedback. With the QI process, because I'm meeting you every fortnight, I do get that feedback."

The project has developed three interconnected outputs, which are now being scaled across the Trust. First, a centralised resources page, created after a survey revealed that clinicians were often unaware of local support available to patients, from voluntary groups to translation services. Second, a suite of cultural competency training modules offering a reflective space for clinicians to examine their own biases, alongside case studies and practical guidance.

The third is the 'About Me' tab on the Trust's patient record system. Functioning as a communication passport written from the patient's perspective, it captures what patients want their clinicians to know, such as their preferred name, primary language, family support structure, and communication needs. "It helps to open that dialogue up to actually know me as a person and not just a label," Rekha explains. She thinks back to her family's experience. "My mum couldn't speak a word of English. There were choices that were made that we didn't understand… There could have been so much more support and signposting."

Early results from the QI project are encouraging: community teams have been trained, the resources page is receiving strong traffic, and a live radio broadcast within the Trust generated a wave of listener questions. "We know it's not there completely, but it's a great start."

Rekha also chairs BSMHFT's LEAR Group, which serves as a critical friend to the Trust's Research and Development team. Comprising service users and carers, LEAR helps inform the entire research process, including funding applications. "Before you even conceive the research question, you come along and ask: what is it that actually needs to be researched?"

She is clear that this level of genuine involvement requires genuine investment: paid lived experience roles, supervision, and psychological support. "Without having that supervision and that psychological support in place, they would not be able to actually be a part of that process." Flexibility matters too. "If you make it too rigid, you're just going to lose people. You need to learn to adapt and be flexible with that co-production journey."

Rekha's involvement in lived experience co-production began with a simple act of kindness: an occupational therapist offering her a cup of tea and a biscuit during a difficult perinatal period. "That's where I started my journey – really humble beginnings." From that quiet moment grew her volunteer work on the wards, her walking groups for new mothers and, eventually, her role as patient voice for NHS England's national co-production Perinatal Mental Health Group.

Though the work is challenging, she is guided by *seva*, a philosophy of selfless service reflected across several traditions and religions, including Hinduism, which has influenced her outlook and enriched her personal life as well. "It helps me with my own recovery, my own self-healing, and my own closure processes," she shares. Her lived experience work has also introduced her to a new community of peers. "I'm completely humbled by this work… This is where I belong, because I know that I'm helping future generations, but I'm also helping myself."

Her appeal to clinicians is one of vulnerability and candour. "You cannot possibly learn everything… Each patient or carer that comes through that door is an individual. Ask them honestly: what would you like me to do? … and be honest. Tell them: 'Yes, we can do this, but no, we can't do that.' Be very clear."

At its heart, Rekha's message is about mutual recognition. Lived experience, she says, is not an add-on or a box to tick. "What I'm bringing to you is absolute gold dust. You can't teach these things. It's so rare and unique," she states. "So, if you come across some gold dust, I would grab it with both hands."

Liverpool's historic waterfront

Congress returns to Liverpool

RCPsych's International Congress returns to Liverpool this June, offering four days of discussion, research presentations and networking.

As summer approaches, the countdown begins to the College's International Congress. This year, it will take place from 15 – 18 June at the Convention Centre on Liverpool's Experience Campus, located on the city's historic waterfront.

The four-day annual event brings together psychiatrists, researchers and others working across mental health from all around the UK and internationally. It offers a chance to reconnect with colleagues while exploring new research, emerging clinical questions and developments in psychiatric practice.

This year's programme features 15 keynote speakers, including leading academics, clinicians and experts by experience. Sessions will cover a wide range of topics, from developments in clinical research and service design to questions around training and education in psychiatry. Many sessions will also be recorded, allowing participants to revisit presentations after the event (the price of accessing recordings will vary according to membership type and any tickets purchased).

Alongside the academic programme, Congress includes a range of informal activities designed to encourage conversation and connection. Delegates can take part in yoga and mindfulness sessions, guided walks and creative workshops, as well as lighter events such as chess, bingo and a psychiatry-themed board game. The popular University Challenge-style Mindmasters quiz will be returning, as will the Congress 5km run and the Congress party.

Delegates will also be able to explore the ePoster hub, where hundreds of posters presenting new research and service innovations will be displayed on interactive touchscreens.

Highlighted sessions

Why we need to take neurodevelopmental conditions seriously in psychiatry – a new science perspective

Bringing forward leading research in the space of neurodevelopmental conditions and mental and physical health, this session addresses an urgent need for psychiatrists to integrate neurodevelopmental science into everyday clinical reasoning. It offers a forward-looking, evidence-based vision of psychiatry that bridges silos, informs policy, and aligns with public demand, and will appeal broadly across all psychiatric specialties.

Sexting, gaming, self-harm and social media: the impact of young people's digital lives on mental health

This session will explore some of the evidence on how the digital world affects young people's mental health. Topics include the use of digital technology and its effect on the risk of self-harm and suicidal behaviour, women's perspectives on sexting and mental health, and the impact of gaming within the clinical context of an NHS gaming clinic.

The right to die debate: taking stock of assisted dying/suicide

As debate and legal reform concerning assisted dying/suicide (AD/AS) have evolved, important implications for psychiatry have emerged. This session will explore recent developments in law reform, including the College's engagement with proposals across Westminster, the Senedd, Holyrood and in the Crown Dependencies. It will cover clinical ethics and law, and discuss debates across the international scene about how AD/AS should be characterised in law and medicine – including whether it should be regarded as a treatment or as a decision to end one's life – and how it intersects with suicide prevention.

Sex hormones and mental health across the life course: insights for women and men

The impact of sex hormones on mental health is a rapidly developing area of clinical practice and research. Integrating clinical expertise, lived experience and emerging science, this panel will equip delegates to better support men's and women's mental health across the life course, providing a clinical update on hormonal psychiatry and increasing awareness of hormone-linked disorders.

Book your place

For more information, including the full programme and how to book, go to: **www.rcpsych.ac.uk/events/congress**