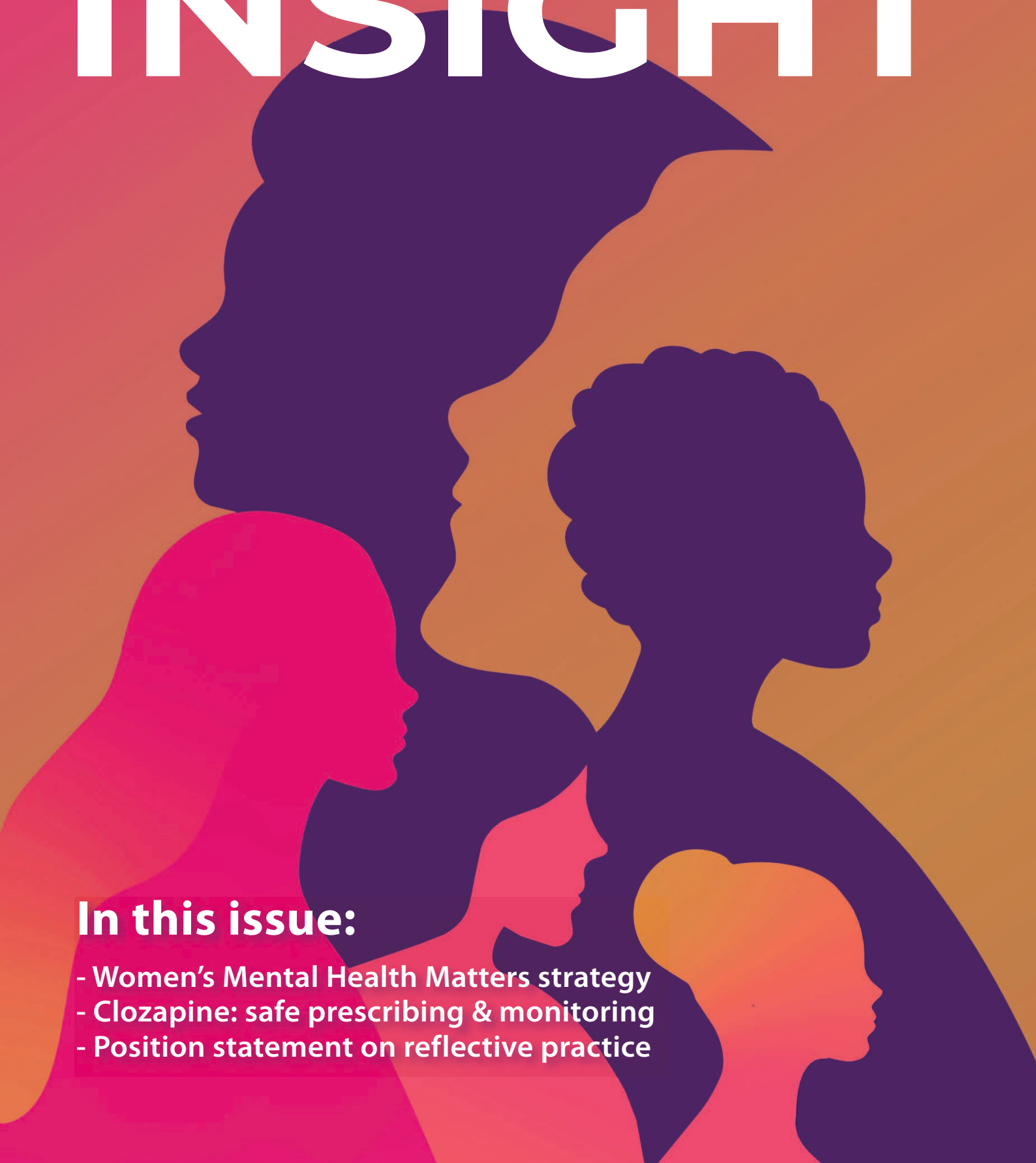
Issue **36** | Summer **2026**

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

RCPsych INSIGHT



In this issue:

- Women's Mental Health Matters strategy
- Clozapine: safe prescribing & monitoring
- Position statement on reflective practice

Contents

COLLEGE **NEWS IN BRIEF**

Highlighting service pressures

Over the past few months, the College's media work has focused on some of the main pressures facing mental health services and what they mean for patients and psychiatrists, from access to timely treatment to workforce capacity and the priority given to mental health in public policy.

In April, the College responded to interim findings from England's review of the prevalence of mental health and neurodevelopmental conditions, and to the UK Government's announcement that it had met its target to recruit 8,500 additional mental health workers. In May, it welcomed plans for a new cross-government mental health strategy for England. Its responses looked beyond headline commitments to whether services had the staff and support needed to provide timely, effective care.

Ahead of the Scottish Parliament election in May, RCPsych in Scotland called on political parties to set out credible plans for services facing sustained demand and workforce shortages. It highlighted priorities including reducing the premature mortality experienced by people with severe mental illness and putting mental healthcare on an equal footing with physical healthcare. The statement received widespread coverage across national and Scottish media.

In June, new figures showed that 3,580 referrals to child and adolescent mental health services in Scotland had not been accepted during the three months to March. RCPsych in Scotland called for clearer, better-connected pathways involving schools, social care, voluntary organisations and specialist services, so that children receive support suited to their needs rather than being left without help when they do not meet the threshold for CAMHS.

Also in June, then President Dr Lade Smith CBE gave evidence to the Nottingham Inquiry on matters including the care of people with severe mental illness, risk assessment, restrictive practice, information-sharing and the wider pressures facing services. The College published a statement and Dr Smith appeared on BBC Radio 4's *Today* programme to address concerns about psychiatric care and the responsibilities of the profession and the wider health system.

Later that month, a College survey found that one in three psychiatrists in Northern Ireland experienced work-related stress or burnout every week. Dr Julie Anderson, Chair of RCPsych in Northern Ireland, told Good Morning Britain that psychiatrists were being stretched thin and felt unable to provide the standard of care they wanted to deliver. The findings were widely reported across Northern Ireland and in UK-wide media.

Policy and possibility at the Senedd

In early July, RCPsych in Wales brought together two strands of its work at the Senedd: helping elected representatives engage with mental health policy and encouraging young people to consider careers in healthcare.

During Y Farchnad, the Senedd's regular event where organisations meet Members of the Senedd (MSs) directly, College representatives spoke with elected representatives from across the political parties about mental health and promoted the College's MS guide to mental health and mental illness.

Designed as a practical resource, the guide aims to help MSs and their staff respond to constituents raising mental health concerns, while supporting more informed engagement with policy and services.

They were joined by Year 11 students attending the College's annual Summer School, who met a Member of the Senedd, took part in a question-and-answer session and visited the Siambr, the Senedd's debating chamber, gaining an insight into how clinical expertise, public policy and political decision-making come together.

BJPsych International

College news on WhatsApp

RCPsych has an official WhatsApp channel, offering another way to keep up with College news and updates.

Scan the QR code to view the channel and choose whether to follow it. Channels you follow appear in the 'Updates' section of WhatsApp. Notifications are optional, so you can turn them on if you would like to be alerted to new posts.

Share your views

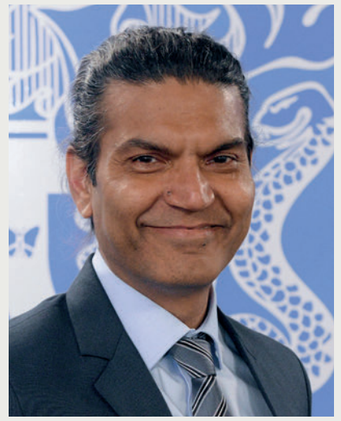
Readers, authors and reviewers are invited to share their views on *BJPsych International* through its 2026 feedback form. It will take around five to eight minutes to complete, and doing so will help shape the journal's future content and development. By default, all responses are anonymous, but there is an option to provide your contact details if you wish.

Complete the questionnaire at:
bit.ly/BJPsychInternationalFeedback

Editors: Gemma Mulreany and Frances Wotherspoon
Membership Engagement Advisors: Dr Lenny Cornwall and Dr Anand Ramakrishnan
Writers: Samara Linton, Colin Richardson, Rebecca Harrington and Gemma Mulreany

Design: Lee Braithwaite
Photography: Katka Photography
Front cover: Composite illustration by Gemma Mulreany, incorporating licensed artwork by Md. Khalid Hossen and Aya_Lines_Design via Shutterstock.com

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



President's message

Welcome to this issue of *Insight*. I've begun my term as President at a time when psychiatrists and services are under pressure and patients are waiting too long for care. My focus is on turning policy and evidence into practical change, so that the right treatment reaches the right person at the right time.

Our first feature examines Wim's Protocol, a practical guide to safer clozapine prescribing and monitoring. Drawing on clinical expertise and the experiences of bereaved families, it sets out core standards for physical health monitoring and helps patients and carers recognise warning signs and know when to act.

We also mark 25 years since the College launched its first quality network. The feature shows how CCQI's standards, peer review and shared learning help services understand how they are performing and where improvement is needed. Another article considers why teams need protected space for reflective practice: time to think together about difficult work and its effect on patient care.

