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Guest Editorial

Where we started, how we travelled and where next?

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Summary

The Royal College of Psychiatrists was established in 1971 with psychiatric training as its core business. Drawing on a feature written by a former president in 2000, this editorial is a reflection on how his predictions played out in the real-life practice of psychiatry and the suggested way forward.

Keywords

Carers; education and training; evidence-based mental health; history of psychiatry; in-patient treatment.

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Where we started?

Established in 1971, the Royal College of Psychiatrists nevertheless celebrated its 180th anniversary in 2021! Time and pedigree matter more in some circles and that may well have persuaded the College to start its history from the Association of Medical Officers of Asylums and Hospitals for the Insane (1841), through the Medico-Psychological Association (1865) and the Royal Medico-Psychological Association (RMPA) (1926). By the late 1960s, discussions were afoot for transitioning from the RMPA to the Royal College of Psychiatrists. For several young psychiatry trainees then, the mere adoption of an archaic system with sole emphasis on an exit examination was unacceptable. By 1968, a 'petition group' was formed to create a college that would have as its core role not just an examination but also an overview of psychiatric training and its standards. Against the odds, the petition group achieved its objectives and the Royal College of Psychiatrists was set up in 1971. The story of the struggle that preceded its formation[1] would suggest that what are now described as the 'College's values' – courage, innovation, respect, collaboration, learning and excellence – were very much ingrained in its founding principles, long before glossy brochures repackaged them in 2017.

How we travelled and where next?

In 2000, Robert Kendall, one of the most erudite presidents in the College's history, published a feature titled 'The next 25 years'.[2] His examination of psychiatry's journey and predictions for what would come next offer a useful template for us to reflect on and consider the future.

Mental illness, stigma and resources

Kendall suggested that increased recognition about the higher prevalence and disabling consequences of mental illnesses would slowly reduce stigma. This in turn, he contended, would increase government spending on mental health. While he was right on the first point, the reduction of around 0.07% for mental health in the NHS budget for 2025–26 suggests that the latter prediction was off the mark. It is worth examining the underlying nuances that inform this.

In 2017, Sir Simon Wessely, the newly elected President of the Royal Society of Medicine commented, 'Every time we have a mental health awareness week, my spirit sinks. We don't need people to be more aware. We can't deal with the ones who already are' (quoted in https://www.bmj.com/content/358/bmj.j4305). The bluntness of his assessment, the candour of its expression and the counterintuitive nature of his conclusion generated interest. While it is true that in a system where the state guarantees universal healthcare, awareness about one's health should not be based on the length of waiting lists, staffing shortages or burnout, Sir Simon's comments touch on a key underlying point. A focus on 'awareness' campaigns often had the potential to blur boundaries between extremes of normal human emotion and severe mental illness. They can both give the appearance of comparable suffering, but they are not the same. Blurring that boundary can detract time and resources from one of psychiatry's core tasks, the active treatment of severe mental illnesses and disorders. That detraction carries the potential to increase stigma for an already marginalised group. Apart from mental illnesses, neurodevelopmental conditions like autism and ADHD have been diagnosed at much higher rates than before. Partly driven by concerns about the rising welfare bill and other costs, there has been political comment describing all this as 'overdiagnosis', although there is little objective evidence for that. With the recent promise from the government of an enquiry into this issue, it will remain a field for psychiatrists to engage with the utmost care in the next few years. We do need meaningful campaigns that focus on these nuances.

Understanding aetiology, therapeutic advances and the relationship with the rest of medicine

Highlighting the massive research investment, particularly in the USA, in brain research, Kendall predicted that psychiatry would become more biological and that differences with the rest of medicine would reduce. There would be major advances in understanding the aetiology and pathogenesis of mental illnesses, and advances in genetics, brain research and functional imaging would drive the discovery of new treatments for a range of mental disorders. Twenty-five years on, it is very clear that this has been an area of disappointment. Thomas Insell, neuroscientist and former head of the National Institute of Mental Health (NIMH), USA, put it pithily: 'I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs, I don't think we moved the needle.'[3] It has been suggested that failure to achieve the promised massive change was due to an exclusive identification with functional biology (anatomy,

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physiology, genetics) and the neglect of evolutionary biology, which considers environmental variables alongside. Rooted within the biopsychosocial approach, a theoretical framework based on the integration of functional and evolutionary biology could be the way forward.[3]

While focusing on biological advances, Kendall also predicted how new psychological and social therapies would be discovered, and indeed the last 25 years has seen the growth of dialectical behaviour therapy (DBT) and eye movement desensitisation and reprocessing (EMDR) therapy. The development of new medications in psychiatry, however, did not keep pace with the rest of medicine. The drug categories of choice for schizophrenia, depression, anxiety disorders and attention-deficit hyperactivity disorder (ADHD), have not changed much since the serendipitous discoveries in the second half of the last century. An examination of this topic recently made several constructive suggestions about the way forward.[4]

The disappointment of not having game changing discoveries in aetiology, pathogenesis or treatment should not lead to unjustified pessimism that devalues the very considerable progress that has been made. In the last 25 years, British academic psychiatry has made significant scientific advances in neurosciences, psychopharmacology, imaging and genetics even, amid a structural deterioration that has constrained research capacity, limited educational opportunities and exacerbated regional disparities.[5] A call to action highlighting the need for an invested stakeholder like the College to take a lead in this area made a series of recommendations and emphasised how academic psychiatry must be seen as 'everyone's business'. It highlighted the transformative possibilities offered by emerging technologies, including digital health, artificial intelligence and precision medicine, the need for regional, networked and virtual academic units that democratise participation, and an entrepreneurial mindset that emphasises collaboration with diverse stakeholders, including the private sector.[5] These changes will chime with the priorities set out in the NHS 10-year plan.[6]

Partnership with patients, financial constraints and competition between professions

Against the background of changing public attitudes to deference, Kendall predicted that organisations representing the patient voice would become more influential and emphasised the need for psychiatry to work in partnership with them. Although there is more to achieve, this partnership has matured over time, and there is acknowledgement that if we want equity of treatment outcomes, then healthcare professionals, patients and family members should work collaboratively, paying due attention to their respective areas of expertise. The lived experience of patients and families can effectively and safely complement treatment approaches that are informed by scientific knowledge and expertise.[7] This remains the way forward.

