Faculty of Rehabilitation and Social Psychiatry

Newsletter

February 2026

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Contents

Chair's Message

Dr. Andrew Molodynski

It's great to see this, the first edition of the Rehabilitation and Social Psychiatry faculty newsletter in the new 4-year cycle. I feel honoured and privileged to be the new chair of the faculty and also feel the weight of responsibility of representing all the people who work with some of the most unwell and disadvantaged patients in the mental health care system and those people themselves and their families.

We have an excellent and active committee. Hina Tahseen has taken over as vice chair and is in charge of this newsletter. She is a rehabilitation psychiatrist in the West Country and has brought huge dynamism and new thinking to our faculty. Saeed Alam is our new treasurer and is getting on top of all the financial aspects to let us do the work that we so desperately need to do to support you all and to support and to advocate for the best care for the people that you look after.

I have been a full time NHS community consultant for more than 20 years now and I'm very aware of how things have changed over that time. There have been many positive changes in services and there is certainly more choice for patients, but at the same time it is abundantly clear that continuity of care has all but been lost in many places and relationships between doctors, nurses, and our patients are not what they were or what they should be. There are many more cracks for people to fall though. Significant service changes have been made in the absence of an evidence base. The clearest example of this was the decision to separate inpatient from community services over the last 15 years or so. It is really heartening to see the beginnings of an approach from the college over the last few years with people working hard to challenge this and campaigning for good quality longitudinal care where relationships matter again. We simply must move away from the overly compartmentalised and packaged services that we have at present in many parts of the country.

I pledge to you that we will work as hard as we can for our faculty to play its part in this. In many senses we are extremely well placed because good quality rehabilitation psychiatry and good quality social and community psychiatry absolutely have relationships with patients at their heart. By definition we take the long view of someone rather than an 'on the day snapshot' which is so common and so damaging.

We have developed communications to all service providers, commissioners, and those in government stating very clearly that there is well evidence-based models for care and that there is a responsibility upon commissioners and providers to ensure these are available. **This is not in any way optional**, as one might sometimes think in meetings of people in senior positions in commissioning and provider organisations! We aim to hold these people to account and to ensure that this group of patients with complex psychosis, our patients, get the care that they need so that they can have the best possible outcomes in life and that those around them can feel optimistic and supported. In turn, we believe that this will help all of us to feel more fulfilled and positive about what we do.

We are very keen to have the input of all members of the faculty (and others!) so please do get in touch with us with any ideas you have, anything you would like us to do, and anything you would like us to stop doing!

We are hoping that over the next few years our excellent conferences so ably organised by the indefatigable Raj Mohan will continue to be even more inclusive and that people will be able to give their ideas and take part. We had an excellent conference in Cardiff in November that is described elsewhere in the newsletter We had some top-class speakers who gave their time and who travelled from different parts of the country to keep us up to date with the latest developments in clinical care and also the wider aspects of psychiatry and the situation of many people with severe mental health problems.

For 2026, we have managed to move our conference forward in the college calendar to September as we hope that this will work better for a lot of people than a late November slot, a time of year when the days are short, the weather usually atrocious, and when people are less keen to travel and are planning for Christmas instead.

Please do get in touch with us directly and please send in things for the newsletter as we want to have as varied and as nutritious a diet as possible for ourselves and for all members.

Faculty Prizes and Bursaries (2025)

Congratulations to Annelore Figari, winner of the Faculty of Rehabilitation and Social Psychiatry Medical Student Essay Prize 2025, for her essay **"How Best Can we foster hope and maintain optimism in psychiatric rehabilitation?"**

We are also pleased to congratulate Dr Jasmine A Hoque, recipient of the 2025 Faculty of Rehabilitation and Psychiatry Bursary, supporting attendance at the annual conference.

Finally, we warmly congratulate Sridevi Kalidindi, who received the Lifetime Achievement Award (see photo below).

Open faculty prizes

Save the Date – Annual Conference 2026

24-25 September 2026 at RCPsych headquarters, London

Faculty of Rehabilitation and Social Psychiatry Conference 2026

Our Annual Conference 2026 is already taking shape — and we want your ideas in the mix.

What themes matter most right now?

What sessions would you want to attend?

Panels, debates, workshops, bold provocations — all welcome.

Have a great idea or want to get involved?

Send it to our email address: rehab.social@rcpsych.ac.uk

Let's shape a conference that reflects the energy, challenges, and ambition of our faculty.

Vice-Chair's Message

Dr. Hina Tahseen

Hello everyone,

A Very Happy New Year!

Welcome to the January 2026 Faculty newsletter. This issue brings together work that reflects rehabilitation and social psychiatry as we practise it: complex, practical, and centred on people whose recovery is rarely quick or straightforward, but always worth pursuing.