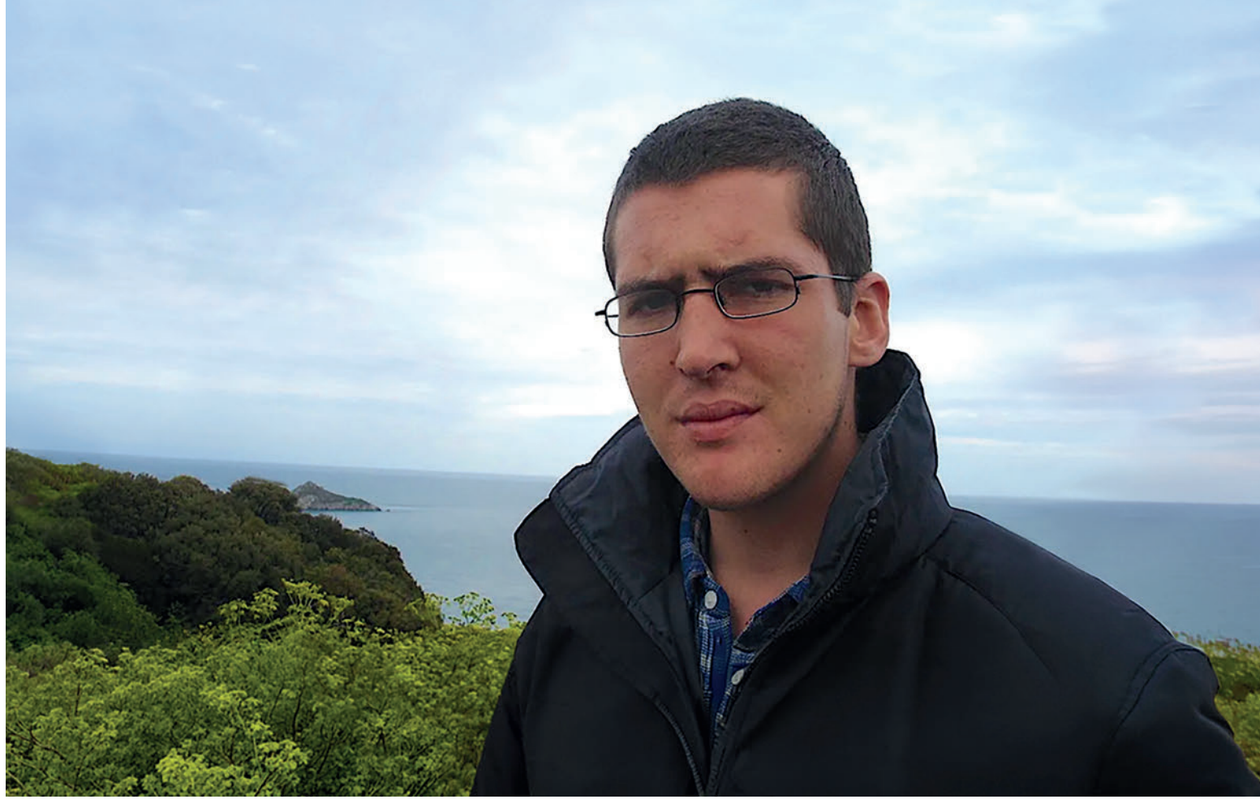
Elsewhere, we highlight the College's Women's Mental Health Matters strategy and its call for coordinated action across policy, services and practice.

This issue also marks a transition: I set out my priorities for the presidency while we also reflect on the term of my predecessor, Dr Lade Smith. Her sharp intellect and clinical instinct kept patients at the centre of policy. I will carry that commitment forward, with a clear focus on turning priorities into action.

Professor Subodh Dave

For Wim and his peers

Wim's Protocol sets new standards across the clozapine care pathway, helping clinicians prescribe and monitor a potentially life-changing treatment more safely, while giving patients and carers clearer information about when to seek help.



William "Wim" Northcott

In June 2021, William "Wim" Northcott died suddenly at the age of 39 at his care home in Devon.

His family had felt relieved when he moved into the home, hoping he was finally safe after years of cycling through homelessness, the criminal justice system and periods of being detained under the Mental Health Act.

After learning of her brother's death, Kate Northcott-Spall, a former health campaigner, requested his health records, where she saw the name of a drug she had never heard of before: clozapine.

She decided to investigate, and what she uncovered would lead to two years of collaboration with RCPsych and, ultimately, to the creation of Wim's Protocol: a new framework for monitoring clozapine safely across its entire treatment pathway. "It comes back to first do no harm," Northcott-Spall says.

In the UK, clozapine is the only antipsychotic licensed for treatment-resistant schizophrenia. "It can be life-changing for some people," says Dr Ed Beveridge, clinical lead for the protocol and former RCPsych Presidential Lead for Physical Health. It can help people return to education and employment, reconnect socially, and build and sustain relationships. "But equally, there are a lot of potential side effects."

First synthesised in 1958, clozapine was withdrawn from the market after being linked to agranulocytosis, a severe and potentially life-threatening fall in neutrophil count that leaves people vulnerable to infection. It was later reintroduced after a landmark trial demonstrated both its efficacy for treatment-resistant schizophrenia and that regular monitoring for agranulocytosis was feasible and could help manage this risk.

Wim had been taking clozapine for over a decade and was being monitored for agranulocytosis. However, he had developed myocarditis and associated toxicity that remained undetected due, in part, to gaps in wider clinical monitoring.

When Northcott-Spall began drawing public attention to what had happened to her brother, the reaction was mixed. Some felt she was misrepresenting the drug and feared this could lead to patients refusing a medication that many rely on. Others recognised the severity of the issue. Among them was Dr Lade Smith CBE, then RCPsych President.

Within the College, clozapine safety and monitoring were already under scrutiny amid concerns about avoidable harm and preventable deaths. An audit-based quality improvement programme on clozapine, run by RCPsych's Prescribing Observatory for Mental Health, had identified issues in prescribing and monitoring. The Psychopharmacology Committee had also started developing the College's position statement on the timely and appropriate use of clozapine, since published this January. Against that backdrop, Dr Smith reached out to Northcott-Spall and, from there, work on Wim's Protocol began.

The problem to address was not simply an absence of guidance. "There was already a lot of existing guidance around clozapine," says Dr Beveridge, "but every place has its own local processes and procedures. Despite the existence of those things, the deaths keep happening." The aim of developing the protocol, therefore, was to pull together the best available evidence for the whole clozapine treatment pathway in a form that anyone involved in a patient's care could use.

Dr Beveridge brought on board Dr Mao Fong Lim, former Presidential Scholar for Physical Health at RCPsych, who mapped the full timeline of a patient on clozapine and identified every type of professional or service they might encounter at each stage, from psychiatrists to community support workers. This led the protocol team to seek input from a wide range of organisations, including the British Heart Foundation, Mind and the Royal Colleges of Emergency Medicine, GPs, Paramedics and Physicians.

Bereaved relatives were also central to the process: alongside Northcott-Spall, Nichola Crawford, whose brother-in-law also died as a result of clozapine side effects, and two bereaved mothers who founded the Clozapine Support Group UK were involved throughout. "This has really made me appreciate what impactful, meaningful and quite courageous public engagement looks like," says Dr Lim. "It's a true public–professional collaboration," Dr Beveridge adds.

Wim's Protocol sets out core standards for monitoring from the point at which clozapine is first considered through to long-term treatment. Crucially, it introduces a preparation stage covering the patient's medical history, support network, practical resources and potential barriers to care.

It does not set out who should be considered for clozapine; that sits in existing guidance and policy, including NICE recommendations and RCPsych's position statement.

Across the clozapine care pathway, the protocol addresses gaps in care, from recognising early warning signs to sharing information between services and involving patients, carers and support networks more fully.

The first of these is the vigilance gap. Some of clozapine's most serious risks can present as ordinary physical symptoms that are easy to miss. Constipation, for instance, may reflect clozapine-induced gastrointestinal hypomotility and progress to bowel obstruction.

Using a traffic light system, the protocol details what can wait, what needs urgent advice, and what requires immediate help. The ten 'red flag' symptoms are constipation, fever, flu-like symptoms, chest pain, shortness of breath, leg or ankle swelling, dizziness or fainting, increased drowsiness, diarrhoea or vomiting, and new or increased seizures.

The protocol also prompts clinicians to ask routinely about substance use, including tobacco. Changes in tobacco smoking, including starting, stopping, reducing, increasing or switching from tobacco to vaping or nicotine replacement therapy, are clinically relevant because tobacco smoking can alter clozapine levels and may require dose review or plasma-level monitoring.

For patients and carers, the document offers clearer information and routes to raise concerns. For clinicians, it offers detailed guidance on how to respond, including escalation processes. It also recognises that safe clozapine care depends on information being shared reliably between patients, carers, prescribers, primary care and acute services.

Clozapine may not be visible on a GP's medication list or be recognised quickly by an acute medical team. The protocol tackles this communication gap by emphasising medicines reconciliation and clear liaison pathways. It also takes aim at the carer and support network gap. Patients and those involved in their day-to-day care may be the first to notice changes between appointments, so they need clear information about what to look out for and when to seek help.

Dr Beveridge says families affected by clozapine-related deaths have often described feeling excluded from conversations about safety and monitoring: "They always say, 'We didn't feel involved. If we'd known this, we would have been able to help.'"

The care Wim received reflects this. "When Wim was put on clozapine, my father was present and was never told that there were side effects that could be fatal," Northcott-Spall says. "It's about being open and transparent," agrees Dr Lim. "How can we say it's informed consent if we're not really having this conversation with people?"

The final gap is the confidence gap. Dr Lim notes that clozapine is "really underprescribed" partly due to clinician fears of adverse effects. However, he and the other authors are clear that the protocol is not a reason to avoid clozapine, but rather a reason to prescribe it with more confidence, so that those who are eligible can access its very real benefits.

