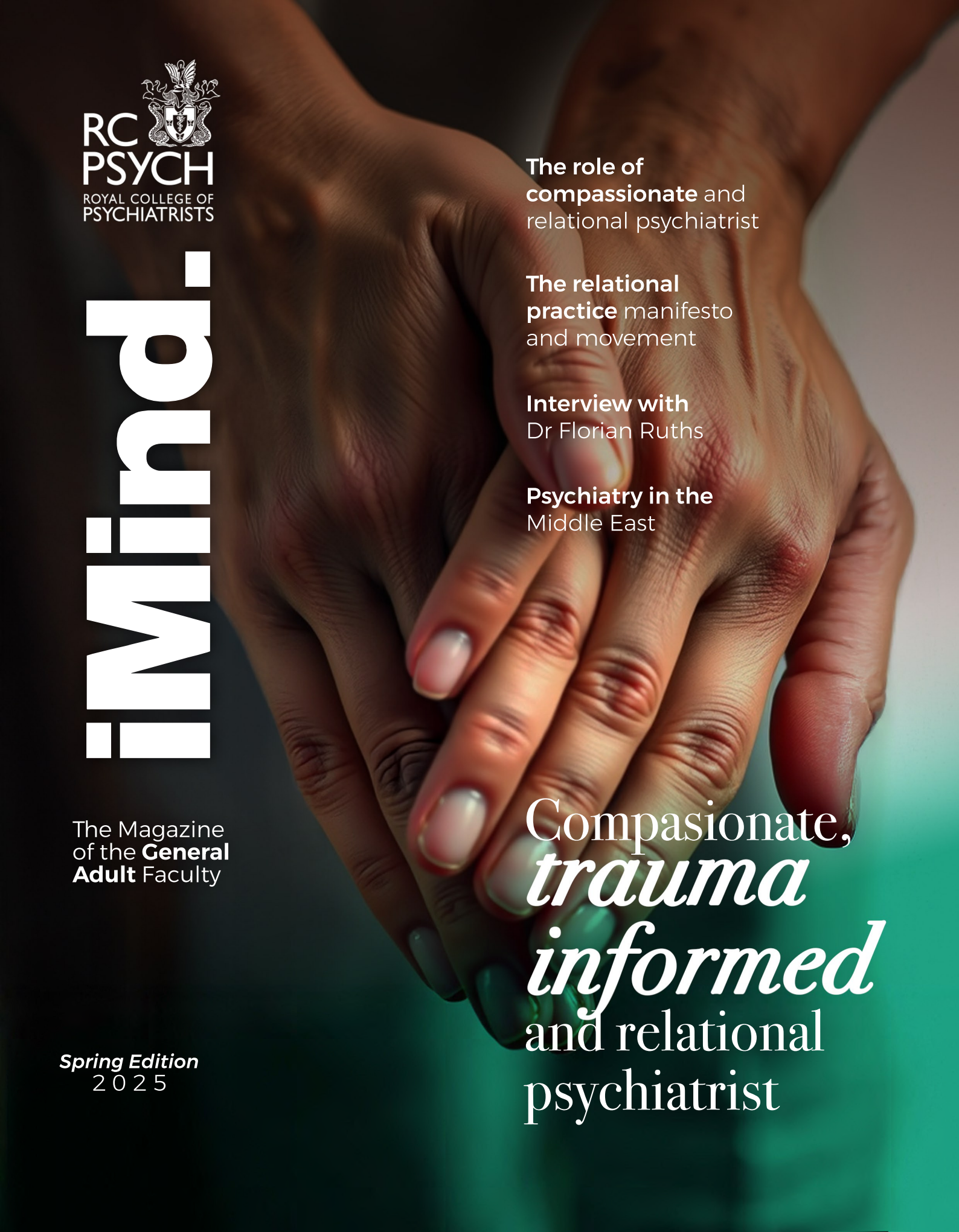

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iMind.

The Magazine of the **General Adult** Faculty

The role of compassionate and relational psychiatrist

The relational practice manifesto and movement

Interview with Dr Florian Ruths

Psychiatry in the Middle East

Compasionate, *trauma informed* and relational psychiatrist

Spring Edition
2025

Content

From the Editorial team

Dear Faculty members,

We bring you this very special edition which brings together a diverse range of perspectives and experiences, all pointing toward the necessity of compassion, and relational care in psychiatry - whether through open dialogue approaches, therapeutic communities, trauma-informed treatments, or cross-cultural psychiatric experiences, these discussions highlight the ongoing transformation in mental health care. We have the pleasure to interview Professor Russell Razzaque Presidential Lead for Compassionate and Relational Care within our College. An advocate for this approach, he describes it as "putting relationships back into the heart of the work we do." This method prioritizes dialogue, understanding, and authentic connections over impersonal, transactional interactions.

In today's rapidly evolving mental health landscape, the need for a shift from a bureaucratic, risk-focused model to one centred on human connection and compassion has never been more urgent. Dr. Gareth Jarvis presents a compelling argument for this change. He highlights the systemic challenges in current psychiatric practice but on a positive note has found experience of Open dialogue as validating, uplifting, energising and supportive to therapeutic relationships.

Dr. Florian Ruth's, in his interview, discusses the role of psychiatrists in psychological therapies, addressing key training gaps and exploring how principles of compassionate and relational care can be better integrated into psychiatric practice.

As we know co-production in mental health acknowledges the need to understand patient experiences and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness. Rachel Bannister a lived experience expert from Mental Health Time for Action in her interview discusses both a carer and a service user experience providing an insightful perspective on systemic challenges within mental health services. She cited Peer-Supported Open Dialogue (POD) and how this approach transformed her family's experience, enabling them to feel truly heard and empowered.

The Relational Practice Movement emerged from debates on personality disorder treatment, it advocates for a shift towards human-centered, and dynamic, relationship-based psychiatric care. This movement encourages greater engagement among colleagues and promotes a culture of empathy, collaboration, and patient-centered care. We were humbled to see how a small

group of psychiatrists are now attracting like minded colleagues to work in a multi professional group with a formal strategy plan.

Dr Mikellides through "rTMS and Ketamine in Trauma-Informed Care: Compassionate Treatment for Complex Mental Health Needs" discusses the integration of repetitive Transcranial Magnetic Stimulation (rTMS) and ketamine therapy into trauma-informed psychiatric care. It highlights their efficacy in treating treatment-resistant depression (TRD) and post-traumatic stress disorder (PTSD) while being less invasive & intrusive. An important made is integration of science and empathy.

Dr. Miriam Barrett, argues that therapeutic communities, supported by NICE guidance and cost-effectiveness data, should be explored further to enhance mental health service delivery in the UK.

An interesting case study featuring the healing power of art therapy and its power of communication, particularly for neurodivergent patient is brought by Dr Rachel Davy in The Compassion at Christmas. It sheds light on the profound impact of creative expression on emotional well-being and mental health recovery.

From our trainee section, Dr Hala's "The Lemon Tree" is a deeply moving and beautifully written reflection on displacement, loss, and resilience. It captures the essence of survivor's guilt, the weight of grief, and the power of connection through shared trauma. Dr Kamran gives his reflection of using the concepts of being trauma informed in his clinical practice and how he aspires to be a holistic psychiatrist using his own individual values.

It is pertinent that the concepts of compassion and relationship are ingrained towards our colleagues which lot many times need the tools of coaching & mentoring. Dr Balakrishnan in his interview with overseas colleagues, "Psychiatry in the Middle East: Adopting a Growth Mindset to Explore New Challenges" offers valuable insights into the experiences of UK-trained psychiatrists working in the UAE and Qatar. It examines the cultural, professional, and systemic differences they encounter and explores how they navigate these challenges while maintaining high standards of care.

In an insightful interview, Professor Swaran Singh shares valuable reflections on his contributions to psychiatry. He emphasizes the importance of compassionate and relational care, urging young psychiatrists to embrace uncertainty, take pride in their work, and learn from each patient encounter.

We have the pleasure and privilege to celebrate prestigious award winners from our faculty- Dr Joan Rutherford, Chief medical member has been awarded OBE; Dr Swaran Singh & Dr.... have been awarded lifetime achievement awards.

As we continue to learn from different models and experiences, the hope is that psychiatry moves toward a more compassionate, person-centred, and relational approach, ensuring that mental health services truly serve those who need them most. Our aim through this edition is for readers to get inspired and motivated in this direction whilst at the same time read through a constructive critical eye and where felt provide valuable feedback. We also invite colleagues to write to authors should they have any follow up queries or unresolved questions. A special mention and thanks to Dr Olusanmi Ibuola, without his talent of designing and IT skills this issue would not have been possible, he is integral to our editorial team.

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Views from the Chair

Dear colleagues,

As we welcome the Spring Edition of iMind, I hope the year has begun with fresh energy and inspiration for you all.

As I reflect on the past year, I've been struck by how often the conversations I've had with colleagues have circled back to one central truth: at the heart of good psychiatric care lies meaningful human connection. This is especially fitting as our Editors introduce the Spring edition of iMind, centred on the theme of the Compassionate, Trauma-Informed and Relational Psychiatrist. This is not just a slogan — it reflects a growing movement within our field to re-centre care around relationships, equity, and emotional safety.

It was an honour to chair the recent Dean's Grand Round on the vital role of revitalising the BioPsychoSocial model in our work as Psychiatrists. I shared some of my reflections on this shift and the urgent need to challenge the status quo — whether that's the tick-box culture of risk assessments, the alienation of families from care planning, or the systemic barriers to truly compassionate practice. If you missed the Dean's Grand Rounds, please follow this link to hear presentation from Dr Jeya Balakrishna, Professor Russell Razzaque and Dr Florian Ruths on the importance of holistic and relational care in psychiatry.

Furthermore, we have seen these values reflected in practice through our Faculty's work. In March, we were delighted to co-host a highly successful joint Spring Conference with the Child and Adolescent Psychiatry Faculty. The theme, From Childhood to Adulthood: Advancing Mental Health Together, brought more than 300 registered colleagues from across the lifespan into one vibrant hybrid event. The sessions — whether attended in person or online — offered thoughtful dialogue, practical insights and opportunities for shared learning. It was also encouraging to see strong engagement from our resident doctors.

https://www.rcpsych.ac.uk/events/free-webinars/free-webinars-for-members/2025/free-members--webinar--dean's-grand-ounds---biopsychosocial-psychiatry

This edition of iMind is packed with contributions from across the Faculty and beyond. You'll find lived experience narratives, service innovations, clinical reflections and even glimpses into practice overseas — all circling back to the essential idea that compassion and relational care are not luxuries, but the bedrock of effective mental health care.

