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Psychiatric doctors' engagement in research and academic careers: a national cross-sectional survey

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Abstract

Background

Over the last two decades, the number of academic psychiatrists in UK medical schools has fallen by a third. Research engagement among psychiatrists more broadly within and outside formal academic training is poorly characterised, as are the barriers they face.

Aims

We aimed to characterise research engagement among UK psychiatric doctors, including demographics, perceived barriers and challenges, and views on what currently works and what could be improved.

Method

A national cross-sectional survey was distributed to psychiatric doctors across all training stages and early-career grades in the UK, in collaboration with the Royal College of Psychiatrists' Academic Faculty, between 05 December 2024 and 17 February 2025. The survey comprised demographic items, Likert-style questions, and free-text responses. Quantitative data were summarised descriptively and compared by formal academic training status using chi-squared and Mann–Whitney U tests; free-text responses underwent inductive thematic analysis.

Results

345 doctors responded (281 outside formal academic training; 64 within it). Most reported at least one barrier to research engagement (79.7%), with financial implications most frequently cited (42.0%) and reported more often by those in formal academic training (56.3% vs 38.8%, p=0.016). Themes centred on systemic and personal barriers, access to resources, and perceptions of what works. Positive signals were strongest among doctors in formal academic training, who largely felt supported by their supervisors (82.8%) and universities (70.3%).

Conclusions

Psychiatrists across training stages are motivated to engage in research but face substantial structural and personal barriers. Strengthening access to resources, enhancing support outside formal academic pathways, and addressing funding and training constraints may help sustain and widen participation in psychiatric research.

Introduction

Academic psychiatrists combine clinical duties with education and research, and they have been at the forefront of driving new innovations in research (Critchley et al., 2024). Alongside this, academic psychiatrists play a key role in supporting the next generation of doctors through their roles in leadership, medical education and scholarship (Shankar et al., 2025) . In keeping with many parts of the medical academic workforce, academic psychiatry is facing a crisis. Over the last two decades, the number of psychiatrists employed by medical schools across the UK has fallen by over a third (Medical Schools Council, 2024). The existing clinical academic workforce is also ageing, with one third of clinical academics now aged over 55; at the other end of the pipeline, the number of early career clinical academics aged under 36 has decreased by 28.8% since 2015 (Medical Schools Council, 2024; Rimmer, 2024). This structural mismatch in the clinical academic pipeline has been recognised as a major threat to the UK's ability to continue to remain a leader in health and life science research (Strain & Gibb, 2025; Wise, 2023).

Academic training in the UK is currently subject to a nationwide review (Sam & Maxwell, 2026), which is examining the structure, capacity and accessibility of integrated academic training (IAT) pathways across specialties. IAT programmes (including the NIHR Academic Clinical Fellowship and Clinical Lectureship schemes in England, alongside SCREDS, WCAT and ICAT in Scotland, Wales and Ireland respectively) provide a formal route through which doctors combine clinical training with protected research time. Yet IAT pathways represent only one entry point into research, and the wider landscape of research engagement among psychiatrists – both within and outside these programmes – has not been systematically characterised. Recent evidence on the enablers and barriers shaping participation in research careers is similarly limited.

A cross-sectional survey was therefore undertaken to examine how resident and early-career psychiatrists, including consultants within five years of CCT and SAS doctors, engage with research and the challenges they encounter.

Methods

Study design and data collection

The authors constructed a cross-sectional survey covering sociodemographic items, Likert-style questions on research engagement and support, and free-text questions inviting respondents to describe their experiences of research and academic careers. Questions on barriers to research engagement used a multiple-response format with four pre-defined categories, derived from the authors' clinical and academic experience: financial implications of an academic career; concerns about the length of clinical training; experience-related barriers arising from difficulty accessing relevant opportunities; and parental or caring responsibilities. A free-text option allowed respondents to describe additional barriers not captured by these categories. The survey cover statement is available in Appendix 1.

The questionnaire was built in Microsoft Forms and underwent peer-review by Academic Faculty executive members of the Royal College of Psychiatrists (RCPsych) prior to circulation; completion was estimated to take approximately ten minutes. The survey was distributed via SurveyMonkey.