Wim's Protocol was launched in June at the College's International Congress. "This is version one; it's meant to be iterative," says Dr Lim. Future versions may incorporate emerging evidence and be adapted for different patient groups and treatment indications. The next steps, he says, will involve implementation and evaluation.

"Everybody knew Wim. Everybody," Northcott-Spall says. "He just had this character, but his life was so small, and he was such a hidden treasure that it breaks my heart that he never got the chance." The protocol, she believes, would have saved his life. Now that it exists, there is some sense of comfort in knowing it may help protect others. "I feel like I can finally say goodbye to Wim," she says. "It's my way of saying I've done everything I can for you, Wim, and for your peers."

Read Wim's Protocol

Practical guidance supporting safe clozapine care:
www.rcpsych.ac.uk/wimsprotocol

RCPsych President, Professor Subodh Dave

Turning priorities into practice

New RCPsych President Professor Subodh Dave discusses prevention and early intervention, supporting and empowering psychiatrists, and the need for safer, more effective services.

For Professor Subodh Dave, the challenge of his presidency is not only to set priorities, but to turn them into practical change for psychiatrists, patients and services under pressure.

His primary objective is to champion psychiatry and ensure the profession has a strong voice with policymakers, funders and healthcare leaders at a time when mental health services, workforce development, research, education and training remain under-resourced. “This is about translating policy and evidence into action – focusing on how we make a difference to our patients and provide the right treatment for the right person at the right time,” he says.

Elected RCPsych’s 19th president in April, Professor Dave took up the role in June. In his inaugural Congress speech, he set out six priorities: clinical effectiveness; safer services; applying research in practice; early-life mental health; wider determinants such as work and housing; and supporting recovery through physical activity and healthier environments. Alongside them is a commitment to empower psychiatrists to influence the systems around them and support their professional wellbeing and fulfilment. Taken together, he describes these priorities as working in synergy to improve patient outcomes.

It is a theme that ran through his work as RCPsych Dean, a post he held for five years starting in 2021. Professor Dave describes his time in the role as being about “drawing a straight line between education and training, workforce numbers, skills and capabilities, and patient outcomes.”

He’s proud of what he achieved. During his tenure, he successfully lobbied for investment in growing the workforce, and the College secured substantial increases in core training posts and more SAS doctors coming through the Portfolio Pathway. He also addressed gaps in the College’s training offer by focusing on areas of particular clinical need. This included developing the first International Diploma in Old Age Psychiatry, as well as working on new credentials, namely the Eating Disorders Credential, which is currently underway, and the recently approved credentials in addictions psychiatry and in neurodevelopmental disorders.

A population-health-based approach was also written into the College’s education programme during his tenure and is now embedded in assessments, exams and training.

“This has been a major focus of the new curriculum, strengthening the emphasis on public mental health alongside psychiatry’s established biopsychosocial and person-centred approach. It means thinking not only about the patients we see, but also about people who do not reach, or cannot access, our services. Holding those perspectives together is a critical skill for every psychiatrist,” he says.

He sees helping to make this shift as one of his biggest contributions as Dean, and it is now woven into his presidential priorities through their focus on prevention.

“A particular aspect of leadership is to look beyond what is right in front of you,” he says. “You don’t just save the lives of people drowning. You go upstream and see why they are drowning in the first place and try to intervene well before things reach a crisis point. You need to give a voice to those people who don’t have access to our care and consider how to meet the demands of the wider population.”

As Dean, he helped launch the Public Mental Health Leadership Certification course to put this principle into practice. The course equips mental health professionals and policymakers to use local data, work across sectors and apply population-health thinking in their communities. Five cohorts – 150 people – have taken part, and he says their enthusiasm demonstrates an appetite to work more preventatively and move mental healthcare beyond “fire-fighting”, even amid intense service pressures.

Professor Dave has also long been a trustee of Doctors in Distress, a charity that works to protect doctors’ mental health and prevent suicide, and for which he has raised thousands of pounds. Supporting psychiatrists’ wellbeing and professional fulfilment is a core priority for his presidency, building on his work as Dean. “By empowering individual clinicians, I want them to feel they can make a difference even when the systems around them are faltering,” he says. This will involve challenging the fragmentation of the psychiatrist’s role and minimising the moral injury, stress and burnout that occur when systems fail. He feels there are lessons to be learnt from services that have found ways to solve systemic problems.

Psychiatry, he says, should be central to the future of healthcare services, shaping change rather than simply responding to it. “The skillset we have as psychiatrists means we are systemic thinkers – seeing the whole picture and the biopsychosocial context of the person.”

When asked what drives his ambition, Professor Dave credits his parents for encouraging him to look beyond the circumstances in which he grew up. Raised in underprivileged circumstances in Mumbai, he was the first person from his community to become a doctor. Pursuing psychiatry required further determination: with only a handful of training places available, he had to challenge rigid rules in the High Court before he could specialise in the field. He went on to complete his psychiatric training in Mumbai before moving to the UK in 1995.

He also credits mentors he has had at work for their thinking, support and time, and describes having been particularly fortunate to have worked with patients who have taught him so much. For the past 17 years, he has been running a successful training programme with more than 60 patient educators in psychiatric education at the Derbyshire Healthcare NHS Foundation Trust. The programme has shown him how powerful it is to involve patients in education as well as service design and delivery. It also led, in part, to the development of RCPsych’s national guidance on patient and carer involvement in training.

This belief in the value of a patient’s story is what motivated Professor Dave to reintroduce the long case into training. “There is a lot of focus on data aggregation in this world, and although that is important, individual stories matter too. The therapeutic relationship is important, whether you are giving your patient a paracetamol or an antipsychotic medication, and it is important to know how to connect with your patient in a professional way so that you can create a therapeutic alliance,” he says.

Professor Dave speaks warmly of his presidential predecessor, Dr Lade Smith CBE, and says he wants to build on her focus on patients. “Lade has such a sharp intellect, which is matched with a strong clinician’s instinct,” he says. “It is easy to get lost in the technical details of policy, but Lade has always kept patients at the heart of everything.”

Reflecting on his leadership style, he says he is generally a consensus builder, but he can also be direct. “The job is also to solve problems. You have to be forthright and vocal at times.” Although he sees the synergy between his presidential priorities, he says he considers clinical effectiveness and safer services to be the most critical. “Providing the best treatment at the right time and knowing how to keep patients safe: that’s the central role I signed up for as a psychiatrist.”

He also has a strong interest in patient safety. “Investing in good clinical practice and creating the environment and pathways needed for good clinical practice to happen each time, every time, is the route to safe practice,” he says. “And while we need full accountability for poor practice, a culture of fear does not create a culture of safety.”

Professor Dave is clear about what he wants to achieve during his term and knows, at times, it will be daunting, but he is also determined to retain the sense of purpose and enjoyment that drew him to psychiatry to begin with.

He is a keen runner, having completed more than 25 marathons around the world, including a hilly course in Cape Town just a few weeks ago. The first marathon of his presidency will be in Istanbul in November, taking him from Asia to Europe across the 15 July Martyrs Bridge.

During his election campaign, Professor Dave said running had taught him that “real progress is rarely a sprint”. His aim now is to bring that same long-term focus to turning his priorities into practice.

Helping services improve, together

As the College marks 25 years since the launch of its first quality network, we look at how CCQI quality network membership can help services use standards, peer review and benchmarking to learn from comparable services, identify what can change and make the case for better care.

When mental health services are under pressure, improving quality can seem hard to prioritise. But without time to examine recurring pressures, variation or ways of working, teams can spend scarce time and resources managing the same issues.

In mental healthcare, where quality depends on culture, relationships and local practice as well as policies and pathways, the College's quality networks offer a shared framework for looking at care. They help teams see whether challenges are local or shared, compare practice with similar services, learn from peers and identify what can change.

What started 25 years ago as a single network for inpatient CAMHS has become a wider system of standards, peer review, benchmarking and shared learning across psychiatry. Today, the College Centre for Quality Improvement (CCQI) runs 30 quality and accreditation networks, supporting over 1,500 services and more than 50,000 staff across the UK, with some extending to Ireland and internationally.

Where the model began

In the late 1990s, RCPsych was funded to run the National Inpatient Child and Adolescent Psychiatry Study, which examined inpatient CAMHS across England and Wales. This highlighted variation in care and limited opportunities for services to learn from one another. In response, RCPsych created QNIC, the Quality Network for Inpatient CAMHS, in 2001.

QNIC set standards for inpatient CAMHS, introduced structured self-review and peer review, and gave services a way to collaborate, compare practice and share innovation. The model soon spread across other specialties and settings. In 2007, the College established CCQI, bringing together its quality and accreditation networks, national audits and health service research.

The most recent network, the Wellbeing Initiatives and Services for Employees Quality Mark (WISE-QM), launched this year as the 30th in the series, showing how widely the approach is now being applied.

What membership means in practice

Services joining a network take part in a developmental review: they assess their own practice against standards for their specialty or setting, before being peer reviewed by multidisciplinary colleagues from comparable services. The findings are brought together in a local report for the member service, setting out what is working, where improvement is needed and what recommendations follow.

Some services use the review as a route towards accreditation. Others remain developmental members for longer, or indefinitely.

Membership ultimately requires investment, including fees, staff time and capacity that might be used elsewhere. But the process is designed to make that investment usable: giving teams a clearer basis for action, comparison and ongoing improvement, including changes that may help use time and resources more effectively.

Standards that keep evolving

Each network's standards are not static; they are reviewed and refreshed every two years and respond to changes in evidence, clinical practice, policy and patient and carer priorities. Standards are developed with input from clinicians and other staff working in that area, as well as patient and carer representatives.