My thanks go to everyone who has contributed to this edition, our wonderful Editors, Himanshu and Sophia, Olusanmi our graphics designer, and especially to those continuing to champion trauma-informed, relational approaches in their everyday practice. The momentum is growing, and our Faculty is proud to be part of that movement.

Best wishes, Jon

The Role of Compassionate and Relational Psychiatry

Interview with the Presidential Lead for Compassionate and Relational Care, Professor **Russell Razzaque**

The practice of psychiatry is built on two essential pillars: technical expertise and relational care. While advancements in pharmaceuticals and other technical aspects have transformed mental health care over the last few decades, there is a growing realization that the relational aspect—the therapeutic bond between clinician and patient—is equally vital. Compassionate and relational psychiatry emphasizes the importance of these human connections, aiming to reintroduce relationships as the foundation of mental health care.

Defining Compassionate and Relational Psychiatry

At its core, compassionate and relational psychiatry is about fostering meaningful, empathetic connections with patients. Prof. Russell Razzaque, a consultant psychiatrist and advocate for this approach, describes it as "putting relationships back into the heart of the work we do." This method prioritizes dialogue, understanding, and authentic connections over impersonal, transactional interactions.

Evidence suggests that the quality of the therapeutic relationship significantly impacts patient outcomes. In fact, the strength of this bond can often predict long-term recovery. Despite this, modern health care systems frequently prioritize efficiency over empathy, with segmented care pathways and limited continuity. Compassionate psychiatry seeks to address these systemic shortcomings by training clinicians to focus on communication techniques, reflective practices, and relational dynamics.

Training and Systemic Implementation

Prof. Razzaque highlights several initiatives designed to integrate relational care into psychiatric practice. One such initiative is the Culture of Care Programme, commissioned by NHS England and implemented across inpatient wards nationwide. This program includes:

1. **Standards for Relational Care:**
New guidelines prioritize developing meaningful relationships and embedding compassion within institutional cultures.

2. **Quality Improvement (QI) Initiatives:**
Teams are encouraged to innovate and experiment with methods to meet relational care standards.

3. **Patient-Reported Experience Measures:**
Patients use QR codes placed around wards to provide real-time feedback on their interactions with staff, allowing teams to assess and improve their relational approaches.

Additionally, training programs are being developed at various levels, ranging from one-day workshops to extensive year-long open dialogue training at Cambridge University. These programs equip psychiatrists and mental health professionals with tools to foster deeper connections, such as open-ended questioning, reflective listening, and group exercises that enhance emotional intelligence.

Addressing Resistance and Challenges

While younger psychiatrists often embrace relational care enthusiastically, some seasoned practitioners may find it challenging to adapt to this approach. Prof. Razzaque emphasizes the importance of experiential learning: "Patients are the best teachers. Simple changes in communication can yield immediate, profound feedback." For instance, clinicians who adopt open, patient-centered dialogue often report hearing phrases like, "No one has ever listened to me like this before." Another challenge lies in the strained resources and high-pressure environments of mental health services. However, Prof. Razzaque argues that relational care is not necessarily time-intensive. Even brief, meaningful interactions can have a transformative impact on patients. The approach also enhances clinician satisfaction, as practitioners reconnect with their core motivation for entering the field: to help others.

Transformative Impact on Patients and Staff

The benefits of compassionate psychiatry extend beyond patients to include the well-being of clinicians and the overall functioning of mental health services. In an ongoing randomized controlled trial comparing open dialogue teams with traditional teams, preliminary findings reveal significant differences in staff retention. While traditional teams experienced 100% turnover over seven years, open dialogue teams retained 80–85% of their staff, with departures largely due to career advancements. This improved retention fosters continuity of care and strengthens therapeutic relationships.

For patients, relational care creates a more humanistic and empowering experience. Many patients express that what they value most is being genuinely heard and understood something often missing in traditional approaches. By prioritizing dialogue and empathy, relational psychiatry not only improves clinical outcomes but also restores dignity and agency to patients.

A Vision for the Future

Looking ahead, Prof. Razzaque envisions relational care becoming a standard part of psychiatric training. Efforts are already underway to incorporate these principles into postgraduate and undergraduate medical education. The Royal College of Psychiatrists is developing a diploma in compassionate and relational care, offering modular training to psychiatrists and other health professionals. Such initiatives promise to make relational care a central component of psychiatric practice.

A Call to Action: Personal Development for Professional Growth

Prof. Razzaque believes that professional development in relational care must begin with personal development. He encourages clinicians to engage in practices like mindfulness, therapy, or coaching to better connect with their own emotions. "No professional development without personal development," he says, emphasizing that the ability to connect with patients stems from a clinician's capacity to connect with themselves. To support this, Prof. Razzaque has organized mindfulness retreats for psychiatrists over the past decade. These retreats not only enhance clinicians' well-being but also equip them with the emotional resilience needed to engage deeply with patients.

Conclusion

Compassionate and relational psychiatry represents a paradigm shift in mental health care. By placing relationships at the heart of treatment, it offers a more humane, effective, and satisfying approach for both patients and clinicians. As the field continues to evolve, the adoption of relational care principles holds the potential to transform psychiatric practice, creating a more compassionate and connected system of care.

Conducted and transcribed by
Dr Himanshu Garg

Compassionate Care and Trauma Informed Approaches:

Why learning from the **Open Dialogue Approach** is timely for Mental Healthcare

At times it can feel like the mental health care sector is in crisis; too few beds, too few staff, burnout and scandals. As AI advances at an incredible pace we need to look at what that means for our profession as well as healthcare as a whole. Prof Alison Pugh argues in her book 'The Last Human Job' 1 that this should all be about human connection. Finding meaning in a fragmented future will be founded upon the opportunities to connect with other people. As a professional group we can be at the forefront of that through the deeply meaningful work we can do every day alongside people in mental distress.

The Case for Change

Have you ever felt that the current system is not quite working? Maybe it's the ever-rising levels of paperwork and data entry that you and your teams seem to be called upon to complete. Maybe it's seeing a service user in an inpatient unit and the gnawing sense of injustice and inadequacy of the tools we have available. Maybe it's the team members who ask for a "medical review" when you can see that a doctor's gaze is going add little to the situation. We have a regular stream of examples put in front of us by the national press when care has failed those who needed it most. We could look at the problems highlighted at Edenfield by a BBC investigation 2.

We could look at the issues found by the CQC on reviewing the events leading up to the multiple homicide in Nottinghamshire 3. We could easily look in our own local services and find examples where we know the care did not meet the standards to which we all aspire.

We know the themes that our local and national inquiries throw up time and again. A lack of involvement of family members in care. Poor communication between staff and those who are accessing care. Inequality and discrimination (pick a protected characteristic of your choice). Rude and dismissive attitudes to those most in need.

There is also a broader economic and political context which we have to take in to account when steering the future of our Mental Health Services. There is little prospect of significant growth in the British economy in the coming years, with the public purse remaining constrained. This deals us a double challenge; there is unlikely to be any major new investment in to our services with the current trajectory, and as most of the challenges we are called upon to assist with in Mental Health Services have their roots or perpetuation in economic misery and its sequelae, we will continue to see rising demand for our constrained resource.

Whitehall has repeatedly stated that it needs to see improvements in productivity across the NHS 4. Productivity has a simple economic equation:

$$\text{Productivity} = \frac{\text{Output}}{\text{Input}} = \frac{\text{Quality x Quantity}}{\text{Resources used}}$$

My experience over the years is that the NHS immediately narrows its focus on to the more readily measurable 'quantity' element of that equation, ignoring the enormous potential gains from delivering better 'quality'. We can all think of examples where we know that extra time spent on completing high quality input with someone earlier in their pathway can avoid the use of expensive options such as resource intensive and restrictive inpatient care. We have not always done ourselves favours in the Mental Health sector in ensuring we articulate well where our quality gains can be found, but our clinical leadership must shape this in the coming decade.

I think at the heart of most of these wicked problems we have been grappling with is a loss of compassion as the focus. Compassion flows from a felt connection between human beings. We are often called upon to care for people at a time when confusion, fear and anger are at their peak, which all too often can end in episodes of violence (physical, verbal, emotional) upon self, to others, or from others. Existing within such circumstances is retraumatising for those accessing care and exhausting (physically, intellectually, emotionally) for those trying to help. The growing awareness of compassion fatigue is being talked about more and more amongst professionals 5.

We have known for a while now that the evidence shows that an actuarial approach to risk is ineffective 6; worse than that, many would argue the tools and forms so often encouraged within mental healthcare interfere with the central task – to make a meaningful connection with the person in front of you. Only through such a connection and the trust that is formed can we expect people to share their darkest thoughts and fears, to trust us to work with them to build a bridge to an alternative future.

I would go further and say that the paradigm in your work exists is already framing and regulating the flow of compassion. Is the person in front of you seen as a fellow human being whom you need to align alongside and build a shared understanding of their unique context and challenges? What about the people who care most about that person? Are they equal partners to care, other fellow human beings to build more complex understandings with? or maybe they are held in the frame of 'distraction', 'irritation', 'irrelevance'?

If we accept that there are always examples to be found in most people's practice where these issues arise, what can be done about it? Is it possible to provide a space for learning and growth for staff struggling with these pernicious, thorny issues?

The Case for Learning from Open Dialogue

For the last decade there has been a growing group of mental health professionals who have been drawing lessons for their practice from the Open Dialogue approach 7. This was developed over a couple of decades in Western Lapland, Finland, following an iterative, participant research methodology that put the highest respect on service user and social network feedback. What emerged was part philosophy, part system model, part clinical skills shift.

It emphasises the involvement of family and social network right from the start and places primacy upon questions which hold this network perspective throughout care. In doing so the person has the need for developing, repairing and growing their social sphere constantly underlined. From an Open Dialogue perspective we would not only consider the family and network of origin as holding the history book of what problems have emerged, but also the keys to what will be the right interventions in this unique context to helping someone to move towards recovery. The family can enrich and grow a more complex understanding of a person and in doing so we are more likely to see them as a whole person whom we can make connection with.