Participant recruitment and eligibility

The target audience of the survey was the early-career psychiatric workforce in the UK, with recent experience of training in psychiatry. The survey invited responses across career grades covering resident doctors, SAS (specialty, associate specialist, and specialist) doctors, and recently qualified consultant psychiatrists (within five years of their Certificate of Completion of Training or equivalent).

The survey was distributed formally by the RCPsych through established communication channels (Resident Doctor Networks, Specialty, Associate Specialist Networks, Postgraduate Training Bodies, and the Academic Faculty). We encouraged further distribution of the survey through resident doctor networks (local postgraduate training programme mailing lists), a clinical academic WhatsApp group, and the College’s academic training network. The study ran between 05 December 2024 and the 17 February 2025.

Respondents indicated at the start of the survey whether, in the previous six months, they had been working within the Integrated Academic Training (IAT) Programme or outside of formal academic training (i.e. in a standard clinical training pathway, a SAS post, or a substantive consultant post). The IAT Programme supports doctors to undertake a formal academic component alongside their clinical training in psychiatry. It encompasses the National Institute for Health and Care Research (NIHR) research career funding programmes in England, the Scottish Clinical Research Excellence Development Scheme (SCREDS), the Wales Clinical Academic Track (WCAT), and the Irish Clinical Academic Training (ICAT) scheme.

Data processing and storage

As an anonymous survey, we did not require participants to provide any personally identifying information (such as name or an email address), prior to taking part in the study, therefore we did not screen responses for duplicates. To protect participants anonymity, we supressed small cell counts (where <5 participants responded) during descriptive analyses.

Ethical approval

The Health Research Authority screening tool indicated that ethical approval was not required; as such, this was not sought. The questionnaire did not collect identifiable personal information. Further, it was to a professional participant group where consent was implicit by participation. All participants were advised at the start of the study that participation was voluntary, and informed consent would be presumed if the survey was submitted. If they chose to participate, data would be pooled, anonymised and analysed. Explicit consent to use data anonymously for research and publication was obtained. This was in a written format of ticking a box to use consent to use data for publication. The Royal College of Psychiatrists ensured the survey was constructed and implemented in line with its governance standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013.

Statistical analysis plan

Quantitative analysis

Descriptive analyses of the data were undertaken using Microsoft Excel (Version 16.107.4) and R (Version 4.5.2 2025-10-31). The distribution of categorical variables are presented using frequencies (*N)* and proportions (%) and subdivided according to whether the participant indicated they had undertaken an IAT pathway. If the survey question was applicable to both groups, comparisons were performed between the groups. For questions exclusively relevant to one group, the results were analysed descriptively within that group only.

The association between observed and expected categorical variables was analysed using the chi-squared test (χ^2) of independence with Yates' continuity correction Likert data were reported using descriptive statistics and the Mann-Whitney U-test was used to compare the distribution of responses among those in formal academic training and those outside formal academic training pathways. For responses to experienced barriers, free-text answers outside the predefined categories were coded into a single 'other barriers' category. All responses were then coded as binary variables (absent or present) and analysed as proportions across each group and training level. Heatmaps describing the distribution of participant responses on the barriers experienced were produced, stratified by self-reported career stage at the time of study completion.

Qualitative analysis

Two study authors (CW and OS) engaged in a inductive thematic analysis of free text response items following the procedure described by Braun & Clarke (Braun & Clarke, 2006). Qualitative analysis was completed using NVivo v15. The authors worked separately to code the data with no pre-defined conceptual framework. They identified initial themes and then met to discuss these. The data was recoded using these themes. After this the authors met again to refine the themes.

Results

Demographics

A total of 345 participants consented to the survey. The demographic features of the sample are shown in **Table 1**.