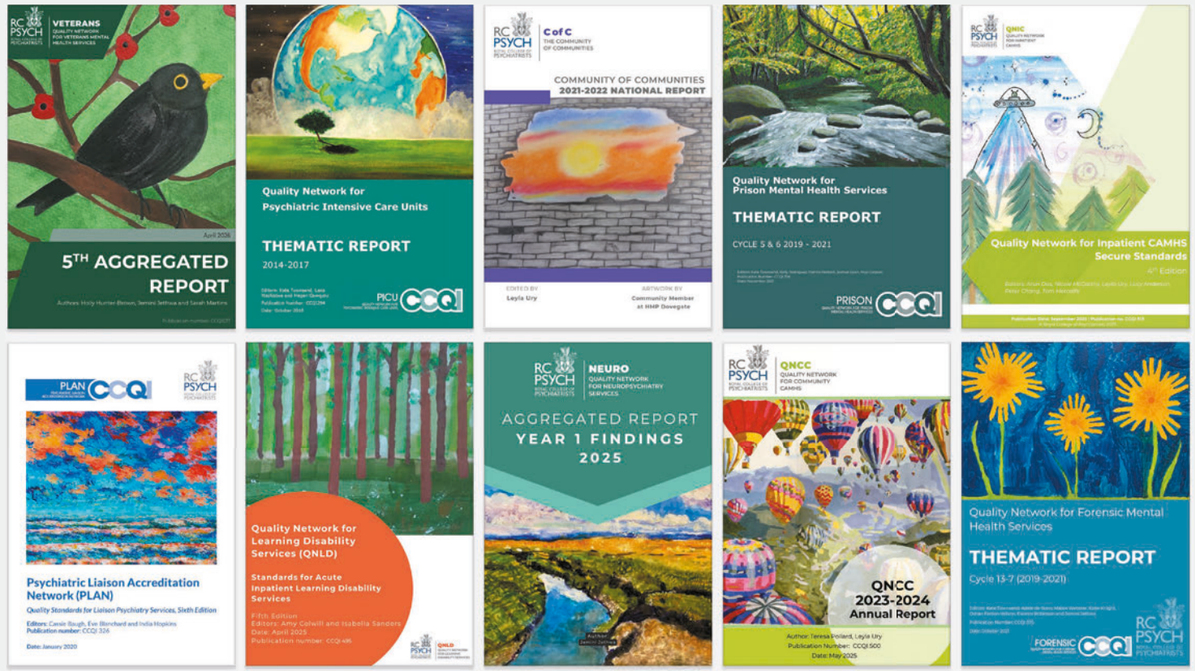
Dr Mary Docherty, Clinical and Strategic Director of CCQI, says standards must balance ambition and realism: "If they are too far removed from the pressures services face, they risk demoralising staff; if they are too cautious, they risk accepting variation that should be challenged." Over time, refreshed standards can raise the baseline, moving expectations into routine practice in areas such as equity, safety, physical healthcare, staff support and sustainability.

The power of peer review

Peer review does not replace statutory inspection; its value is different. Review teams bring together volunteer clinicians and other staff from comparable services, usually alongside a patient or carer representative and a member of CCQI staff, to look at care collectively, test assumptions and share practical learning.

Reviewers "get to see how different services operate and critically reflect on their own practices", says Dr Docherty, while host services gain "fresh, external perspectives, which often spark ideas for problem-solving and improving service delivery". Because the purpose is "genuinely learning from each other, and not regulation", she adds, the process fosters a "collaborative, non-judgmental, positive environment".

For Angela Sergeant, consultant nurse and founding member of QNIC, the network's lasting significance is cultural as much as structural. She describes reviewers returning from other CAMHS services "energised", with "a spirit of willingness to share good practice" emerging across the network.



A selection of CCQI network reports, with covers designed by people with lived experience

What improvement looks like

The most recent QNIC annual report captures practical learning from the network. Patient representative Emilola Johnson describes wards working to become more autism-informed by asking neurodivergent patients what could make a ward feel safer. She also notes streamlined admission processes and simpler, more accessible welcome packs.

People using services may not know whether a change followed a CCQI review or accreditation process, but they know whether information is clear, families are involved and they are treated with dignity. Patient and carer representatives help bring that test into the process.

A further example, from the Memory Services National Accreditation Programme (MSNAP), shows how review and feedback can identify gaps in access and service experience.

Rotherham Memory Service, part of Rotherham Doncaster and South Humber NHS Foundation Trust, says the programme helped the team benchmark its work, reflect on practice and make improvements. After an equity audit found people from the South Asian community were under-represented in referrals, the service introduced a link worker role and community-based screening clinics to strengthen links with local organisations and reduce barriers. It also developed dedicated patient and carer feedback surveys, strengthened consent documentation, updated patient information and improved recording and auditing processes.

Value beyond accreditation

Accreditation is not the only reason for organisations to join a CCQI network. Participating services are provided with benchmarking data, examples from comparable teams and evidence to support business cases and wider conversations about staffing, resources and service improvement.

For staff across the multidisciplinary team, membership can also support development through reviewer training, forums and special interest days.

In recent survey feedback, 97% of respondents said being part of a network had helped improve the quality of their service, while 96% said it had helped monitor or sustain quality. Feedback from last year also showed 98% of peer reviewers rated their experience of visiting another service as good or very good.

Quality network reports also show movement against standards over time. The Quality Network for Veterans Mental Health Services Aggregated Report (2023), for example, compared 10 anonymised services between developmental and accreditation reviews. After around two years, the average proportion of standards met rose from 85% to 98%. While not a measure of clinical outcomes, it shows closer alignment with the agreed framework.

Making the case for change

At its best, network membership can help teams separate what can change within existing constraints from what needs support, investment or decisions beyond the service.

In a pressured system, that distinction can be protective. It helps teams show how financial and operational decisions affect the conditions needed for safe, consistent care and where quality may be at risk of being eroded.

For members and service leaders, the value lies in evidence and comparison: providing either assurance about performance against the standards or a basis for improvement – whether that means changing practice locally or making the case for resources or support.

Get involved

Find out more about CCQI quality and accreditation networks, membership and how to become a peer reviewer: **www.rcpsych.ac.uk/CCQIgetinvolved**

Making space to think

A new College position statement calls for reflective practice to become a routine part of mental healthcare, giving teams protected space to think together about clinical work, team dynamics and patient care.

"**This** isn't to be confused with wellbeing," says Dr Simon Heyland, consultant psychiatrist in medical psychotherapy. "Reflective practice is about looking at your work and its impact on you. It asks what you can learn from that – about yourself, your patients, how your team is functioning, and how your organisation is functioning."

Dr Heyland is one of the lead authors of a new College position statement calling for reflective practice to be embedded as a core component of clinical practice in mental healthcare organisations.

Healthcare professionals are exposed to distress, trauma and risk as a matter of routine. Without dedicated spaces to process these experiences, the emotions that arise can linger and find their way into clinical decisions, team relationships, and the quality of care patients receive.

"There can be a prevailing view that being emotionally affected by clinical work is somehow unprofessional, but that's a misunderstanding," says Dr Jo O'Reilly, Chair of the College's Faculty of Medical Psychotherapy and a key contributor to the position statement. "As psychiatrists, we work primarily with distress, which can take many forms. Our own emotional responses may offer clues or information about this distress that, if reflected on carefully, may serve to deepen clinical understanding and formulation."

"For example, if you're in a clinical consultation with a patient who seems very calm and detached and you find yourself filled up with anxiety, you might be picking up on some of the patient's anxiety rather than your own." Reflective practice provides a "third space" in which to reprocess those complex emotions, "so that you have a better grasp of what might be going on clinically or organisationally, and you're less likely to act on the projected distress that might be located in you."

"It's a sign of healthy organisational functioning"

The Covid-19 pandemic may have highlighted the need for staff wellbeing support, but reflective practice differs from that considerably as its focus is clinical work and team dynamics. It requires a trained facilitator – someone outside the immediate clinical team – and protected time away from direct clinical tasks or interruptions.

There is no single format. Reflective practice may be organised around a team, a case, a recurring clinical dilemma or a particular area of risk. It might take the form of a monthly multidisciplinary risk panel, a Balint-style case-based discussion group, or a dedicated group for a ward-based team. What matters is the protected space in which teams can bring issues to light before they become clinical risks – from uncertainty around whether the team is aligned on boundaries with patients, to the varying emotional weight that different staff may be carrying, to whether unspoken tensions are affecting communication.

Reflective practice can also help teams move from reactive responses to a fuller, more considered view of a clinical situation. Dr O'Reilly recalls facilitating a session for senior consultants on an inpatient ward at the height of the pandemic, when staff were consumed by anxiety about the lack of PPE. Through examining their frustrations as a team, the sense of helplessness lifted. Someone remembered that the ECT suite was stocked with surgical scrubs, and a practical solution emerged from a group that had felt immobilised.

"Once they started to think about their helplessness as a feeling that may have some truth to it, but wasn't the whole situation, they started to come up with ideas," she says. "It can be a very creative process."

The evidence base for reflective practice remains limited by small sample sizes and reliance on self-reported outcome measures. Nonetheless, what does exist points towards reflective practice as helping staff process emotions, maintain compassion, support clinical learning, enhance safe care and teamwork, and reduce burnout.

Despite growing recognition of these benefits, provision across the NHS remains patchy. Access still relies heavily on geography and on whether an individual champion happens to exist within a given team. "Trained facilitators are still relatively scarce, so there is an issue of supply," says Dr Heyland. And equitable access to reflective practice remains "a very, very long way away".