We hold to a philosophy of having all treatment discussions in front of the person and their network, 'nothing about us without us'. This draws from the reflective conversations of Family Therapy practice. In doing so our language remains more respectful and

compassionate. We are more likely to avoid using technical jargon or shortcut labels which can so rapidly dehumanise a person. We have to follow a more radical transparency which builds greater trust between all involved.

My experience of working this way has been to find the people we are helping give remarkably positive feedback. The kind of phrases I hear time and again from the recipients are "we felt heard for the first time", "the staff felt like fellow human beings", "I don't know how or why it works, but it does!" The word that jumps out time and again for me is felt. To feel heard does not require an act of listening, it requires a felt connection with a shared emotional experience. A lot of the training you have to undergo to successfully deliver this approach focuses on self-development; looking at what your own origin stories may have been, reflecting upon your practice, reflecting upon your underlying assumptions and beliefs. Within mental healthcare the most important tool you have at your disposal is yourself.

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The word that jumps out time and again for me is felt

The constant honing of one's own skill set should be a primary responsibility of every mental health practitioner. Open Dialogue provides a frame and intentional design that leans in to cycles of constant practitioner feedback to better achieve that constant self-development.

There is obviously a need for better quantity and quality of research in to the effectiveness of the Open Dialogue approach and its ability to be applied outside of its original context. Having now spread to over 36 countries around the world (including Poland, Italy, Germany, USA, and South Korea) that question around translation is beginning to be answered. We all await with great interest the outcomes of the landmark ODDESSI study 8 which has followed up 500 participants over 2 years in the UK.

Beyond the research there are efforts afoot to look at how such a radical shift in approach could be practically achievable within western Mental Healthcare systems.

However, whatever the outcome of the research and any implementation efforts which follow, I would still argue there is a moral imperative to learn from the approach lessons which are often hard to quantify and express about the nature of human experience. The feelings of respect, trust and connection that are so often articulated by those who have received an Open Dialogue approach; these are values which we all cherish and aspire to.

The experience of trying to implement a new approach

Much of the last decade of my life has been dedicated to finding ways to help services to learn from the Open Dialogue example and implement more humane and transparent ways of working. It has been a privilege and absolute joy at the moments when connections are made, new understanding formed and hope given back to service users and staff alike. However, it has also been a journey of repeated frustrations. Trying to bring change in to a large and complex system like the NHS is very challenging. Large institutions are by their very nature 'small c conservative', being managed by people who are given stewardship and therefore tend towards avoiding risks to the organisation (safety, financial, reputational). This means large scale and radical change is often avoided or boxed where it can be controlled. Bringing the leaders of an organisation along with the ideas is essential in developing momentum and 'air cover' for change and ensuring barriers are removed. Clinicians have a vital role to play in this space in

terms of advocacy and championing of new models of care.
To implement change takes dedicated resource and time. A professional project management team with experience in organisational development and change is invaluable as a partner in such a process.

If I were to be more forthright in my analysis of the barriers to change I would say the most significant barrier is people themselves. This is at all levels of organisations. Asking people to examine themselves and understanding their own motivations is a big ask, but if we are willing to ask it of the people we try to help, we should be willing to ask it of ourselves. Over the years I have observed that resistance to changes that could humanise psychiatry do not always come from the best motivations; they seem to be rooted more in cynicism, fear, prejudice and the hoarding of power. We need a more honest conversation about those dynamics if we want care to move in a better direction. To be truly compassionate and relational in care you need to approach that with humility, with curiosity, dare I say it, with love.

To hold oneself in a relational space with the people you are trying to help can be a challenging and exhausting experience.

The inverse is also true. I have had plenty of experiences since training in Open Dialogue where that space has been experienced as validating, uplifting, energising. The NHS often woefully underestimates what it takes to hold yourself in a relational space. It needs thorough, in depth training on skills and attitudes, a process to which there is no short cut. For decades I have heard our healthcare leaders espouse the importance of "compassion", "co-production", "involvement of families". Enough talk! It requires dedicated, sustained action from all of us to implement change in our staff, our teams and our organisations to embody those principles at a deep level. It requires substantial investment in the training of all our staff. It requires structures to be put in place at the team level to hold and support relational practice. It requires a mindset shift of our leaders to challenge the status quo and hold the course as the inevitable shocks of events and circumstance threaten to divert our attention and purpose.

There is a more effective and kinder way of delivering care than what we currently do. It requires putting human connection and compassion back at the heart of care. It will need all of us to commit to making it a reality for everyone who needs our help.

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Dr Gareth Jarvis

is a Consultant General Adult Psychiatrist and Medical Director at Central and North West London NHS Foundation Trust.

Interview with Dr. Florian Ruths

Sophia Senthil: Good morning, Florian. Can you tell me about yourself?

Dr. Florian Ruths: I'm a Consultant General Adult Psychiatrist with expertise in different forms of psychological therapies, including Cognitive Behavioural Therapy (CBT), Mindfulness-Based Cognitive Therapy (MBCT), and Schema Therapy. I work as a Medical Psychotherapist at the South London and Maudsley NHS Trust, where I am the lead for CBT interventions. I'm also a Trust Advisor for Medical Psychotherapy.

Sophia Senthil: Can you share your thoughts or perspectives on compassionate and relational psychiatry?

Dr. Florian Ruths: My thoughts are that this is an area where we have had deficits over the last 30 or 40 years. Psychiatry, particularly general adult psychiatry, has been pushed away from psychological thinking. Psychiatrists used to lead psychological interventions. Many psychological interventions in history were developed by psychiatrists. For example, Aaron Beck developed CBT, and David Veale has done significant work over the last 30 years in bringing CBT into psychiatry and developing models for body dysmorphic disorder, among others. Starting with Sigmund Freud, who was a doctor, many psychological therapies have been developed by psychiatrists.

However, over the last 30-40 years, we have been pushed out of this domain. The biopsychosocial model has not been fully applied; instead, a biological model with some social aspects—mainly concerning the Mental Health Act—has dominated. As professionals, our ability to engage with patients on a more relational basis has been gradually eroded. Additionally, understanding how to systematically cultivate and bring compassion to our interactions has been neglected.

I believe that with the current focus on compassion and relational efforts within the Royal College of Psychiatrists, we are essentially reclaiming lost territory. It's crucial to engage all our colleagues in discussions about how to implement these ideas practically. This shouldn't just remain abstract. We need to figure out how to do this in practical terms: What skills do we need to learn or reclaim, and how do we integrate this into our day-to-day practice with patients?

Sophia Senthil: Do you think there is enough focus on training in this area?

Dr. Florian Ruths: That's a good question. What is enough, really? There have been efforts to rejuvenate this ethos within the College. Russell Razzaque is the Presidential Lead for Compassionate and Relational Psychiatry and

is developing course to equip psychiatrists with the necessary tools. However, this is just a drop in the ocean. With about 15,000 general adult member psychiatrists worldwide, we need a much broader effort to reach every single one of them.

Conversations are happening, but we also need to allow psychiatrists to decide what would be most useful for them to enhance these skills. Collaborating with our psychology colleagues is essential to facilitate effective training. There are many different psychological models, e.g. DIT, CBT, CAT, DBT, CFT, EMDR, schema therapy, MBT, MBCT and others—like a bunch of colourful flowers rather than just one or two. Each 'flower' has solid evidence base and offers a slightly different but often complementary perspective on understanding human beings. We need to harness this existing knowledge to support our colleagues in psychiatry because we have been lagging behind.

Sophia Senthil: Considering the demands of the service, how can general adult psychiatrists incorporate this aspect into job planning?

Dr. Florian Ruths: The first step is to reach a consensus among ourselves that this is an important endeavour to bring the psychological back to the heart of psychiatry. It's too easy to dismiss it by saying, "We're too busy." We need to reflect more deeply on what it means to be too busy to do the things we genuinely want to do with our patients. Many people enter psychiatry because they want to work relationally and psychologically, yet they end up too busy to practice these aspects. That cannot be right.
The General Adult Faculty Chair, Jon Van Niekerk, and others suggest that we allocate 10% of our working time specifically to developing our ability to act compassionately and relationally. Making this a priority could mean psychiatrists deliver psychotherapies,

The General Adult Faculty Chair,
Jon Van Niekerk, and others suggest that we allocate
10% of our working time specifically to developing our ability to act
compassionately and relationally.

or receive psychological supervision themselves.
This approach would have two benefits: we would become better psychiatrists for our patients. Psychological models implicitly and explicitly offer an understadning of ourselves in the therapeutic relationship. They help us learn how to look after ourselves more effectively. Burnout rates among psychiatrists are a clear indicator that something needs to change. We need to learn to care for our wellbeing and how to deal with stress and overwhelming emotional challenges better.

Sophia Senthil: Thank you. Do you have any further advice for colleagues and trainees?

Dr. Florian Ruths: My advice is to make bringing back the psychological and relational effort a priority for yourself. Trainees are often eager to do more psychological therapies and relational work with patients. They tend to have a bias towards a psychosocial approach, which is encouraging. The challenge is to convince senior colleagues that this is worth doing, worth fighting for, and worth engaging with.

Once that decision is made, the next step is to explore training options. Psychiatrists should familiarize themselves with NICE guidelines to identify which psychological models are recommended. It's essential to have a clear overview of the various models available and their respective power—the many flowers blooming in the psychological field, so to speak. This will take time and effort, but if we come together as a group, we can make this happen. The college is trying to support us all in this effort.

Sophia Senthil: Thank you. Do you have any final thoughts, Florian?

Dr. Florian Ruths: Yes, whenever I discuss this, people often ask, "It all sounds good, but how do we find the time?" I think it's about starting somewhere. There are many training courses in different psychological models available that twe can join and train in. There is a wealth of research-based literature available. Sometimes, starting with a reputable self-help book by known leaders in the field—the kind we might recommend to our patients—can be a good way to understand the principles of different self-help techniques.