Variable	Total cohort (n = 345)	
Age	**n**	**Percent (%)**
25-34	180	52.2
35-44	107	31.0
45-54	30	8.7
55 or over	11	3.2
Prefer not to say/not answered	17	4.9
Sex	**n**	**Percent (%)**
Female	192	55.7
Male	135	39.1
Other	18	5.2
Ethnicity	**n**	**Percent (%)**
African/Caribbean	25	7.2
Asian/Asian British	76	22.0
Middle Eastern	16	4.6
Mixed/Multiple	19	5.5
White	183	53.0
Other or Not said*	26	7.6
Training Stage	**n**	**Percent (%)**
Foundation Training	11	3.2
Core Training	119	34.5
Higher Training	109	31.6
Specialty Doctor or Non-training	51	14.8
Consultant	41	11.9
Prefer not to say/not answered	14	4.1
Location	**n**	**Percent (%)**
England	259	75.1
Scotland, Wales and Northern Ireland**	52	15.1
Not currently working	6	1.7
Prefer not to say/not answered	28	8.1

Table 1. Demographic profile of survey respondents.

* Other or Not said includes Latin/Latin American respondents; these categories were merged due to small cell counts.

** Merged due to low cell counts from Northern Ireland.

81.4% (n = 281/345) of respondents were outside of formal academic schemes; the remaining 18.6% (n = 64/345) were within formal academic training schemes. The groups were similar in all regards, except a notably higher proportion of Asian/Asian British doctors inside formal academic training (n = 28/64, 43.8%) compared to those outside (n = 48/281, 17.1%).

Systematic and Personal Barriers to engaging in Research

Quantitative analysis

Across all stages of training, barriers to applying to academic posts or engaging in research were frequently reported (number and percentage reporting at least one barrier; n = 275/345, 79.7%). Barriers were common in both doctors with IAT experience (n = 56/64, 87.5%) and those outside of formal academic posts (n = 219/281, 77.9%). Barriers were reported across all training stages; a heatmap of the barriers reported by training stage is shown in **Figure 1**.

Financial implications were the most frequently reported barrier to engaging in research across the total cohort (n = 145/345, 42.0%). Doctors in formal academic training (n = 36/64, 56.3%) reported this barrier significantly more often than those outside of formal training pathways (n = 109/281, 38.8%; $\chi^2(1, 345) = 5.8$, $p = 0.016$). Concerns over the length of training were also common (n = 102/345, 29.6%); again, doctors in formal academic training (n = 29/64, 45.3%) reported this significantly more frequently than those outside of formal training (n = 73/281, 26.0%; $\chi^2(1, 345) = 8.5$, $p = 0.004$). Experience barriers were frequently reported (n = 114/345, 33.0%), but this was more commonly endorsed by doctors outside of formal academic training (n = 101/281, 35.9%) compared to those in formal schemes (n = 13/64, 20.3%; $\chi^2(1, 345) = 5.1$, $p = 0.024$). Parent and carer responsibilities were cited as a barrier for 27.2% of doctors (n = 94/345), with similar proportions in both groups (n = 74/281, 26.3% and n = 20/64, 31.3%; $\chi^2(1, 345) = 0.4$, $p = 0.521$). Other barriers, including illness, disability, lack of support, clinical pressures and SAS-specific challenges, were also reported.