In addition to these structural challenges, cultural barriers persist. For example, a common concern is that time away from direct clinical contact is a dereliction of duty. However, Dr O'Reilly argues: "It is part of our work as psychiatrists to think and to process difficult emotions, and we do that better if we have a regular space to do it in."

Misconceptions can also get in the way. If reflective practice is to become routine, teams need to be very clear about what it is, and what it is not.

"Some think it's therapy, which it isn't," says Dr O'Reilly. "Others fear they might feel exposed or criticised, but reflective practice is intended to be a safe, facilitated space for thinking about the work, not a forum for judgement."

It also differs from supervision, line management, and psychological debriefing. The latter, as the position statement notes, may actually be harmful for staff in the immediate aftermath of a traumatic incident.

Other misconceptions include equating reflective practice with talking to a friend or attending a wellbeing session. While these practices are valuable, they are distinct from reflective practice, which is work-based and a part of continuing professional development.

As Dr O'Reilly puts it: "There is no other space in your working week where you're invited to say to your team, 'I'm finding this really difficult', or 'I didn't understand this', or 'why are we doing that?' or 'we need to think together as a team about the complexities of this case'."

RCPsych's Strategic Plan for 2024–26 highlights reflective practice as a crucial part of providing high-quality care in over-stretched, under-resourced services. The position statement sits within this wider ambition, advocating for reflective practice as a core part of clinical practice and providing practical guidance on how to do so. It calls on organisations to appoint a lead professional and steering group for reflective practice, allocate protected time for it within job plans, and ensure access to trained facilitators. Some mental healthcare providers have structures that can be built upon: a supervision lead can become a supervision and reflective practice lead, with a multidisciplinary working group forming a hub that receives requests and oversees governance.

"It's a sign of healthy organisational functioning," Dr O'Reilly says, "to embed reflective practice in all clinical teams, and to make clear that it's an expected, valued and prioritised part of the work." This requires senior buy-in. "Just because you're senior and experienced doesn't mean you don't need spaces to reflect," she says. "If anything, people in senior roles may need those spaces, just as much, if not more, because they carry such levels of responsibility."

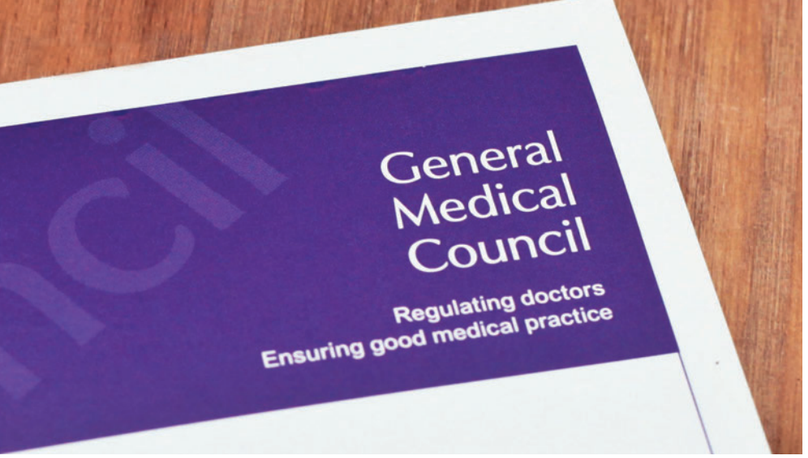
The ultimate ambition is for every clinical team in the NHS to have a reflective practice group of its own. "That would require a significant culture shift," Dr Heyland admits. "It's about staff's experience of providing care, and that cuts across mental and physical."

The Health Services Safety Investigations Body has already referenced the statement in a report on mental health community services, a signal of its potential reach beyond the College itself.

Ultimately, Dr Heyland believes the College is uniquely placed to drive change. "Psychiatrists have a really key role to play in promoting reflective practice within their organisations," he says. "They should dare to say to their organisations: 'We need this'."

Read the position statement

Reflective practice in mental healthcare is now available on the College website: **www.rcpsych.ac.uk/reflective-practice**



Implications of GMC reform

The College has recently responded to UK Government proposals to reform the GMC's legislative framework by calling for clearer safeguards around specialist training, protected titles and fitness to practise.

The legal framework behind the General Medical Council (GMC) can feel remote from day-to-day psychiatric practice. But when that framework is being rewritten, the detail has consequences: it can affect training, professional titles, regulation and the way doctors and patients experience the system.

The UK Government's draft General Medical Council Order 2026 proposes changes to the legal framework behind the GMC's work, as part of a wider attempt to modernise professional regulation and make regulatory processes more flexible, consistent and efficient.

Efficiency is not the only test of good regulation, however. In analysing the proposals, the College focused on whether the new framework would protect the standards, safeguards and clarity that doctors, patients and the public rely on.

In its comprehensive response, submitted in late June, the College supported reforms intended to improve clarity, fairness, equality, diversity and inclusion, and independent oversight, but called for stronger safeguards and further clarity where the draft order could have unintended consequences.

The response was developed after seeking views from faculties, divisions, officers and senior College leaders. It was also informed by concerns raised separately by some members at an earlier stage. Members were encouraged to contribute to the College's institutional submission and to respond separately as individuals, allowing them to share their own views and professional experiences directly.

Clear roles and titles

The College supported making 'registered medical practitioner' a protected title, reinforcing the distinction between medically qualified doctors and other professional groups. It also backed changing 'Physician Associate' to 'Physician Assistant' and 'Anaesthesia Associate' to 'Physician Assistant in Anaesthesia', with both titles protected in law.

Clear titles support transparency, accountability and patient confidence. In psychiatry, where care is often delivered by multidisciplinary teams, patients and colleagues need to understand each professional's qualifications, role and level of responsibility.

However, title changes alone are not enough. They must be accompanied by clear governance, supervision and scope-of-practice arrangements. The College has also recommended adding 'psychiatrist' to the list of protected titles.

Protecting specialist training

One of the College's most significant concerns relates to education and training. The draft order refers to postgraduate education and CCT eligibility, but, in RCPsych's view, the wording does not make it sufficiently clear that only medically qualified doctors should be eligible for CCT.

This is a technical point, but an important one. RCPsych is not suggesting that the UK Government intends to allow non-medical practitioners to enter the medical specialist register. Its concern is that ambiguous legislative wording could be interpreted differently in the future.

The College has therefore called for the draft order to make explicit that CCT eligibility depends on medical qualification and successful completion of postgraduate medical education and training. That clarity matters because specialist status reflects medical education, validated assessment, supervision, clinical responsibility and the standards expected of a medical specialty.

The College also emphasised that medical royal colleges must continue to have a clear role in setting and assessing standards, developing curricula and advising on specialty qualifications.

Right of appeal

The College also has significant concerns about the proposal for the GMC to retain its right of appeal to courts against specific interim registration measure and fitness-to-practise decisions made by a tribunal panel. Processes must protect the public, but they must also be fair, transparent and trusted by the profession.

RCPsych is concerned that allowing the GMC to appeal decisions made through the tribunal process could undermine confidence in the system's independence. The College maintains that the Professional Standards Authority should hold the right to appeal tribunal decisions, where necessary, to protect the public and uphold professional standards. The GMC, meanwhile, should focus on improving the quality, fairness and transparency of its own fitness-to-practise processes.

What happens next

The College is engaging with the UK Government to reiterate the key messages in its response. RCPsych President Professor Subodh Dave also met with the GMC in early July to raise the College's concerns directly, including on CCT eligibility, protected titles and fitness-to-practise appeals. RCPsych will continue to engage with the GMC and the UK Government as the reforms develop.

Professor Dave says: "These proposals matter for psychiatrists, patients and the future of specialist training. The final legislation must contain the right safeguards and clarity to ensure that the GMC is able to discharge its important function of protecting the public, without also creating a culture of fear in the profession."

On members' behalf

Dr Anand Ramakrishnan and Dr Lenny Cornwall reflect on membership engagement after completing five-year terms as Associate Registrars.

RCPsych members connect with the College in different ways at different points in their careers. Some of this is practical, through exams, training, CPD, guidance, events or support. Other College work is less immediately visible: the structures through which decisions are made, policy positions are formed, and standards and quality improvement work are developed.

So, membership engagement raises two connected questions: How clearly can members see – and shape – work being done on their behalf? And how easily can they find the support, information, opportunities and routes into College work that may be relevant to them?

These questions sat behind the remit of the Associate Registrar roles for Membership Engagement, which were shaped by RCPsych's first full membership survey in 2021 and the action plan that followed, much of which was about making the College easier to understand and easier to reach.

Dr Cornwall first became closely involved in College work as a resident doctor, before contributing through a range of College roles. He has previously served as chair of the General Adult Faculty and as a member of Council, and he was recently elected to Council again. For him, representation means bringing members' working lives into the places where decisions are made.

This matters because the College's public voice depends on the range of experience behind it. "Psychiatry is not one single view," he says. "If the College is going to speak as the voice of psychiatry, it has to draw on the experience of members working in different specialties, services, parts of the UK and stages of their careers. That depends on the College keeping visible routes for those experiences to feed in."

Those routes include formal representative structures, such as elections, Council, devolved Councils, divisions, faculties, committees and Special Interest Groups, as well as consultations, events, newsletters and mentoring. Some connect members with College decision-making. Others help them raise concerns, support colleagues or find relevant opportunities.