Once we start reading, we'll find things we can discuss with our patients from our own learning and experience. It doesn't have to be overly complex.. Sometimes, when I recommend prescribing a book, people look at me like I'm from Mars! Suggesting books to patients can be beneficial, it makes sense—patients often have the time to think about different techniques and approaches. Understanding what constitutes good therapy versus ineffective therapy is also crucial. Not all therapies work for all patients, and prescribing the wrong therapy for a disorder can cause harm.

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Transforming Mental Health Services:

A **Lived-experience** Perspective on Compassionate and Relational Care

Mental health care systems around the world are increasingly recognising the need for a shift toward compassionate, trauma-informed, and relational care. Rachel Bannister, a former teacher turned mental health advocate, has become a powerful voice in this movement. Her personal journey—rooted in lived experience both as a carer and a service user—highlights the challenges of navigating traditional mental health services and offers a vision for a more compassionate future.

From Carer to Service User: A Journey Marked by Struggles

Rachel's journey into the world of mental health advocacy began when her daughter developed severe mental health issues more than a decade ago. As a devoted mother, she found herself advocating for her daughter through a fragmented system that often-lacked continuity of care. Their experiences were harrowing, with Rachel's daughter being placed in inpatient units as far as 300 miles away from home, causing immense strain on the entire family. The ongoing stress and trauma of advocating for her daughter's care took a toll on Rachel's own mental health, leading her to develop an addiction to benzodiazepines. Eventually, Rachel became a service user herself, requiring inpatient care. "It was only when I received compassionate, non-judgmental care that I began to heal," she .recalled, underscoring the importance of relational approaches in mental health services

What Compassionate and Relational Care Means

Rachel's understanding of compassionate care is deeply personal. She described how, during her early interactions with mental health professionals, there was often a lack of genuine human connection. While some clinicians showed individual compassion, systemic constraints, such as time pressures and high caseloads, prevented the development of trusting relationships. One encounter, however, stood out. Rachel recalled a psychiatrist who listened to her story without resorting to diagnostic labels or judgment. "He simply looked me in the eye and said, 'You just need a hand to hold to see you through this'. That moment changed everything for me," she said. The psychiatrist's empathy helped reduce her sense of shame and gave her hope for recovery. Rachel emphasised that compassion in care is not about grand gestures but small, consistent acts: listening without interruption, making eye contact, and showing genuine interest in the patient's well-being. "Without that relational foundation, progress is hard to achieve," she noted.

Systemic Barriers to Compassionate Care

Despite her positive individual experiences, Rachel highlighted significant systemic issues that hinder compassionate care. Chief among them is the lack of continuity in mental health services. Frequent changes in clinicians make it difficult for patients to build trust, which is crucial for effective therapeutic relationships. Staff shortages and high turnover rates further exacerbate the problem. Rachel pointed out that clinicians often lack the time to offer relational care, even if they want to. "It's not that professionals don't care; it's that the system doesn't allow them the time and space to care," she explained.

Lived experience
Rachel Bannister

The Need for Structural Change

For compassionate care to become the norm, Rachel believes systemic reform is essential. She cited the North East London NHS Foundation Trust's creation of a relational care faculty as a promising development. Additionally, she expressed optimism about the Open Dialogue approach, which involves the patient's family and social network in their care and allows for flexible, person-centered treatment. Preliminary results from the Open Dialogue trial indicate that this approach not only improves patient outcomes but also enhances staff satisfaction and retention. Rachel described how her own family is benefitting from Peer Supported Open Dialogue (POD), with her daughter feeling genuinely heard and the family feeling supported, for the first time in the decade under secondary mental health services.. "It's about enabling patients to have agency and ensuring they don't feel abandoned if they don't improve within a set timeframe," she said.

A Call for Compassionate Psychiatry

When asked what she would like to see in psychiatrists, Rachel emphasised the need for empathy and active listening. "I want psychiatrists to meet patients as equals, not as experts sitting across from someone who is unwell," she said. She recounted a negative experience where a psychiatrist introduced a student into the session without her consent and immediately began listing potential diagnoses. This approach left her feeling overwhelmed and dehumanised. Rachel called for psychiatrists to engage in consultations with an open mind, listen without preconceived notions, and avoid making the patient feel like an object of study. "Active listening, reflective practice and being present are key," she stressed.

Training the Next Generation of Mental Health Professionals

Rachel believes that embedding relational care into psychiatric training is critical for long-term change. She advocated for training models that bring together psychiatrists, nurses, and peer workers, fostering collaboration and shared responsibility. She also highlighted the importance of self-care for clinicians alongside continued self-work and reflection, noting that they must look after their own well-being to remain compassionate and present for their patients. In addition to technical knowledge, Rachel suggested that training should focus on trauma-informed care and equip professionals with a range of therapeutic tools. "It's about having a well-rounded toolbox that includes trauma therapeutic modalities that have been fundamental to her family's recovery, so clinicians can adapt their approach to each patient's unique needs," she said.

Co-Production: Involving Service Users in Service Design

Another key element of Rachel's vision is co-production, where services are designed

and delivered in partnership with service users. Another key element of Rachel's vision is co-production, where services are designed and delivered in partnership with service users. While co-production is often discussed, Rachel noted that it is rarely implemented in its true form. "Service users are usually brought in at the end, rather than being involved from the start," she observed. She cited Peer-Supported Open Dialogue (POD) as a model of genuine co-production. In this approach, the patient leads their care, deciding who should be involved and how often meetings should occur. Rachel described how this approach transformed her family's experience, enabling them to feel truly heard and empowered.

Overcoming Barriers to Change

Rachel acknowledged that advocating for change is not without its challenges. She noted that some professionals are reluctant to engage with service users who have had negative experiences, fearing criticism. Additionally, many lived experience workers face financial and structural barriers, as much of their work is unpaid or undervalued. Despite these obstacles, Rachel remains committed to her advocacy. She credited the Royal College of Psychiatrists with providing her a platform to share her experiences and contribute to policy discussions. "The College has been instrumental in giving me the confidence to believe that my voice matters," she said.

Advocacy and Activism: A Lifelong Mission

For Rachel, mental health advocacy has become a lifelong mission. Having left her teaching career behind, she now dedicates her time to campaigning for compassionate, relational care. She chairs a grassroots charity focused on mental health activism and serves on the board of the Centre for Compassionate and Relational Care at the Royal College of Psychiatrists. Rachel's work includes contributing to reports on addiction and trauma, speaking at conferences, and participating in training initiatives for mental health professionals. Despite the emotional toll of revisiting her past experiences, she remains driven by the hope that sharing her story will inspire change.

A Message of Hope

In closing, Rachel emphasised the importance of hope in mental health care. She recounted how a simple phrase from a psychiatrist—"You just need a hand to hold"—gave her the strength to continue. It is this belief in the power of human connection that fuels her advocacy."Compassion and relational care are not optional; they are fundamental to healing," Rachel said. She urged mental health professionals to prioritise relationships, listen without judgment, and work collaboratively with service users. By doing so, she believes we can create a mental health system that truly supports recovery and well-being.

Conclusion

Rachel Bannister's story is a powerful reminder of the transformative potential of compassionate, trauma-informed, and relational care. Her lived experience underscores the urgent need for systemic reform, from training the next generation of mental health professionals to involving service users in service design. As Rachel continues her advocacy, she offers a vision of hope—a future where mental health services are built on empathy, trust, and genuine human connection. It is a future worth striving for, and one that can be achieved through collective effort and unwavering commitment.

Interview by conducted and transcribed by

Dr Himanshu Garg

Co-Editor, iMind

Psychiatry in the Middle East:

Adopting a **Growth Mindset** to explore new challenges.

In promoting coaching & mentoring for psychiatrists to encourage peer support and professional development, the College coaching & mentoring team often explores with peers how we tend to sit in our comfort zone... but things don't stay still around us, and we could embrace challenge – learning a new way of working or taking on a new job in a new location helps us to grow, change things that are in our control, improve our working lives and wellbeing.

The author (JB) reached out to several College peers working in the Middle East – our conversations were certainly enlightening!

Giles is on a sabbatical from an NHS trust in the Midlands, while Teizeem's journey began on a sabbatical, initially with Maudsley Health in Abu Dhabi to benefit from some familiarity with UK practice. Ovais appreciates the similarities between HMC and NHS in terms of settling into clinical practice in Qatar. In the UAE, healthcare is provided via comprehensive health insurance.

Ovais Wadoo (OW) is a General Adult Psychiatrist leading neuromodulation services at Hamad Medical Corporation (HMC) in Doha, Qatar. Ovais also has medical education roles, including Clinical Professor, in HMC and Qatar University.

Teizeem Dhanji (TD) is a Child & Adolescent Psychiatrist and Medical Director, working with both young people and adults who have eating disorders, at Sage Clinics in downtown Dubai, United Arab Emirates (UAE).

Giles Berrisford (GB) is a General Adult Psychiatrist and Lead Clinician for perinatal mental health services with Maudsley Health in the UAE and looks forward to opening the first inpatient Mother & Baby Unit in the region later in 2025.

What has struck you about working in these Middle East nations?

TD: I have experienced Dubai as welcoming, tolerant and accepting of all religions and backgrounds. I appreciate the respect given by local Emiratis to expats and vice versa. The UAE is a great hub for travellers, so I have quality time with friends and family who visit throughout the year.

OW: Arab culture places a strong emphasis on family; collective decision-making is the norm, influencing healthcare delivery. I have learned to respect these cultural nuances and adapt my approach while staying true to my values.

GB: I continue learning how the culture and healthcare system works. The local population are happy to be seen by Western trained doctors and I have not encountered any language barrier. Psychiatry is an amazing job as it allows you to speak to people you would never ordinarily meet, to learn something about their lives and their thought processes – practising in a new country takes this to a whole new level.

What about challenges and opportunities – how have these played out for you?

OW: Adapting to cultural differences...and harsh summers! I learned to navigate cultural sensitivities, which has enhanced my personal and professional relationships. I have been able to grow in a rapidly developing academic health system.

GB: It is an enormous challenge establishing a new specialist service in mental health, but Maudsley Health has offered this opportunity; the new team has a careful balance between perinatal expertise across the MDT with UK experience, and committed clinicians working in the UAE for many years who are keen to develop a new service.

TD: The biggest difficulty was working out how to navigate mental health practice in a country that is new (52 years) without some structures or processes that I am accustomed to, having been born in the UK. However, there are positives in mental health awareness and reduced stigma.