Highlighting the significant financial constraints in a publicly funded health system, Kendall predicted increasing limitations on clinical autonomy. This is manifested now in how healthcare is shaped by treatment guidelines, most of these also having a 'value for money' test. These guidelines are not just about medications or therapies but also settings of treatment. A stark example of the latter is the 73% fall in bed numbers in mental health over the last 30 years, a move that has contributed to severe limitations in the effectiveness, safety and patient experience of treatment outcomes. There is a need to highlight the difference between treatment guidelines that facilitate cost-effective medicine and protocols that impose financial management strategies based on ideological positions.

Rather presciently, Kendall warned about a takeover of medical roles by other professions as a means of controlling costs. He gave examples of how therapies devised by psychiatrists were now being run by clinical psychologists and predicted an increasing prescribing role for nurses and pharmacists. This has very much been witnessed in recent years, not only with Kendall's examples but also the rise of clinical practitioner and physician associate roles. To navigate this increasingly fraught area, there is a need for clear and measured medical leadership that will emphasise the centrality of medical training, the need for transparency for patients about the qualifications of those treating them and an emphasis on patient safety. The Leng review[8] offers a thoughtful starting point for this.

Who is a doctor?

Medical education and training in the four nations of the UK is characterised by a partnership between the state-run national health service (NHS), the General Medical Council, the royal colleges and regional deaneries. On 24 October 2025, NHS England published the much awaited Medical Training Review.[9] Described as an initial *diagnostic* report, it concluded that a fundamental rethink of medical training was needed.

To explain this, the review highlighted some key points. There are now more medical student places and more foundation year doctors coming out of UK universities, all seeking entry into postgraduate training. With medicine having been declared a shortage profession in 2019, international medical graduates (IMGs) are also applying for this training. While the number of such postgraduate training posts has increased, it has not increased enough. In 2023, over 77% of UK doctors completing foundation year 2 in England did not or could not progress directly into core training. This led to a sharp increase in the number of locally employed doctors, currently not part of formal training. The shortage of postgraduate training positions was not uniformly distributed.

The report's recommendations included less rigid differentiation between training and service roles, reviewing the number of new IMGs seeking to enter training, more flexibility in training, more training places in areas with a greater need for them, reducing bureaucracy for educators, widening training sites, introducing changes in line with the NHS 10-year plan, reviewing recruitment structures and developing clinical academics. In psychiatry, some of these have a particular resonance with the urgent need to explore the reasons for the disparity between the excellent core trainee fill rates and the vexing consultant psychiatrist vacancies, the regional disparities in the latter and the creation of better career pathways for those currently described as being in service rather than training roles.

That exploration must be informed by the acknowledgement that a doctor is not just a collection of skills. If it were so, anyone attending short courses for skills could do the role. Medicine, at its core, is a rigorous academic pursuit. In the UK now, it takes 15 years of slog, study and sweat to mould a medical student into a consultant or equivalent. It is that long academic, practical and interpersonal process that allows them to be comfortable with uncertainty, to make sense of stories that don't fit patterns and to make decisions when no algorithm will. It is a process that creates the foundation for the abiding trust between doctor and patient. While striving for consensus, we also need my generation of doctors, those who have had the benefits of long training and stable employment, to dissent constructively when needed, offer clarity without hostility and courage without grandstanding.

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References

1 Royal College of Psychiatrists. *Looking Back – 1968: A Vital Year*. RCPsych, n.d. (https://www.rcpsych.ac.uk/about-us/history–art-and-exhibitions/history/our-history/1968-a-vital-year [accessed 21 Nov 2025]).

2 Kendell RE. The next 25 years. *Br J Psychiatry* 2000; **176**: 6–9.

3 Troisi A. Biological psychiatry is dead, long live biological psychiatry!. *Clin Neuropsychiatry* 2022; **19**: 351.

4 Nutt DJ. Drug development in psychiatry: 50 years of failure and how to resuscitate it. *Lancet Psychiatry* 2025; **12**: 228–38.

5 Shankar R, Bowater L, Laugharne R, Tracy DK, Critchley H, Young AH, et al. British academic psychiatry at a crossroads: lessons from the past 20 years and priorities for the next 20 years. *Int Rev Psychiatry* 2025; 1–11. Available from: https://doi.org/10.1080/09540261.2025.2560038.

6 Alderwick H. Government's 10 year plan for the NHS in England. *BMJ* 2025; **390**: r1396.

7 Alexander RT, Langdon PE, OHara J, Howell A, Lane T, Tharian R, Shankar R. Psychiatry and neurodevelopmental disorders: experts by experience, clinical care and research. *Br J Psychiatry* 2021; **218**: 1–3.

8 Leng G. The review of physician and anaesthesia associate roles will be transparent and evidence based. *BMJ* 2025; **388**: r145.

9 NHS England. *Postgraduate Medical Training Review*. NHS England, 2025 (https://www.england.nhs.uk/postgraduate-medical-training-review/ [accessed 21 Nov 2025]).

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