Question Time with the Officers is one example of a more visible route. Launched in 2023, it gives members a regular way to submit questions or ideas to the College and hear Officers respond. While this does not replace representation through elected and appointed structures, it does give members another clear point of contact with the centre of the College.

Dr Ramakrishnan brought longstanding College experience to the engagement role, having held faculty, Council, divisional chair and trustee roles. Having moved to the UK 30 years ago with senior medical experience in India, he says learning to navigate a different professional system helped him understand how decisions were made, where support could be found and what members might need to know about work being done on their behalf.

He describes the Associate Registrar work as a liaison role between members and the centre of the College. "It is not just about sending information out," he says. "There is a responsibility to members, to understand their issues and difficulties, and a responsibility to the College, to feed back what members are saying and what could be done about it."

That responsibility sits with the College. It means explaining more clearly how the organisation works, listening to what members raise, and making sure their voices can reach the parts of the College where decisions are made.

The 2021 action plan gave that work an early shape. It included efforts to explain areas of the College that can otherwise feel remote, such as the Board of Trustees, and to highlight work members may not always see directly, including Quality Improvement Collaboratives. More broadly, it focused on making College activity easier to understand and take part in.

A member feedback exercise conducted in 2024 suggests the same questions remain live. The recommendations that followed included actions for the College to make governance and decision-making clearer, improve communication about College roles, strengthen ways for members to raise concerns, and make clearer who represents members on Council.

RCPsych has since created a Head of Engagement role, giving this work a more explicit home within its staff team. The post reflects a recognition that members need clear routes into the College's work, and that listening, explaining and feeding back require sustained attention as part of its ongoing remit.

Dr Ramakrishnan and Dr Cornwall's terms as Associate Registrars have ended, but the work continues: helping members understand what the College is doing on their behalf, where they can find support or opportunities, and how their experience can inform the work of the organisation that represents them.

Share your views

If you have any comments or suggestions about membership engagement, contact the College's Head of Engagement: **Catriona.Grant@rcpsych.ac.uk.**

Foundations for change

RCPsych's new *Women's Mental Health Matters* strategy calls for coordinated action across policy, clinical practice, service design, research and workforce development.

Women's mental health needs are not consistently being recognised or met, contributing to inequalities in access, experience and outcomes. Women are disproportionately affected by common mental health disorders, but services often fail to take into account the biological, social, environmental and structural risk factors that contribute to their development or exacerbation.

Distinct patterns of ill health among women can emerge across the life course. For some women and some psychiatric conditions, vulnerability may increase during reproductive and hormonal transitions including puberty, pregnancy, the postpartum period and menopause. It is therefore essential that women's mental health is always considered alongside physical health. Yet this has not been consistently reflected in policy or practice, with systems often shaped around male norms and fragmented models of care that fail to account for the complexity of women's lives.

Not all women are affected equally. Those facing the greatest burden of intersecting disadvantages, including severe mental illness (SMI), poverty, disability, racial inequality and gender-based violence (GBV) – may experience poorer outcomes and greater barriers to healthcare.

RCPsych's new *Women's Mental Health Matters* strategy, produced as part of Dr Lade Smith's priorities during her 2023–26 term as RCPsych president, was led by her Joint Presidential Leads for Women and Mental Health – Dr Catherine Durkin and Dr Philippa Greenfield. It focuses on prevention and early intervention to reduce the disease burden in women who are most at risk. Doing so can help improve outcomes for all women.

The strategy was grounded in coproduction and an aim to share power. "We both had a real sense that this is about justice and health inequalities," says Dr Durkin.

Three years in the making, the document presents a clear evidence base, including case studies and profiles of best practice. "We didn't want women's experiences to be minimised, reduced or dismissed," says Dr Greenfield. "Those experiences needed to be conveyed through clear language. That is why we opted for the accessible style we did: the strategy needs to be open to everyone."

Its holistic, person-centred approach rests on three principles: a trauma-informed approach, a life-course perspective, and an intersectional understanding of need. It also identifies three interlinked pillars that affect outcomes for women: sexual, reproductive and hormone health; GBV; and structural inequity in the health service.

Trauma is central to the strategy, which highlights the disproportionate impact of GBV on women and notes that domestic and sexual violence are particularly common among women in contact with mental health services.

"Services must understand the full neuro-biopsychosocial impact that trauma can have on a person," says Dr Greenfield. "The evidence shows us that cumulative experiences of trauma and adversity across the life course are strongly associated with poor mental health outcomes. GBV must be understood as a significant risk factor and must be addressed as a serious public health issue. GBV cannot be viewed as just a social issue; it is inextricably linked to physical and mental health."

The strategy emphasises the need for psychiatrists to give equal weight to a woman's physical and mental health, while recognising points in their lives where they may be particularly vulnerable to mental illness.

"We need to talk about physical health issues, such as endometriosis and stress incontinence as a result of birth trauma, which absolutely have an impact on mental health, recovery and overall wellbeing," says Dr Durkin. "But it's not just down to psychiatrists. We need to see action across the board, including from governments, local systems, NHS services, and other key stakeholders, for example, the UK National Screening Committee. We need to create a system that identifies women who are likely to need more care and ensures that their health needs are met."

Both Dr Durkin and Dr Greenfield hope any clinician who reads the document will be able to implement change to their practice immediately. The strategy includes a list of questions that clinicians can ask sensitively, and in accordance with trauma-informed principles, as part of biopsychosocial assessment and routine review.

"Asking about periods, for example, can tell you a huge amount," says Dr Durkin. "A woman may be postpartum, have recently had a miscarriage or be perimenopausal. Changes in mood across the course of the month may also indicate premenstrual exacerbations of mental health conditions."

Compassionate routine enquiry about domestic abuse and GBV is also important. "Asking 'Do you feel safe at home?' or 'Is there anyone in your life that you are scared of?' can shape a conversation that could make a real difference. Small changes in practice can have a huge impact on outcomes," says Dr Durkin.

The strategy also calls for widespread structural change with recommendations for clinicians, governments across the UK, NHS leaders, regulators and research funders. Its five broad recommendations cover national action on women's mental health; recognition and response to GBV as a major public health issue, including its links to suicide and sexual safety in services; safe, trauma-informed and therapeutic care; better physical health outcomes for women with SMI and/or trauma histories; and a workforce equipped to provide women-centred care.

Suicide prevention is a notable area that could be transformed by a gender-informed approach. "Evidence tells us about the risk factors and risk points for women, but we don't design services with this in mind," says Dr Greenfield. "Suicide remains the leading cause of maternal death in the first year after childbirth. Women aged between 45 and 54 are at the highest risk of suicide, and this age range overlaps with the demographic most likely to be experiencing menopause. And women who have experienced domestic abuse are at particular risk. Workforce training, policy and strategy built on this knowledge are essential to effect change."

The problem is not simply an absence of data or research into women's health needs. Mental health datasets have not been routinely disaggregated to take into account sex, gender and other intersectional determinants of inequality. Women have also historically been underrepresented in some areas of research and diagnostic frameworks, while women of childbearing age have sometimes been excluded from clinical trials.

Between 2015 and 2021, 3,908 women in the UK died by suicide while in contact with mental health services. Among those for whom data were available, 26% were known to have experienced domestic violence, alongside high rates of self-harm. The strategy argues that failures to recognise and respond to these risks represent missed opportunities for intervention. "We are strongly calling for a national suicide prevention strategy for women to really make progress," says Dr Greenfield.

To accompany the strategy, a five-part women's mental health podcast series has been launched. The first episode discusses the strategy itself, and future episodes will cover women in the workplace, preconception care and the physical/mental health overlap, GBV and suicide, and creating safe and therapeutic services.

The strategy is intended to lay the foundations for change rather than mark the end of the work. Dr Greenfield and Dr Durkin are contributing to the expert reference group for a multi-professional core capabilities framework for women's health being developed by NHS England. They will also meet with the Domestic Abuse Commissioner and continue to work with the National Association of Psychiatric Intensive Care Units to develop a position statement on safe and therapeutic services for women.

"We want to empower people to use the strategy as a mandate for improving and evolving care," says Dr Durkin. "Its strength lies in its foundation in collaboration with people with lived experience."

Find out more

Visit RCPsych's women's mental health resource hub to access the strategy, menopause position statement, podcast series and other information:

www.rcpsych.ac.uk/womensmentalhealth

Reading beyond the abstract

Why a clear understanding of research and statistical methods is so important for psychiatrists, from interpreting published evidence to designing studies that can reliably answer the questions they ask.

When reading a research paper, many people move quickly from the abstract to the reported findings. Dr Sajid Suleman, a consultant psychiatrist and Chair of the MRCPsych Critical Review Examination Writing Panel, takes a different approach. Having taught critical review and research methods to psychiatrists for many years, he advises looking at the methods carefully before going on to the conclusions.

"The abstract is marketing; the methods are the product," he says. The methods section shows what the results are built on: who was included, who was left out, how outcomes were measured, what happened to missing data and whether the design could answer the question being asked.

Dr Dawn Holmes, a data scientist based at the University of California, looks at these questions as a statistical reviewer. She has reviewed submissions to two of the College journals, *BJPsych* and *BJPsych Open*, for more than two decades and sits on the editorial boards of both.

Her work is not simply to check calculations after the analysis is complete. In applied statistics, by definition, context is everything. A statistical reviewer needs to understand enough about the aims of the paper to judge whether the research question, sample, methodology, analysis and conclusions hold together.

The issues she identifies in submitted manuscripts often relate to whether the paper is coherent. A study may say it is about one age group, then include participants outside that range. A paper may begin with one number of participants, then give a different number later without explanation. Figures in tables may not add up. Percentages may be wrong. A sample may be described as random when the recruitment method does not support that claim.