How about connections with our College and/or UK groups, in relation to adjusting to new location and practice?

GB: The team at Maudsley Health (a collaboration between SLAM NHS trust and the private sector in UAE) has been more cognisant of the magnitude of the transition than I have; the team has supported me with a myriad of practicalities. I have been able to draw on networks from my prior experience as NHSE Specialty Advisor for perinatal mental health.

TD: I have connected with a group of UK-trained child psychiatrists in the UAE, continue to have College peer group meetings and attend CPD events. This has enabled continued peer support.

OW: My ongoing involvement in our College – as Chair of the Middle East Division – helps me maintain professional ties and connect to colleagues across the region.

What support networks or schemes have been made available to you (e.g. induction, shadowing, networking, coaching and mentoring) to help you settle into the new job and location?

OW: These include employer relocation assistance and onboarding programmes. Colleagues with similar experiences are invaluable in helping me understand local systems and adapt to new challenges. Building a network of peer mentors, including remote mentors, provides valuable opportunities for learning and global contributions. On a personal level, my family's support is crucial, and connecting with fellow expats provides a sense of belonging.

TD: Sage Clinics are relatively new; I have been involved in shaping the clinic with the founding clinicians. Given that Dubai has a large population of expats, it is a very welcoming (and transient) place, where people are open to making new connections. Networking is easy due to the communities that are created on WhatsApp (e.g. British Doctors in Dubai group, Middle East Eating Disorder clinicians' group), plus working with schools and GPs.

GB: Moving house, moving country, moving job all at the same time are major life events and inevitably impact your wellbeing. I had worked and trained in the same English city for 30 years, well-established with many friends and colleagues. I feel lucky to be embraced by a new team who are keen to welcome me, in UAE. It is important to meet and work with the general population to better understand the local mental health services. I have enjoyed seeing a broad range of patients and clinical presentations, not just perinatal.

Drawing from your personal and professional experiences thus far, what insights or lessons would you like to share with Adult Psychiatrists working in the four nations of the UK? (Noting that adult psychiatrists do engage in special interest areas of perinatal or eating disorders, and in transitional pathways with CAMHS)

GB: Having only worked in the NHS previously, I had not really considered how else healthcare could be provided – this has therefore been an eye-opening experience. There are many things which the NHS does well, but there are other ways of doing things from which we can learn. As a psychiatrist, it is a true privilege to have a deeper understanding with a new way of being.

OW: Adaptability, cultural intelligence, and clear communication are crucial to addressing the needs of diverse patient groups. With any move to another country, it is important to consider healthcare system, licensing process and language requirements; consider family needs and cultural fit to ensure smooth integration.

TD: The infrastructure for mental health continues to need work – there are no specialist inpatient or day patient eating disorder units in the UAE and few CAMHS inpatient beds. This means that several of our patients need to be transferred to a unit in their home countries or abroad. The transient nature of Dubai means we are also involved in considerable transitional work. Given these challenges, my experience is that one can have a real impact in the UAE.

The author (JB) moved early in his psychiatric career to the UK from Singapore, recognised for its modern and advanced healthcare system that combines public and private healthcare, funded by taxpayers' money plus state-mandated health insurance and savings. So it interests me to hear Giles, Teizeem and Ovais talk about the challenges of shifting from nationally-funded to mainly private healthcare in the Middle East – we could learn from potential benefits in relation to demand and capacity as well as in public health education, promoting personal responsibility for one's health, when one recognises the real cost of healthcare.

Our three College peers are generous in sharing their apprehensions and aspirations about moving away from the UK; they also show much courage in taking on a challenge and all the implications for self, family and established networks in the UK. Both Giles and Teizeem note the life-expanding experience and how it has added to their growth and self-development. Ovais reminds us that adapting requires flexibility, openness to new ways of working and a commitment to continuous learning. That they have endeavoured to engage with professionals across medical disciplines and communities in diverse, multicultural nations is useful learning for us in the UK about embracing cultural diversity with respect and curiosity, and about the value of nurturing networks, both professional and personal.

Dr Jeya Balakrishna

Finance Officer of GA Faculty and Associate Registrar for Coaching & Mentoring, is 'in conversation with' College peers working in the UAE and Qatar.

The Relational Practice Manifesto and Movement

This document tells the story of how a government mental health programme, shut down in 2011, led to a movement and manifesto aimed at national policy changes. It gives an overview of how and why the Relational Practice Movement emerged, and what it is now doing.

The 'Personality Disorder Problem'

The process began with a public argument between the then Home Secretary, Jack Straw, and the President of the Royal College of Psychiatrists, Robert Kendal. Kendal claimed that 'Personality Disorder' was untreatable, which Straw refused to accept. This resulted in an expensive programme to treat the 300 most 'Dangerous people with Severe Personality Disorder' (DSPD) and a community-based 'National Personality Disorder Development Programme' (NPDP).

The DSPD programme faced public and professional disagreement, especially about detention without conviction and indeterminate sentences for 'dangerousness'. The much smaller NPDP received £9.8m and started with the 'No Longer a Diagnosis of Exclusion' (NLDE) policy guide. It was a DH programme, alongside IAPT, and set up eleven community pilot projects, a national training programme, and a formal research evaluation. The successful pilot service applicants were chosen by service users who had experienced good or bad services. The workforce development programme became the Knowledge and Understanding Framework's (KUF's) 'training escalator'.

Emerging Themes

The different projects were reviewed, and frequent 'learning network' events were held. A common theme emerged: the importance of the 'quality of relationships' between service providers and recipients. This was hinted at in the formal research project, 'Learning the Lessons', and confirmed in the commissioning team's end-of-project evaluation 'Innovation in Action'.

After funding was withdrawn, those involved continued to meet, growing from a dozen delegates to the British and Irish Group for Study of Personality Disorder (BIGSPD) conference in 1999 to over 600 in 2023. The conference evolved from discussing pure research to including presentations on novel service designs and welcoming and fully including delegates with lived experience.

The 'Golden Thread'

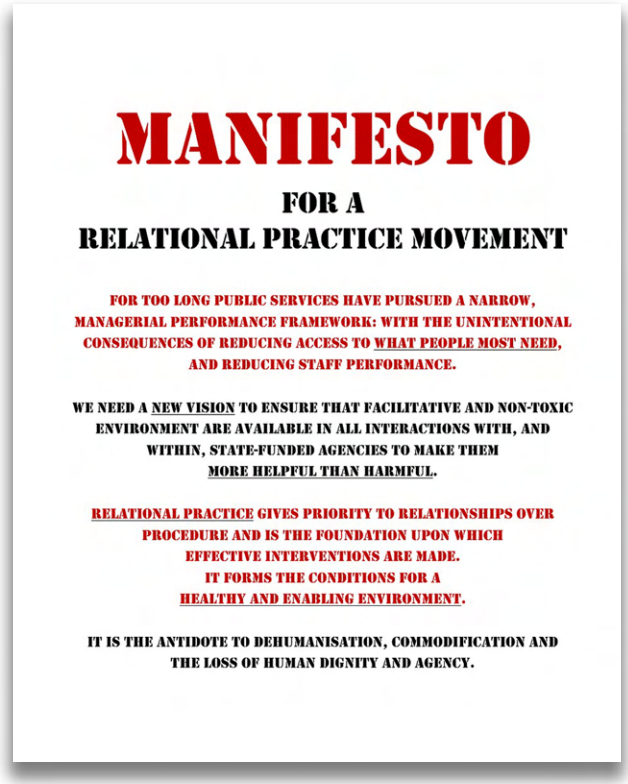
The focus shifted from competing therapies to common principles, similar to the 'Dodo Bird Verdict' from 1975. People with lived

experience emphasized that relationships mattered, not just between them and therapists, but also within therapy groups and with the wider system and culture.

Nick Benefield and Rex Haigh produced increasingly complex diagrams, resulting in the 'complexity model'. This was included by the Ministry of Justice for their 'Offender PD Programme', which continued the NPDP's - but lost the NHS community focus. The idea that 'relationships are key' persisted among clinicians, academics, commissioners, and policy-makers.

Towards a Manifesto and Movement

Since retiring from the NHS in 2022, Haigh has been energized by the idea of a movement pushing away from biomedical determinism towards something more fluid and less institutional. An initial draft of the manifesto (below) was too strident, so young 'wordsmiths' produced the 'Little Green Book', launched at the Royal College of Psychiatrists on 7 July 2023 (available on request).



Rationale

Nick Benefield described the rationale: change happens when dissatisfaction plus vision plus accessible first steps outweigh resistance. Dissatisfaction includes the commodification and dehumanization of public service culture, professionals' loss of belonging and efficacy, and emotional consequences like sadness and anger. The vision is for psychodynamically informed coordination across public services, prioritizing relational over bureaucratic concerns. As first steps, the Relational Practice Movement and Manifesto aims to bring together individuals and organizations already practicing relational methods.

The founding group includes senior policy-makers, clinicians, academics, and people with lived experience. The resistance comes from a lack of public awareness, change-fatigue amongst professionals, and unhelpful commissioning mechanisms.

After the Manifesto Launch

A formal 'strategy plan' was agreed upon, defining the movement's intention and methods. Five areas of activity have developed: networking, training, quality, research, and commissioning. Networking has included local and regional action groups and presentations at conferences: the voluntary sector, and groups with lived experience, have shown particular interest. The other four areas of activity have been defined and are led by experts committed to relational practice principles: 'Relational Learning Academy', 'Relational Research Collaborative', 'Relational Development Initiative', and 'Relational Regulation Collaborative'.

The 'Relational Learning Academy' will succeed the national Knowledge and Understanding Framework (KUF) programme, by mapping and disseminating information on non-specialist training activities, especially experiential learning.

The 'Relational Research Collaborative' will aid cooperation between centres and senior academics. The 'Relational Development Initiative' will focus on improving relational practice and therapeutic environments. The 'Relational Regulation Collaborative' aims to influence public service standards and commissioning.

Join the movement

We have just under 1000 interested people on our mailing list, including a couple of dozen from abroad - but only a handful of them are psychiatrists. If you are at all interested, we would very much welcome you as 'part of the movement' – with as much or as little involvement as you want. We have a 'collaborative' (aka steering group) of about ten which meets several times per year at the Tavistock Clinic or online. Because we are keen to keep the movement open and fluid, we are not wanting to become an 'institute' or formal organisation. We work with friendly and like-minded organisations to manage the administration and this means that the work is all voluntary, so please be aware that nobody's time is paid for!