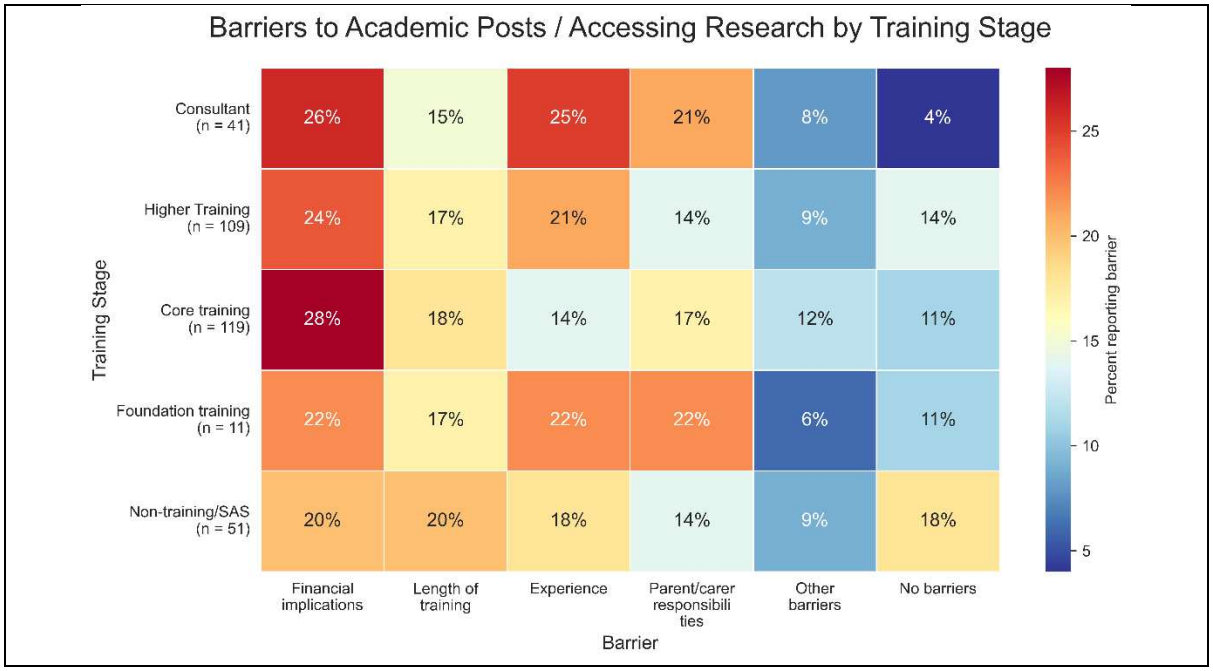


Figure 1. **Heatmap of barriers reported to engaging with research, across training stages.** Data include doctors both within and outside of formal academic training posts. Doctors who did not report their training stage (n = 14) are excluded from this heatmap.

Qualitative analysis

Responses related to this theme were broken down into four subthemes: particular challenges for doctors with caring responses, cultural barriers within organisations to clinical academia, the perception of academic psychiatry and costs associated with clinical academia.

There were a broad range of responses highlighting the challenges associated with pursuing academic careers for doctors with caring responsibilities or disability, including the need to work less than full time and possibly relocate to obtain an academic role. One respondent noted: "*I am a parent and cannot easily move to where the opportunities are*." This was echoed by another: "*Following my academic foundation post, I have not been able to pursue an academic route formally due to time out and now children*."

A second subtheme of responses related to organisations' cultural barriers within the NHS and higher education institutions to clinical academic careers. One respondent remarked that "*as soon as you go to the NHS because you have to earn money that's it in these times - you're bled dry by clinical services, you have no time for research, and in my experience there's no local interest in research (unless you want to do it in your own time, then that's ok!) because there's a waiting list of several years and that's the priority*."

Several respondents highlighted perceptions of academic psychiatry as elitist, with rigid training structures and an 'us and them' culture being a commonly encountered barrier to engaging in research activities as exemplified in the following response: "*I applied for an ACF but didn't get shortlisted. My understanding is these posts are to help people engage in research and build a portfolio so they can eg do a PhD and become a clinical academic. If you can't get onto these without several publications and projects and qualifications it makes these posts inaccessible to most doctors (especially people with less time/money to do free research outside of work) and makes it an elitist thing. It's a shame*."

The final group of responses identified relate to the costs associated with academia. Costs included those to the individual (both personally and financially) and costs to the academic world through underutilised talent. For example, "*the constant lack of funding and support provided for me as a SAS doctor has put immense financial pressure*."

Support and access to resources

Quantitative analysis

Across the full cohort, awareness of the Academic Faculty within the Royal College of Psychiatrists was variable (**Table 2**). Just over half of all the participants reported being aware of the Faculty (n = 185/345, 53.6%). Doctors within formal academic training pathways were markedly more aware of the Academic Faculty compared to doctors outside of formal academic training (n = 56/64, 87.5% *vs.* n = 129/281, 45.9%; $\chi^2(1, 345) = 33.7$, $p = < 0.001$). Views on the extent to which the Royal College supports academic development were mixed (**Table 2**). The most common response was neutral (42.6%, n = 147/345). There was a trend for doctors in formal academic training pathways to report more favourable views than those outside of formal academic training pathways (Mann-Whitney U test, U = 6898.5, p = 0.057).