Inclusion and exclusion criteria can often be overlooked or poorly handled. Yet they define the population being studied and, therefore, the population the results can be applied to.

"It's a matter of consistency," Dr Holmes says. "You'd be surprised how often it's not there."

Missing data are also common and can be very easy to underestimate. Maybe a questionnaire was not completed, a record was incomplete, a patient was lost to follow-up. But Dr Holmes warns that authors cannot necessarily "just decide to exclude participants because some of the data are missing". If participants with incomplete data are simply removed from the analysis, the remaining sample may no longer represent the group the researchers set out to study.

There are techniques for handling missing data, including imputation, but the first step is to determine why the data are missing in the first place. If participants drop out because they feel worse, feel better, experience side-effects or stop attending follow-up, those gaps are not necessarily neutral and may affect what can be concluded from the results.

Attrition, small sample sizes and patients not wanting or being able to take part are all familiar challenges in psychiatric research, Dr Suleman says, and each can affect what a study is able to show. In psychiatry, where severity of illness, social circumstances and engagement with services may all influence participation, missing data can affect how the results should be interpreted.

This is one reason he argues that research knowledge matters to every psychiatrist, not only to academics or journal reviewers. Psychiatrists are expected to practise evidence-based medicine, interpret guidelines and apply research to the management of patients. "Research is not just for researchers," he says.

Judging how far research results can be applied to clinical practice can be particularly challenging in psychiatry. The same diagnosis can present differently in different people, and studies often rely on rating scales, questionnaires and clinical assessments, so the size and clinical meaning of a measured change need careful interpretation.

A statistically significant result is not always clinically meaningful. A small change on a rating scale may be real in statistical terms, but not large enough to make a noticeable difference to patients or to alter clinical care. A relative change in risk may sound striking, but mean little without knowing the absolute risk and how many people are actually affected. And a result may be valid for the people studied but difficult to apply to another patient group, service or setting.

Dr Suleman also points to a common interpretation error: assuming association proves causation. A study may show that two factors are linked without showing that one caused the other. That distinction is fundamental, never more so than in research where outcomes may be shaped by multiple overlapping factors.

When reading a paper published in a reputable journal, you have a level of assurance about the scrutiny it has received. The paper will have been through layers of editorial assessment and peer review which are important quality control processes that many submissions do not make it past. Publication therefore carries weight.

Nonetheless, Dr Suleman emphasises that the reader's role is not passive. A paper may be well conducted and worth publishing while still answering a specific and limited research question. The methods help clarify what that question was, what the study design allows the authors to show, and the extent to which the results can be applied to clinical practice.

Journal clubs offer a setting in which clinicians can practise critically reviewing published research together. They provide a forum for testing whether the methods support the claims being made, considering how uncertainty has been handled and challenging assumptions in the interpretation of results. Over time, this shared discussion and scrutiny can help build confidence in interpreting research and strengthen the analytical skills needed to apply evidence critically.

Many of the same areas Dr Suleman encourages readers to consider are just as important when designing research. The research question, study design, inclusion and exclusion criteria, potential sources of bias, possible confounders and approach to missing data all need attention before the study is under way.

Dr Holmes says authors can sometimes "gallop on" to the parts they find most interesting or, because they are time-pressured, fail to give enough attention at the design stage to how the sample will be obtained, whether bias may be introduced or whether the methods are coherent.

By the time the data are collected, the sample, measures, and inclusion and exclusion criteria have already shaped the study population. Statistical review can still help authors clarify their analysis, explain missing data and interpret uncertainty more carefully. But some problems belong to the design itself.

Dr Suleman draws a distinction between confounding, which can sometimes be addressed statistically, and bias introduced through design, sampling or measurement. "You can control for confounders, but not bias," he says.

Selection bias is one example. A study may collect data rigorously and apply sophisticated statistical techniques, but if the recruitment process has already distorted the sample, that distortion remains. Measurement bias can have the same effect. If the wrong scale or assessment is used, the resulting data may not answer the question the authors hoped to ask.

Input from statistical expertise is therefore often most valuable before data collection begins. Different study designs, including case–control studies, cohort studies, randomised controlled trials and retrospective analyses, each have their own strengths, limitations and potential sources of bias. If the design does not match the research question, even rigorous analysis may not be able to produce a reliable answer.

For readers, examining the methods closely helps determine how far the results can be applied. For authors, the same level of discipline needs to be built in from the design stage.

New MRCPsych Critical Review book

Dr Suleman's new book, *Critical Review for the MRCPsych,* is relevant not only to psychiatrists preparing for the Critical Review exam, but also to those wanting to refresh their understanding of research methods, statistics and critical appraisal.

The book is available to purchase in both a digital format and in paperback. To find out more or order a copy, go to: **bit.ly/MRCPsychCriticalReview**

Calling for statistical reviewers

The College's *BJPsych* journals are looking for more statistical reviewers. Statisticians and researchers with health or mental health research experience may be well placed. Members with relevant expertise, or who know someone who might be interested, can find out more at: **bit.ly/StatsReviewers** or contact **publishing@rcpsych.ac.uk**.

From evidence to influence

During her three years as President of the Royal College of Psychiatrists, Dr Lade Smith CBE sought to influence policy and change how decision-makers understood mental illness, treatment and investment in psychiatric care.

Dr Lade Smith CBE began her presidency in 2023 determined to raise the profile of psychiatry, tackle mental health inequality and, in her words, "speak truth to power". Once in post, she became convinced that progress would depend in part on persuading politicians, officials and financial institutions that mental illness is treatable, effective care improves lives, and underinvestment has consequences for families, public services, the wider economy and society as a whole.

Six priorities guided her term: closing the treatment gap, supporting psychiatrists, advancing fairness, championing research, strengthening international psychiatry and improving members' experience of the College.

She built her presidency around collaboration. Although she says she is not a natural delegator, early in her term she expanded the College's presidential leadership structure, appointing eight presidential leads across six areas of focus, with each lead dedicated to a particular area. Three of those areas, physical health, compassionate and relational care, and women's mental health, were introduced by Lade to give them greater prominence in the College's work.

Together, she says, the group functioned like a cabinet, guided by principles she established at the outset. "Our business is mental healthcare and we took an evidence-based approach," says Lade. "Evidence drove our values and, because it demonstrates that people who are marginalised, discriminated against or poorer have worse mental health outcomes, that was what we prioritised."

That commitment translated into substantial work spanning equity, disability inclusion and workforce retention, including the Fairness for All Strategy, which set out the College's commitments to improving equity for patients and carers, psychiatrists and College staff; the Delivery for Disability work, which produced guidance for mental health employers on making reasonable adjustments and creating more inclusive workplaces for staff with disabilities; and the Retention Charter, which sets out how employers can better support and retain psychiatrists and has attracted interest from other medical royal colleges.

Other significant outputs included Wim's Protocol, developed with bereaved family members and clinicians to strengthen clozapine prescribing and physical health monitoring, as well as a position statement on menopause and the College's *Women's Mental Health Matters* strategy, both addressing gaps in recognition and care.

By the time Lade demitted office, work was also well advanced on a College report proposing a life-course approach to tackling the physical health inequalities experienced by people with mental illness, including the premature mortality associated with severe mental illness. A forthcoming position statement on non-recent child sexual abuse had also been completed, ready for imminent publication. Co-produced with survivors, it sets out recommendations to improve recognition of the impact of abuse, strengthen trauma-informed care and support, and reduce the risk of survivors being re-traumatised by mental health services.