For more information or to get involved, visit http://www.relationalmovement.net or email relationalpractice2023@gmail.com

Nick Benefield

National Personality Disorder Programme Lead, 2002-11

Neelam Khwani-Connett

Chair, Growing Better Lives CIC; Lived Experience Lead, Relational Practice Movement

Rex Haigh

Consultant Medical Psychotherapist, Berkshire NHS, 1994-2022
Clinical Advisor to National Personality Disorder Programme, 2002-11

Disclaimer

It has been assumed that the author (s) discussed and took consent from the artist(s) of the attached photos

rTMS and Ketamine in Trauma-Informed Care:

Compassionate Treatment for Complex Mental Health Needs

Abstract

Within the field of psychiatry, trauma-informed care has become essential for delivering compassionate, relational care tailored to the unique needs of those who have endured complex trauma. A promising, evolving approach within this framework combines repetitive transcranial magnetic stimulation (rTMS) and ketamine therapy for treating patients with conditions such as treatment-resistant depression (TRD) and post-traumatic stress disorder (PTSD). This article explores the efficacy and trauma-sensitive aspects of rTMS and ketamine, and how these treatments provide new avenues for compassionate, relational psychiatry.

Introduction

Both rTMS and ketamine are at the forefront of treatment modalities for severe and treatment-resistant mental health conditions, offering a novel approach where traditional therapies may fall short. rTMS, a non-invasive brain stimulation method, modulates brain activity in mood-related areas and has shown efficacy in reducing depressive symptoms with minimal side effects (Perera et al., 2016). Ketamine, meanwhile, has emerged as a rapid-acting antidepressant, particularly effective in cases of TRD, and offers a reduction in symptoms such as suicidal ideation through modulation of the NMDA receptors (Abdallah et al., 2018). In a trauma-informed care context, these therapies present unique benefits.

rTMS and Ketamine: A Trauma-Sensitive Approach

Trauma-informed care seeks to foster safety, trust, and choice within therapeutic settings. For many patients, traditional pharmacotherapies or therapies may feel invasive or lack the rapid response needed for symptom relief, especially in cases of severe depressive or PTSD symptoms. By integrating rTMS and ketamine into a care plan, psychiatrists can offer treatment options that not only reduce physical intrusion but can also provide quicker symptom relief, contributing to a safer and more supportive treatment experience (George et al., 2010).

Clinical Efficacy in Trauma and Depression

Studies indicate that rTMS effectively reduces symptoms of depression, even in patients unresponsive to antidepressants, with low side-effect profiles. For patients with trauma histories, the minimal invasiveness of rTMS supports the trauma-informed principle of reducing re-traumatization. Ketamine, similarly, has shown rapid efficacy, with results emerging within hours to days—crucial for

individuals struggling with suicidality or severe depression. Moreover, ketamine's ability to modulate affect and reduce hyperarousal symptoms aligns well with the needs of PTSD patients (Feder et al., 2014).

A Compassionate, Relational Model for Psychiatry

This combined approach emphasizes not only effective symptom management but also a respectful, patient-centered approach. Psychiatrists practicing trauma-informed relational care recognize that treatments, particularly those offering rapid relief, can play an essential role in building therapeutic trust and stability, both of which are crucial in trauma recovery. The relational nature of trauma-informed care ensures that the psychiatrist and patient engage in a collaborative, empathetic therapeutic relationship, providing a stabilizing presence during a transformative treatment course (SAMHSA, 2014).

Conclusion

In an era where trauma-informed care is paramount, rTMS and ketamine offer innovative, compassionate treatment options for patients with complex mental health needs. This approach aligns with the Faculty's mission of safe, therapeutic, and relational care that addresses mental health needs comprehensively and respectfully. As psychiatrists, embracing such methods allows us to embody compassion in our clinical practice, integrating science and empathy to promote healing in those we serve. (Mikellides, 2022)

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Disclaimer

Ketamine is licensed (i.e., officially approved) for medical use in the European Medicines Agency (EMA) area, which includes EU countries and a few others (like Norway, Iceland, and Liechtenstein). This usually refers to **esketamine (Spravato)**, which is licensed for treatment-resistant depression, for example. Ketamine as the original racemic mixture is used off label for Mental Health around the world.
The UK has its own regulatory authority — the MHRA (Medicines and Healthcare products Regulatory Agency) — and its licensing decisions can differ from the EMA's, especially post-Brexit.

Georgios Mikellides
MD, PhD, FRCPsych

Director, Centre for Repetitive Transcranial Magnetic Stimulation, Cyprus rTMS
Clinical Assistant Professor, University of Nicosia

Interview with Prof Swaran Singh

Can you introduce yourself?

I am a Professor of Social and Community Psychiatry at the University of Warwick and a Consultant Psychiatrist for the Coventry and Warwickshire Mental Health NHS Trust's Early Intervention Team. I am also the Associate Medical Director for Research and Innovation. Additionally, I hold various other roles, both big and small.

I trained in India in 1987 and came to the UK in 1991. Initially, I worked in Nottingham before setting up the first Early Intervention Service in London in 2001. In 2006, I moved to Warwick, where I have been based ever since.

What are your thoughts on receiving the RCPsych General Adult Faculty's Lifetime Achievement Award?

I am absolutely delighted. It is a pleasure and a privilege to receive this award—it is a genuine honour. There is nothing quite like peer recognition for one's self-esteem, and having my peers judge my work so positively is deeply gratifying.

What do you consider your key contributions to psychiatry?

I see my contributions to psychiatry in four distinct areas

1. Epidemiological Studies and Ethnic Minority Mental Health (1990s):

My early research focused on epidemiological studies of first-episode psychosis and the pathways to care for people with severe mental illness from ethnic minority backgrounds. My first major work aimed to identify the real barriers and challenges they face.We have successfully shifted the debate from the simplistic accusation that psychiatry is institutionally racist to a more nuanced understanding of how psychiatry is perceived, the role of cultural differences, and how mutual mistrust contributes to this complex phenomenon.

We also demonstrated practical ways to improve these care pathways. Our research showed that identifying and treating psychosis was not working well—people with schizophrenia were often receiving treatment only two to three years after the onset of their illness. We had to intervene earlier to assess whether treatment was effective.

2. Early Intervention in Psychosis:

At the time, there was a general belief that schizophrenia was a chronic and disabling illness and that our role was merely to manage its decline. This approach reflected a therapeutic pessimism about psychosis.

Having trained in India, I had seen different ways of working and better outcomes in some patients.

Along with other pioneers such as Max Birchwood from Birmingham and Pat McGorry from Australia, I helped establish early intervention models. In 2001, I set up an Early Intervention Service in London because I was convinced that delaying diagnosis and treatment—due to stigma or a narrow focus on symptom management—was not enough.
By 2004, we had enough data to show that early intervention was the way forward. Today, I am proud that specialist early intervention services exist for people experiencing first-episode psychosis.
In 2012, the Schizophrenia Commission Report, chaired by Robin Murray, stated that early intervention was the most positive development in psychiatry since deinstitutionalization. I am proud of what we have achieved in improving care for first-episode psychosis in the UK. Early intervention represents a genuine advancement in how we manage emerging psychosis.

3. Transitions Between CAMHS and Adult Services:

Through our research, we also identified a major issue: the transition at the age of 18. There were significant differences in how CAMHS (Child and Adolescent Mental Health Services) and adult services managed care. Young people receiving care in CAMHS often experienced a completely different model of care compared to those entering adult services for the first time.
We conducted the first longitudinal transition study on psychosis, which revealed major weaknesses in the interface between these services. Today, I am proud that transition care has become a worldwide priority, and England has led the way in setting up new models of care for the 0–25 age group.

4. Global Mental Health Initiatives:

More recently, I have returned to my geographical roots by working to improve services for severe mental disorders in low- and middle-income countries. I am currently involved in projects across sub-Saharan Africa, India, and Southeast Asia to enhance psychiatric care and address emerging mental health challenges.

> Psychiatry is an extraordinarily broad discipline—we must understand psychology, anthropology, sociology, culture, humanities, and the arts.

What are your thoughts on compassionate and relational care in psychiatry, especially given the increased demand for services and workforce shortages?

I initially trained as a surgeon before moving to psychiatry, and I remain astonished by how effective psychiatric medications can be.
We must not forget that psychiatry has done more to alleviate human suffering than any other branch of medicine.
I believe there is both a craft and an art to psychiatry. The craft involves the biomedical practice of psychiatry, while the art is about being a healer—offering compassion and human connection to those who suffer. Both are essential, and neither is sufficient on its ownA good psychiatrist must be a master of psychopharmacology while also understanding the therapeutic effect of human connection. If we want patients to take their medication, they must first trust us. Building relationships is the foundation upon which all interventions depend.
Relationships based on compassion and trust are the building blocks of psychiatry, and I

I believe they are absolutely fundamental. Other areas of medicine and surgery are only now beginning to realise this.

What advice would you give to colleagues and resident doctors?

My first piece of advice is: be proud of what you do.

Psychiatry is an extraordinarily broad discipline—we must understand psychology, anthropology, sociology, culture, humanities, and the arts. It is far too vast to be labelled as merely a specialty within biomedicine.

We should also be prepared to question our own work. Sometimes, there is a seductive appeal to joining in with psychiatry-bashing, but this does a disservice to our field and, more importantly, to our patients.

I have worked in parts of the world where there are very few psychiatrists, and the reality for patients in those regions is grim. I have personally encountered cases where people with mental illness have been chained, shackled, or even nailed to prevent them from running away.

Embrace uncertainty. The mind is not a physical entity like the cardiovascular or respiratory system. Despite this complexity, psychiatry has made significant progress. While we may not always fully understand how our interventions work, we do know that they do work.

So, first:

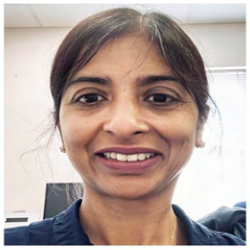
- Be proud of what you do
- Embrace uncertainty
- Do not let uncertainty shake your confidence in your work

Secondly:

- Learn from each patient.
- Every patient encounter should serve two purposes: it should be therapeutic for the patient and a learning experience for us, the psychiatrists.