Variable	Pathway				Traditional vs. Academic pathway
	Outside of formal academic training (n = 281)		Academic pathway (n = 64)		
Are you aware of the RCPsych Academic Faculty?	**n**	**Percent (%)**	**n**	**Percent (%)**	
Yes	129	45.9	56	87.5	
No	149	53.0	8	12.5	
Unanswered	3	1.1	0	0	$\chi^2(1) = 33.7$, $p < 0.001$
The Royal College supports my academic development.	**n**	**Percent (%)**	**n**	**Percent (%)**	
Strongly Agree	4	1.4	3	4.7	
Agree	45	16.0	17	26.6	
Neutral	119	42.3	28	43.8	
Disagree	58	20.6	10	15.6	
Strongly Disagree	26	9.3	6	9.4	Mann-Whitney U test
Unanswered	29	10.3	0	0	= 6898.5, p = 0.057

Table 2. Survey responses on awareness of the Royal College of Psychiatrists Academic Faculty and perceived support for academic development. The total cohort data are shown (n = 345), together with the split between doctors outside of formal academic training (n = 281) and those in formal academic training (n = 64). The chi-squared (χ^2) statistic with degrees of freedom and p-value are reported for yes/no questions. The Mann-Whitney U statistic and p-value are reported for Likert scale questions.

Qualitative analysis

Ensuring access to the appropriate resources for research was identified as a key theme within the data. This theme was broken down into two main subthemes.

Firstly, we identified a range of responses highlighting the challenges that doctors can face in obtaining appropriate posts or funding to enable them to spend sufficient time developing their research interests. A respondent stated "*I know that there used to be more clinical academic posts within the University which seem to have disappeared in favour of us bringing in our own funding*."

The responses also highlighted a lack of appropriately trained and motivated supervisors, mentors and professional services staff to guide doctors and support them to navigate the academic career pathway. One respondent noted that "*it has*

been extremely difficult to find support, particularly a research or academic supervisor who has availability or interest to offer support."

What works and how can things change

Quantitative analysis

The survey identified several positive signals, particularly amongst doctors in formal academic training schemes. Most doctors in this group endorsed that their primary academic supervisor supports their development (number and percentage reporting 'Strongly agree' or 'agree'; n = 53/64, 82.8%) and were satisfied with clinical aspects of their training ('Strongly agree' or 'agree'; n = 53/64, 82.8%). Similarly, the majority had plans to continue their careers as clinical academics (n = 55/64, 85.9%) and felt that career progression in academic medicine was clear ('Strongly agree' or 'agree'; n = 40/64, 62.5%). Although more mixed, most doctors in academic training reported that they felt part of the university they were affiliated with (number and percentage reporting 'Strongly agree' or 'agree'; n = 43/64, 67.2%) and felt that their university supported their research (number and percentage reporting 'Strongly agree' or 'agree'; n = 45/64, 70.3%).

Doctors outside of formal academic training reported either a positive (number and percentage reporting 'Strongly agree' or 'agree'; n = 94/281, 33.4%) or neutral (n = 106/281, 37.7%) attitude towards the level of academic support received. However, there were also signals highlighting important areas of development for this group. First, these doctors were less frequently satisfied with the support their primary clinical supervisor offers for academic development (reporting 'Strongly agree' or 'agree' = 47/281, 33.4%). Furthermore, access to funding was frequently cited as an important issue. Approximately 40% reported that a lack of funding in mental health research had impacted their career prospects (number and percentage reporting 'Very much' or 'Somewhat'; n = 113/281, 40.2%). Concerns were similarly raised about access to funding (reporting 'Strongly disagree' or 'disagree' to *Obtaining research funding is easy in my area of research*; n = 41/64, 64.1%). There were also concerns that academic training was inflexible; n = 33/64 (51.6%) disagreed or strongly disagreed that there is sufficient flexibility in training pathways.