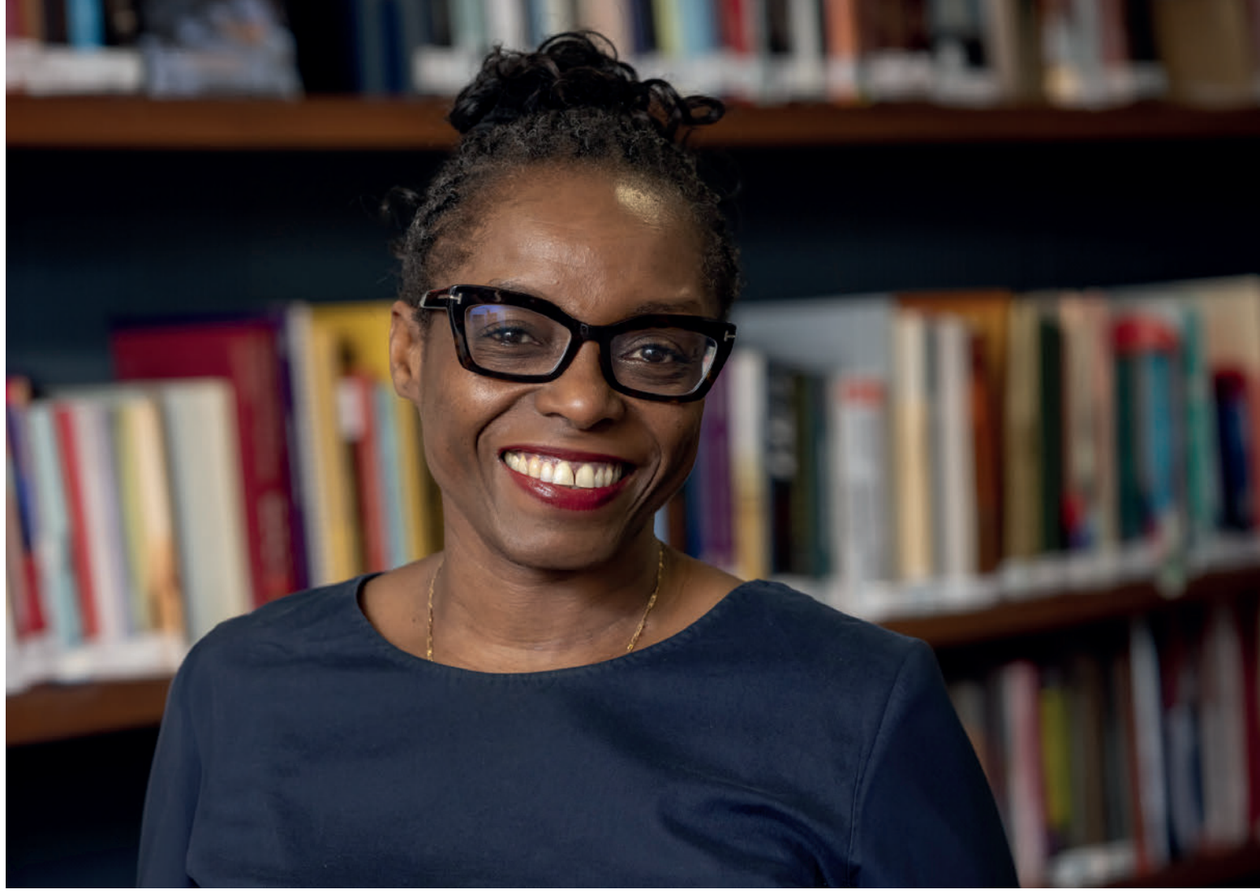
Alongside the UK-wide College initiatives, Lade is keen to acknowledge the nation-specific work by RCPsych in Scotland, RCPsych in Wales and RCPsych in Northern Ireland, with priorities shaped by members working within each nation's distinct health and political systems. Among many examples, RCPsych in Scotland saw priorities from its Scottish Parliament election manifesto reflected across the major parties' platforms, while RCPsych in Wales worked to shape debate ahead of the Senedd election and build relationships with newly elected members.

RCPsych in Northern Ireland's years of campaigning helped secure a formal government commitment to establish a dedicated mother and baby unit in Belfast. Lade describes the commitment as an emotional high point. Once operational, the unit should mean that women requiring specialist inpatient care after childbirth no longer face separation from their babies or transfer elsewhere in the UK.

From very early in her presidency, Lade was struck by how persistent misconceptions about mental illness remained, including among people with influence over health policy and funding. She encountered assumptions that psychiatric services were concerned more with containing patients than treating them, and that little could be done to help people with mental illness. She came to see these attitudes not only as stigma but as a barrier to investment.

"We are not going to get more investment when people think there is nothing that can be done about mental illness and that we are containing patients rather than treating them," she says. "People need to understand that we can effectively treat over 80% of mental illness."

Education consequently became an important part of how she approached the presidency. "My job in every single meeting was to be educating," she says. In meetings with politicians, officials and other decision-makers, she challenged assumptions about treatment and drew attention to the gap between the burden of mental illness and the resources devoted to care.



Dr Lade Smith CBE

At a World Psychiatric Association (WPA) meeting, Lade describes having a light-bulb moment: she realised that global financial institutions and investors had largely been overlooked in efforts to increase investment in mental healthcare. Their influence over lending and investment priorities offered another way to encourage governments to give mental health greater priority.

That thinking fed into the Prague Agreement, which is one of Lade's most significant presidential achievements. Developed by RCPsych in collaboration with the WPA, which represents 147 psychiatric societies in 123 countries, the Agreement calls on global financial institutions and investors to recognise the relationship between mental health, productivity and economic development and to use their influence to encourage national investment in mental healthcare.

The Agreement was launched with international partners at the World Congress of Psychiatry in Prague in October 2025 and has been endorsed by more than 50 national psychiatric associations and organisations from around the world. Lade also promoted it at the United Nations General Assembly, reflecting her belief that the case for mental health investment must be taken to institutions with the power to influence national economic priorities.

Another highlight Lade recalls is the inaugural Women's Mental Health in Bloom 'webathon', a 24-hour international event held in March, spanning 21 time zones and featuring speakers from 90 countries. The idea came to her at a meeting of the International Association for Women's Mental Health in Bangalore. She hopes it will recur, but if it does not, she jokes, "it will be like psychiatry's Woodstock".

The final months of her presidential term had a more sobering tone. At a time when she expected to be preparing for a handover, she was instead giving evidence to the Nottingham Inquiry. The experience, she says, drew together much of her clinical, research and policy work.

"It felt like everything in my life and career had been working towards that," she says. "It was full on, but it was really useful to be able to give an overview of the state of psychiatric services that was true and honest. It was a fitting end to my presidency."

Having continued to practise throughout her term as a consultant forensic psychiatrist at South London and Maudsley NHS Foundation Trust, Lade is now adjusting to this being her "only" role.

She says she misses the "cut and thrust" of the presidency and the team around her. But, after taking a well-earned holiday, she may soon be back educating at high-level meetings, this time on the international stage, as she has been nominated to stand for president-elect of the WPA.

RCPsych has grown by more than 2,000 members since her term began, while the College has remained active in policy debates across the UK and internationally. Lade urges members to get involved in its work. "It means you can really make a difference in a tangible way to what happens on the ground," she says.

Her parting message is not that the College's influence is secure, but that it must continually be earned: "We not only have a seat at the table, but we are now starting to shape decisions at the highest level. That influence had to be fought for, and the work does not stop now."

Embracing neurodiversity

Neurodivergent medical students can face considerable challenges during their training and beyond. The College is working with students, educators and medical schools to develop solutions.

"I have benefited from reasonable adjustments, including extra time in examinations and support through my university's disability services. These adjustments have been valuable, but what has helped most is an environment where neurodiversity is understood rather than simply accommodated."

Medical student Sulaiman Ghiyas shared this reflection at the College's online conference, *Embracing Neurodiversity: Supporting Neurodivergent Medical Students*, in April, as part of his presentation, 'From accommodation to empowerment: rethinking support for neurodivergent students'.

The full-day event brought together representatives of the College, the General Medical Council and medical schools, as well as medical students. Its programme explored student experience and inclusion, learning and clinical environments, and support during postgraduate training and in the workplace.

As part of his presentation, Sulaiman highlighted practical steps that can be taken to improve students' experiences: "Medical schools can make a significant difference through relatively simple measures such as clear communication of expectations, accessible learning materials, recorded teaching sessions, flexibility where possible and increased awareness among staff and clinical educators. Many changes that benefit neurodivergent students ultimately improve learning for all students."

The conference grew out of discussions across the College involving the former Dean and now President, Professor Subodh Dave; Dr Jessica Eccles, Chair of the Neurodevelopmental Psychiatry Special Interest Group; and Dr Sherlie Arulanandam, the College's Associate Dean for Undergraduate Education.

"There is great interest in providing suitable support for neurodivergent medical students," says Dr Arulanandam, who chaired the conference. "It was encouraging to hear the experiences of students and the wide range of activities that can be undertaken, some relatively easily, to better support them."

More broadly, the College's links with medical schools are supported by the College Undergraduate Education Forum, chaired by Dr Arulanandam. The Forum brings together undergraduate psychiatry teaching leads from medical schools across the UK, supports communication and strategic planning between the College and medical schools, and contributes to national policy in undergraduate medical education.

Initiatives already under way elsewhere in the UK are also beginning to show what support for neurodivergent medical students can look like in practice.

At the University of Bristol, Dr David Rogers and his colleagues have trialled several innovative strategies that are already proving successful.

Dr Rogers is a GP and co-director of the university's clinical medical programme, with a particular focus on the impact of neurodiversity in medical education. His team has been working with lecturers to deepen their understanding of neurodiversity and has devised a template to help students and facilitators communicate during clinical placements – one of the most chaotic and challenging settings for neurodivergent students.

A different approach to admissions is also being tested, which could help make the process more inclusive. "If we look at the admissions process for medical school," says Dr Rogers, "this involves a UCAT exam – essentially, a speed-dependent IQ test – and online mini-interviews. These are very much neurotypical forms of communication."

By comparison, the workplace-based assessment gives candidates longer to demonstrate how they work and interact. "Since last year, we've been piloting a workplace-based assessment process, where candidates spend 24 to 36 hours in one of our clinical environments alongside other applicants," he says.

The model also has practical limitations. "It's hard to fill a 300-student programme through residential assessments alone," he says. "But this helps broaden the range of people we recruit."

While approaches will differ between institutions, work like this shows the scope for medical schools to consider what more inclusive practice could look like.

Following the College's conference on supporting neurodivergent medical students, RCPsych has begun discussions with the Medical Schools Council (MSC) about working together to develop shared guidance for medical schools across the UK. Dr Arulanandam says the guidance would take account of differences between the four nations while addressing the core issues and concerns common to all four.

"This is now a live and important topic for the College," says Clare Wynn-Mackenzie, Careers Manager for the Professional Standards Team. "It's very much a collaborative piece of work, both internally, within RCPsych, and externally, with the MSC and other relevant bodies."

"We're also seeking medical students to help co-produce this work," says Dr Arulanandam. Their perspectives will help shape the guidance as it develops.

Get involved

Medical students and educators can contribute to the College's work on supporting neurodivergent medical students. RCPsych members who are undergraduate psychiatry teaching leads at their medical school can also enquire about joining the Undergraduate Education Forum.

For either, email **careers@rcpsych.ac.uk.**