Do you have any final thoughts or advice for our readers?

Every instance of suffering is an untold story. Mental suffering is often invisible, so we must ensure that every patient's story is heard, acknowledged, and validated.



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Community Nottingham City North LMHT

Breaking the Cycle

Patients with a history of trauma have a tendency to repeat traumatic experiences or situations throughout life, for example through flashbacks and nightmares, their actions and hallucinations or by putting themselves in situations where the event could happen again. Freud called this 'repetition compulsion' and understood this as an unconscious tendency in an attempt at mastering problems. He described the psychoanalytic process whereby repeating becomes a way to remember and work through repressed material, and ultimately to gain a deeper understanding and resolution of unconscious conflict (Freud, 1914).

Remembering, Repeating and Working Through

The Cassel Hospital, a national, centrally funded NHS service, offers assessment and treatment on an inpatient and outpatient basis to patients experiencing severe mental health problems with a background of complex trauma. Often, those suffering in this way inflict further damage on their bodies. It can be difficult to comprehend the mental states underlying such acts, although the disturbance created or communicated by these wounds may be felt strongly by all around. This experience is one which staff and patients have long sought to make sense of in a psychoanalytically informed therapeutic community.

The concept of a therapeutic community

Thomas Main, psychiatrist and psychoanalyst, who coined the term 'therapeutic community' suggested that 'by tradition a hospital is a place wherein sick people may receive shelter from the stormy blasts of life... The concept of the hospital as a refuge too often means, however, that patients are robbed of their status as responsible adults.' (Main T., 1946). Patients at the Cassel are informal and play a vital part in their own and each other's treatment, knowing that there are healthy parts to all our patients, and take on active roles and responsibilities for the running of the hospital, alongside staff. Relationships between patients are at the centre of the therapeutic work (relationships between staff and patients are also important but mainly as a way to support collaboration between patients).

For a patient's account of Life in a Therapeutic Community please see link below: Life in a Therapeutic Community — EUPD Recovery

Staff help patients manage their difficulties in a thoughtful and emotionally responsive way, whilst challenging and encouraging enquiry into destructive behaviours. Risk is managed via the therapeutic relationship, rather than through close observation and restriction. The aim of treatment is to help patients reduce self-harm, suicidal and self-destructive behaviours, build healthy relationships and

integrate back into the community, with a reduced reliance on mental health services.

Challenges and potential benefits for patients and staff

The treatment can be hard work and challenging for patients who require motivation and courage to face their traumatic past and reflect on themselves. However, patients also benefit from being part of a community as one former patient described: 'The other patients become your support and all sorts of odd and familiar dynamics get played out simply just through living, eating, working, playing together. There will be rows but there will be repair' (former patient, 2019). For staff, and the psychiatrist, this means comprehensive training, working as a team and having to tolerate uncertainty and not knowing. It requires self-reflection and regular reflective spaces as a team. One of the hallmarks of a therapeutic community is the 'culture of enquiry', yet as in all organisations it can be a struggle to maintain a space where this can adequately function. Positive patient outcomes, strong team collaboration, shared values and belief in the therapeutic model, empowerment and autonomy can contribute to staff satisfaction.

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Can relational care be integrated in acute psychiatric settings?

Therapeutic communities for patients with borderline personality disorder have been available in the NHS, prison and other settings for many years. The principles of this way of working are supported by NICE guidance (CG78), evidence based (Lees et al. 2004) and cost effective (Campling P, 2001). Local intensive therapeutic services can reduce the number of costly out of area placements and provide a model for future rehabilitation pathways (Mizen S. 2024).

The latest Health Services Safety Investigation Body (HSSIB) investigation report (24 Oct 24) offers opportunities to make improvements to systems and future plans to support the delivery of therapeutic care in acute mental health settings. Therapeutic communities have the potential to improve patient outcomes, enhance staff's job satisfaction, well-being and retention. At the same time, they are under-researched, in particular in terms of identifying and maximizing the potential therapeutic benefit. Veale et al. (2014) suggest that compassion-focussed therapy and social learning theory offer new approaches for a therapeutic environment, and have developed a scale to measure interpersonal processes in a therapeutic environment.

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Dr. Miriam Barrett

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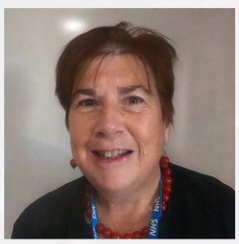
Compassion at Christmas

Our ward is an acute male ward with a multidisciplinary team very focussed on compassionate trauma-based care. Acute mental health wards in current times accept all patients unlike more specialised services so its always a learning experience to see what care and treatment is needed for acute mental health patient group.

Mr X neurodiversity estranged from family is admitted due to social care crisis and has limited communication skills thus communicates by his art. What is fascinating he draws each member of the multidisciplinary team and we even had a sketch of father Christmas pinned to notice board during the festive period. On reflection art therapy is a form of psychotherapy used as a medium of expression for our patient group and can be a very emotive way of viewing distress.

Our ward with other teams across hospital site decided to celebrate Christmas for our patients with an Art exhibition in the meeting area of our local canteen. Our catering staff supported with the necessary infra structure and of course for patients and staff mince pies and chocolate. A simple exhibition brought so much happiness to all the patients and we had various specialities including perinatal and forensic wards represented at exhibition. It is wonderful use of art therapy in such a compassionate healing way but so simple, the original idea being how can Mr x can feel valued?

Disclaimer
It has been assumed that the author discussed and took consent from the artist(s) of the attached photos



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The Lemon Tree

In the dimly lit room, shadows danced across the walls, their shapes indistinct but deeply familiar, like the fragments of memories that often surfaced unbidden. I sat across from a patient whose story mirrored my own in many ways—tales of displacement, survival, and the quiet resilience forged in the crucible of trauma.

I was once that person, fleeing a homeland ravaged by war, where the sound of bombs punctuated my days, and the uncertainty of survival haunted my nights. I remembered the weight of leaving behind everything familiar—the smell of the earth after rain, the hum of evening prayers, the faces of loved ones who could not escape. That weight had settled in my chest for years, threatening to silence the voice I now used to comfort others.

As my patient spoke, their words were halting, fragmented, laced with a pain I knew all too well. I saw it in their trembling hands, in the way their eyes avoided mine when they spoke of what they'd lost.

It was impossible to sit there and not be reminded of my own journey. I, too, had fled Sudan, my homeland, torn apart by war. The sounds of bombs and the panic of escape were seared into my memory. I left behind more than a home; I left behind the life I thought I would always have.

I had fled Sudan, leaving behind not just a home but a piece of my soul. It was there, in that parched land, where a lemon tree stood tall in my family's front garden.

My Father had tended to it with care. My mothers' hands gently plucking lemons at dinner time, filling the air with their zesty perfume. That tree was more than a plant; it was a symbol of my roots, my resilience, and the simple beauty of an ordinary life. But now, I had learned it was gone. No one had watered it after we left. It had withered, like so much of what I had lost.

Survivor guilt gnawed at me in quiet moments, the unrelenting question: Why me? Why did I survive while so much of my country, so many of my people, perished or remained trapped? I carried this guilt into every space, even as I sat with patients who looked to me for healing.

And yet, as a psychiatrist, I understood the power of grief—its ability to fracture and, paradoxically, to connect. I recognized it in the way my patient's voice trembled when they spoke of a family member left behind, or in the silent tears they shed for a home they could never return to.

"It's okay to mourn what you've lost,"
I told them softly,
my voice steady but tinged with the vulnerability
of someone who knew.
"Grief doesn't mean we're weak.
It means we loved deeply."

"It's okay to mourn what you've lost," I told them softly, my voice steady but tinged with the vulnerability of someone who knew. "Grief doesn't mean we're weak. It means we loved deeply."

I paused, feeling the lump in my throat as the image of the lemon tree surfaced. "When I think of what I've left behind, I often think of a lemon tree in my family's yard. It's gone now because no one was there to care for it. I grieve for that tree, for my country, for the life I had. But I also know that loss doesn't mean the end of love. It means we carry it with us in different ways."
The patient looked at me, their gaze softening. It was the connection they needed, the understanding that their pain wasn't theirs alone to bear.
My journey as a compassionate, trauma-informed psychiatrist was as much about my own healing as it was about guiding others. I had faced the darkness of displacement, the despair of starting over, and the long process of reclaiming a sense of self. These experiences shaped my practice, allowing me to approach each patient with a depth of empathy that could not be taught.

When I left the session that day, I stepped into the sunlight and closed my eyes. I thought of the lemon tree, its branches heavy with fruit, the smell of its blossoms in the warm air. It lives on—not in the soil of Sudan, but in my memory, in my work, in the hope I try to nurture in others. In tending to their wounds, I tend to my own. And in every connection, every moment of shared understanding, I water the roots of something new—a resilience that grows, even in the face of loss.

Hala Elhardlu

CT2 Psychiatric Resident
to Dr Jatan Parmar
Northamptonshire Healthcare
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Trainee's Opinion:

Compassionate, trauma informed and relational psychiatrist

Half a decade ago when I started my core psychiatry training having ICD10 diagnostic manual in one hand and Maudsley prescribing guidelines in the other, I thought I had it all covered to be a competent psychiatrist. I still remember one of my very first review in an outpatient clinic where I felt an immense amount of self-inflicted pressure to box all the symptoms described by a patient into a particular diagnosis. I was lucky to have a supervisor who told me that having 'no diagnosis' is also a diagnosis, and that it is easy to know when to prescribe psychotropics whereas it is difficult to know when not to prescribe them. I learned a very valuable lesson quite early in my psychiatry career: To look beyond a diagnostic label and not resort to medication for a symptomatic control as a quick fix without delving into the underlying driving force of presenting problem. These valuable lessons paved way for me in striving to become a compassionate, trauma informed and a relational psychiatrist over the years.