Qualitative analysis

Although many responses focussed on the challenges of pursuing an academic career, several respondents highlighted positive experiences and reflected upon their successes. One respondent noted "*I have loved all my experiences with research and plan to have a hybrid career across both clinical work and academia.*"

We were also able to identify several ideas for how to effect positive change within the world of academic psychiatry. For example, one respondent recommended that "*a clearer indication of what roles are available, what it will entail, and the level of time commitment would be helpful.*" For one respondent the answer was more straightforward: "*I think we need more academic training opportunities or funded OOPR* [Out of Programme Research] *opportunities around the country.*"

Discussion

Principal findings

In this cross-sectional study, we describe the research experiences and motivations of the future academic psychiatry workforce. To our knowledge, this is the first survey of research engagement across psychiatric doctors in the UK, both inside and outside formal academic training schemes, providing a novel and timely evidence base at a moment when academic training pathways are under active national review.

Our findings from 345 psychiatrists, at varied stages of their careers, describe broad enthusiasm for academic psychiatry, but highlight the complex pressures that contribute to attrition of the future workforce. These findings corroborate qualitative research in medical specialities more generally (Lambert et al., 2015), and support previously described enthusiasm from medical students in Scotland to engage in academic psychiatry (Penades et al., 2026).

It is crucially important to retain the academic psychiatry workforce. Each pillar of the NHS 10 year plan (*10 Year Health Plan for England*, 2025) will require ongoing and new research. Developing, establishing and evaluating efficient services for community healthcare settings; transforming the NHS into a digitally led service, incorporating artificial intelligence; and understanding the best ways to address the public mental health crisis, all require academic psychiatrists to be involved and lead on projects. There is, notably, a commitment to making research a core activity within the National Health Service to drive forward innovation. The academic psychiatry workforce – both inside and outside of formal training schemes – are uniquely positioned to integrate the biological, psychological and social factors which underpin mental illness. The diversity in research perspectives, from research into translational and theoretical neuroscience (Sinclair et al., 2025), to epidemiology and population mental health, all need to be fostered and valued. Organisations must facilitate a culture that enables academic psychiatry to be everyone's business, rather than confined to established academic centres and university health partnerships. Dedicated academic psychiatry departments, complete with research and training opportunities, are sorely needed in many areas of the country (Laugharne et al., 2026).

Notably, barriers to research engagement were very common, reported by nearly four in five respondents, and were present across all training stages and grades. Financial concerns were the most frequently cited barrier overall, and doctors within formal academic training schemes reported these (alongside concerns about training length) significantly more often than their non-academic peers. Doctors who take time out of training to engage in research face a stagnation in their salary and the loss of or reduction in on call supplements. Importantly such pressures may be felt particularly strongly by female academic psychiatrists (Hassiotis et al., 2025). More generally, large overt and covert economic costs have been recognised in medical training (Jerjes & Majeed, 2025; Medisauskaite et al., 2023), and the financial burdens faced by training doctors have been brought into national focus during the resident doctor strikes. The financial constraints placed on doctors engaging in research can limit access to doctors who are from the most affluent backgrounds.

At more senior levels, the removal of Clinical Excellence awards increases financial demands on newly qualified consultants. All too often, research is expected to be pursued in doctors' own time, effectively unfunded. Appropriate incentivisation for doctors engaging in research is crucially important, to ensure the future growth of the academic workforce, and for the UK to maintain its place at the forefront of academic psychiatry. Our findings support calls for additional funding for research to be made available at all stages of the medical career and to embed research time in job plans (Toh & Haynes, 2022), which may go some way to improving research engagement whilst ensuring adequate recompense.

The impact of disability and the added challenge of being a parent or carer were clear, further limiting equitable access to research opportunities. Cultural barriers were also highlighted – both the perception that the NHS places high demands for more clinical time, and that academia is elitist. Experiential concerns were also commonly reported, particularly in doctors outside of formal academic pathways. To address these barriers, support networks for academic psychiatrists need more prominence in the UK. For instance, awareness of the Royal College of Psychiatrists' Academic Faculty was generally poor. The principles of academic psychiatry also need to be 'woven' into other faculties, with research engagement being made a priority in all faculties of the Royal College. The Royal College has a role to highlight areas in psychiatry which need further research, and to support research in these areas through pump priming, bursaries, and training schemes to harness talent. Support for more junior colleagues from senior academics – both in the form of formal mentoring schemes, and informal support networks – will be invaluable in aiding doctors to navigate these barriers.

Encouragingly, despite the barriers described, qualitative responses highlighted that for many doctors working in psychiatry, research is an area of significant interest and there is intrinsic motivation to be research active. Doctors in formal academic training felt well-supported by their supervisors and universities, and most intended to pursue clinical academic careers. Harnessing this enthusiasm will require structural change at local departmental levels. Building a local culture in which clinical psychiatrists are actively involved in research recruitment and delivery could embed research as a routine expectation within clinical teams, rather than the preserve of a self-selecting few. Opportunities in all NHS providers for clinical psychiatrists to buy out dedicated research time would be a practical and meaningful step in this direction. This reflects the broader principle that academic psychiatry is "not confined to a minority of university-employed clinicians," and that sustaining the pipeline will require engagement across the whole psychiatric workforce, not only those within formal academic training schemes (Critchley et al., 2024; Shankar et al., 2025).

Respondents proposed a range of positive solutions to the challenges identified, such as the development of clearer guidance around advertising research opportunities, so that doctors with limited prior experience of research can fully assess their suitability and time commitment before applying. Additionally, standardised and transparent communication of what academic posts entail (including protected research time, funding arrangements and expected outputs) would lower the threshold for engagement, particularly for doctors from less research-active backgrounds.

Strengths

The use of a mixed-methods design (combining quantitative Likert-scale data with inductive thematic analysis of free-text responses) allowed us to both quantify the prevalence of key barriers and understand the personal experiences that underlie them. The survey was distributed through established Royal College of Psychiatrists communication channels, providing national reach across all four UK nations and across a broad range of training grades. The sample was reasonably balanced for sex, ethnicity, and training stage, enhancing the representativeness of the findings relative to the demographic profile of the UK psychiatric workforce.

Limitations

There are several limitations to this survey. First, the sample reflects only a subset of the total psychiatric workforce in the UK; while 345 responses represent a reasonable response for a voluntary national survey, the true response rate cannot be calculated given the cascaded distribution method. Second, as a self-selected sample, there is likely a response bias. Respondents may be systematically more engaged with research than the broader psychiatric workforce, potentially overestimating levels of research interest and underestimating barriers among the most disengaged doctors, which is a limitation inherent to survey methodology in this context. Third, most respondents were from England (75%), reflecting the distribution of the psychiatric workforce, but limiting generalisability to Scotland, Wales, and Northern Ireland, where training structures and academic infrastructure may differ. Fourth, the anonymous design of the survey, whilst necessary to protect participant confidentiality and maximise response rates, precluded screening for duplicate responses. Finally, the Likert-scale items used in this survey were not externally validated instruments, and responses reflect subjective perceptions at a single time point, which may not be stable over time or fully generalisable across institutions.

Conclusions

This national survey reveals a psychiatric workforce that is broadly motivated to engage in research, but faces substantial structural, financial, and personal barriers to doing so. The challenges are not confined to those within formal academic training schemes; instead, they extend across all grades and training stages and are particularly acute for doctors from less privileged backgrounds, those with caring responsibilities, and those outside established academic centres.

Addressing these barriers will require coordinated action across multiple levels: from the Royal College of Psychiatrists and national training bodies, who must increase visibility of academic opportunities and embed research cultures across all faculties; to NHS organisations, who must create the protected time and financial incentives necessary to make research a viable career choice; to universities and academic departments, who must invest in mentorship, supervision, and accessible pathways for a more diverse academic workforce. Without such action, the decline of the academic psychiatry pipeline will continue, with significant consequences for the UK's capacity to generate the evidence base that underpins modern mental healthcare. The findings presented here offer a foundation from which targeted, evidence-based interventions can be developed to address this decline.

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