Few months ago, I reviewed a gentleman who was referred to my team in early intervention service with some diagnostic ambiguity. I was able to flesh out psychopathological features, arrived at a diagnosis of first episode psychosis and came up with a pharmacological management plan. I was satisfied with my assessment and treatment plan and confidently brought it up in my weekly supervision as a case-based discussion. The feedback was nothing less than an eye-opener. As anticipated, I received positive feedback about the assessment in general, and that treating psychosis will not be an issue given my specific interest in psychosis and relevant experience. However, a question was posed to me by my supervisor which made me think hard.

The question was: what do these symptoms represent? Why is the patient presenting with these symptoms at this time in life?
These questions echoed another question which was regularly put forward by the leader of a Balint group which I was a part of a few years ago; 'What do we know about this patient?'
It shouldn't be difficult at a higher trainee level how to elicit and manage symptoms of psychosis and to describe the presence or absence of unusual perception and belief system. Understanding the origin of experiences can help us value the person more holistically rather than limiting them to a

particular diagnostic category.
By virtue of this notion, I can categorically say that my scope of practice has changed dramatically over recent past and in all of my clinical encounters, I strive to understand the person beyond their described symptoms. In other words, putting the patient as a person first rather than simply addressing their symptoms is what makes a psychiatrist compassionate, and being a compassionate psychiatrist is what we all psychiatrists should aspire to be.
For me, being compassionate means to provide a protected space to an individual where emotional support is fostered so that they can safely discuss their life journey which may have led to current life struggles. My approach would be to be empathetic, non-judgemental, considerate and respectful so that the individual feels heard, understood and validated in their experiences.

Trauma-informed care addresses the underlying causes of distress which presents in the form of various symptoms, rather than focusing exclusively on symptom management. It leads to asking a question, what do these symptoms represent? Is it enough to gather that the person is hearing derogatory comments of an unrecognised voice which is distressing to them and prescribe psychotropic medication for it? Or should we be probing more into past to find out any events of trauma to make sense of what could this voice be representing? Trauma-informed psychiatrist will not resort to the medication as a sole
treatment as they will know the medication can only mellow down the voice, but they may not resolve the underlying source which could be trauma-induced and may need a psychological intervention to come to terms with. It is fair to

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symptoms at this time in life?

Understanding and recognizing the widespread impact of trauma on mental health is an important attribute of being a Trauma-informed psychiatrist. Trauma from any significant adverse life event can severely impact an individual's psychological and emotional well-being. Understanding that trauma is often at the base of many mental health conditions is the focus of this approach.
As a trauma-informed trainee psychiatrist, I attempt to familiarize myself with the individuals' background and any likelihood of past trauma which may potentially be perpetuating the ongoing symptoms. Working in Psychosis team and dealing with common presenting symptoms like delusions and hallucinations,
behind these experiences and wonder whether any of these could possibly be a manifestation of any past trauma event or events.

say that as psychiatrists, we are in an extremely privileged position that people share their most personal and intimate stories with us. For an individual to be able to trust their psychiatrist to an extent that they are able to feel safe in the room to share their experiences, a psychiatrist needs to be able to build trust through connection and bonding. Psychiatrists need to work collaboratively with individuals and co-generate a treatment plan according to the values of individuals.

Preparing to see a patient in clinic by reviewing notes have two main purposes for me. One is to gather enough clinical and social information to be able to formulate a robust management plan, and the other most important aspect of preparation is to be able to find a common ground so that a decent rapport is established, and the individual feels relaxed in the

consultation room. I often ask my patients what they are watching on television these days and what are their favourite books or movies. If they are interested in travel or cricket, I make sure to spend a few minutes to have a routine conversation with them which serve as a change from prescriptive medical interview questions. Strong therapeutic relationship fosters a collaborative environment where the patient feels comfortable exploring their thoughts, feelings, and experiences.

To conclude, a compassionate, trauma-informed, and relational psychiatrist approaches an individual's mental health in a holistic and personalized manner. I consider myself fortunate that I have been trained by various psychiatrists along my training journey to be aware of the importance of being compassionate, trauma-informed and relational. I aspire to be a psychiatrist who not only challenges the danger of a purely medical model of treatment, and advocate for a holistic biopsychosocial model, but also demonstrate how a compassionate, trauma-informed, and relational psychiatrist can contribute to a significant positive change in the life of an individual by looking beyond their presenting symptoms and diagnosis.

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Bringing Co-Creation to Life:

A **Reflective** Conversation

Co-creation has rapidly become a cornerstone of modern mental health services, particularly at Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). But what do we truly mean by co-creation? At its core, co-creation means genuinely working together towards shared goals—not merely consulting, but actively collaborating. It represents a fundamental shift in how we view each other, moving away from traditional hierarchies towards equal partnerships between staff, patients, carers, and partner organisations (TEWV NHS Foundation Trust, 2025).

The journey towards genuine co-creation has required patience, honesty, and the courage to challenge established norms. Over three years, extensive conversations, workshops, and informal tea-and-chat sessions have collectively shaped our Co-Creation Framework. More than 500 individuals—patients, carers, staff, and partners—contributed, transforming what could have been just another document into a meaningful, evolving guide (TEWV NHS Foundation Trust, 2025). This collective effort illustrates that co-creation is not simply about outputs, but about deeply embedding shared values into everyday practice.

Why is co-creation so crucial to the future of mental health services? Literature consistently emphasises that involving individuals with lived experience in leadership roles significantly enhances the compassion, relevance, and effectiveness of care (NHS England, 2024). Those who have personal experience of mental health challenges and navigating healthcare systems offer invaluable insights, helping to ensure services are genuinely responsive and patient-centred. Yet, achieving this genuinely shared leadership is not straightforward.

Research indicates significant challenges in shifting power dynamics and establishing true parity between lived experience and professional expertise (ImROC, 2024). Often, peer workers and those with lived experience report feeling constrained to limited roles rather than seen as equal partners shaping systemic change. Our Co-Creation Framework explicitly works at addressing these challenges, underscoring the equal importance of lived experience alongside clinical and professional insights, and actively seeking to dismantle traditional power structures.

Practically, this needs to translate into tangible, impactful changes within TEWV.

A notable example is embedding co-production deeply into personalised care planning. Historically, care plans might have been created largely by clinicians with widely variable patient input. Now embedded into a personalising care planning policy, our approach positions service users and carers as genuine partners.

Keyworkers are no longer just coordinators; they are facilitators of ongoing, meaningful dialogue about what truly matters to the individuals they support. Co-production training will be implemented to empower staff to move beyond procedural care planning to relationship-based, genuinely person-centred support.
However, meaningful collaboration requires continuous investment in training, supportive infrastructure, and reflective practice.

create environments where every voice feels respected and valued.

Expanding leadership roles for individuals with lived experience at TEWV has been transformative. Introducing dedicated Lived Experience Directors and peer support leadership roles has significantly shifted organisational culture.
These roles ensure that lived experience perspectives influence strategic decision-making, service design, and policy development. Yet, gaps remain, highlighting the ongoing challenge of fully integrating lived experience leadership across all services. Literature supports this approach, confirming that embedding lived experience at leadership levels fosters deeper organisational learning, more responsive services, and improved patient outcomes (ImROC, 2024; NHS England, 2024).

Authentic co-creation demands engaging voices traditionally unheard or marginalised — young people, autistic individuals, those with learning disabilities, and carers.

Real co-creation is not a straightforward tick-box exercise; it involves navigating complex interpersonal dynamics, challenging entrenched ways of working, and consistently reinforcing the importance of mutual respect and shared understanding. These nuances remind us that authentic co-creation is as much about cultural change as it is about practical methodologies.

Another critical insight from our journey has been the indispensable role of diversity and inclusion. Authentic co-creation demands engaging voices traditionally unheard or marginalised—young people, autistic individuals, those with learning disabilities, and carers. To ensure inclusive participation, TEWV has implemented dedicated roles, targeted outreach, and tailored communication strategies. This proactive approach helps ensure our conversations and outcomes reflect the full diversity of the communities we serve. Equally important is acknowledging existing power imbalances and working intentionally to

Capturing and learning from patient and carer experiences further illustrates how co-creation can drive meaningful improvement. Moving beyond traditional satisfaction surveys and routine feedback mechanisms, recent improvements to our complaints handling process exemplify this shift. Feedback, including complaints, is now seen as valuable insight rather than an administrative burden. Through empathetic, structured dialogue, complaints become powerful tools for learning, reflection, and continuous service improvement. This approach aligns with broader evidence indicating that meaningful patient engagement significantly enhances service responsiveness and empathy (ImROC, 2024).
Despite significant progress, our co-creation journey is far from complete. Ongoing reflection and dialogue are essential. Critical next steps for TEWV include developing fair and transparent reimbursement policies for involvement members, creating clear and robust processes to address and resolve

conflicts or challenges collaboratively, and ensuring comprehensive training and support structures for all participants. These commitments are essential to ensuring that our Co-Creation Framework continues to be dynamic, relevant, and truly lived.

Sustaining meaningful co-creation also means continuously evaluating our practices and remaining open to adaptation and innovation. It requires creating spaces for honest conversations about what is working, what is not, and how we can improve. It also involves engaging actively with external literature and evidence-based practices to keep our approach fresh, informed, and effective.

Furthermore, building and nurturing relationships with external partners—such as voluntary, community, and social enterprise (VCSE) organisations, local authorities, and broader NHS bodies—will be crucial. Co-creation is inherently collaborative and benefits immensely from broader partnerships that provide fresh insights, complementary strengths, and opportunities for shared learning.

Strengthening these partnerships can enhance our collective capacity for innovation and improve mental health outcomes for our communities.

In conclusion, co-creation at TEWV represents more than just a strategic initiative—it embodies an ongoing, evolving practice rooted deeply in shared humanity and mutual respect. Co-creation invites all participants—staff, patients, carers, and partners—to be active contributors to a transformative vision for mental health care. The journey ahead will undoubtedly involve complexities and challenges. However, the potential rewards—true empowerment, meaningful connections, improved care, and stronger communities—make every step worth taking.

As we continue our collective journey, maintaining a reflective, honest, and inclusive approach will be essential. By doing so, we ensure co-creation remains not only a powerful methodology but also a living testament to the possibility of genuine partnership, resilience, and shared humanity in mental health services.

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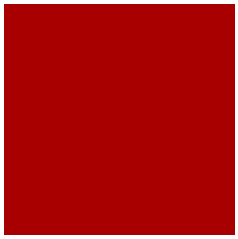

Chris Morton

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