You'll find a strong piece on Extended Packages of Care (EPCs) and what they can offer when someone is stuck in hospital because the community cannot yet hold the level of support they need. We also include an article on AI and VR in autism care, exploring where technology might genuinely help with engagement and personalised interventions — while keeping the therapeutic relationship at the centre. Ros' carer perspective is one I'd encourage everyone to read closely: it cuts through service language and brings us back to what matters — dignity, belonging, and helping someone build a life that feels worth living. I've also included a short article on Mental Health Act reform through a rehabilitation lens, focusing on the practical implications for review processes, thresholds, and the discharge realities we face every day.

Congratulations again to our prize and bursary winners. You'll also find our successful Annual Rehab Conference 2025 highlights in this issue, and details about this year's conference in September 2026. Plans for our Faculty Conference 2026 are well underway. Following the success of last year's event, we're focusing on the themes you've identified as priorities - from practical implementation challenges to innovative service models. We particularly encourage members to submit abstracts sharing your local innovations, however modest they might seem. Often the simplest ideas have the greatest impact when shared across services. If you have suggestions for sessions, speakers, formats, or themes, please send them in. We want the 2026 programme to be shaped by members and grounded in real-world practice.

Thank you to everyone who contributed to this issue. Your willingness to share experiences and innovations makes this newsletter a genuine community resource. Please keep contributions coming - whether it's a reflection on MHA reforms, a QI project that surprised you, or an innovation you're proud of. Here's to 2026 - a year that will bring challenges, but also opportunities to demonstrate rehabilitation psychiatry's essential value.

Best wishes,

Dr Hina Tahseen

Vice-Chair, Faculty of Rehabilitation and Social Psychiatry (RCPsych)

Newsletter Editor

Let’s Care Deeply: The Era of The Extended Care Packages

By Dr Somya Pandey and Dr Azmathulla Khan Hameed


Dr. Somya Pandey


Dr. Azmathullah Khan Hameed

Having had experience in the complex presentation of autism and intellectual disability, we have come to understand the importance of bespoke services in the care provision for such patients—not only to hasten their discharge from inpatient settings, but also to provide all-round, person-centred care targeting their specific needs and behaviours that challenge. Autism and intellectual disability present unique challenges to support services, often unmatched in their complexity.

Some individuals with autism and learning disabilities require long-term admission to specialist inpatient units due to highly unpredictable and aggressive behaviours. As inpatients, they often present serious risks of harm to others, sometimes even grievous bodily harm, necessitating enhanced observation levels—such as 3:1 or 4:1 staffing ratios—with minimal chances of reduction.

Encouraging participation in inpatient activities and therapies proves to be a daunting task, with individuals often being reluctant to engage - requiring long term, relentless planning and troubleshooting of implemented plans. With overall slower rates of progress through the inpatient system, planning for discharge also becomes convoluted. While both the inpatient and commissioning teams continue to invest in the care of these patients, the outlook for a life in the community oftentimes looks bleak.

A significant issue arises when patients become “stuck” in inpatient services without a viable discharge plan, particularly when they no longer meet the criteria for detention under the Mental Health Act. Despite regular Care and Treatment Reviews, meaningful transition into the community can seem nearly impossible. This is where **Extended Packages of Care (EPCs)** emerge as a vital solution.

EPCs are highly specialised, structured services designed for individuals with complex needs. These packages often mirror the level of inpatient support, including continued high staffing ratios (2:1, 3:1, or even 4:1), provided by highly trained staff skilled in managing challenging behaviours. A multidisciplinary team—including therapists, social workers, and healthcare professionals—contributes to ongoing care provision, with input tailored to each individual. Services may be further supported by partnerships with not-for-profit organisations and educational services specialising in autism and intellectual disability.

https://www.shutterstock.com/image-photo/down-syndrome-woman-her-mother-making-2419140571

Community-based EPCs are distinct from traditional supported living arrangements, which typically cater to individuals with a reasonable degree of functionality. While those models work well for many, they fall short for individuals requiring deeper, more intensive levels of care—resulting in prolonged hospitalisation if EPCs are not considered. Fortunately, the UK is increasingly recognising the need for these specialty services.

In some cases, however, EPCs may not yet be feasible in the community. For individuals who have remained in Psychiatric Intensive Care Units (PICUs) or community inpatient units for extended periods—and have failed community placements—a *bespoke inpatient EPC* may be the most viable interim solution. These bespoke settings are designed around the individual’s needs and may include a self-contained unit with personal living spaces, a sensory room, private gardens, and robust safety measures.

The development of such care packages requires meticulous collaboration between inpatient and community teams, funding commissioners, and often the psychologists who have supported the individual across settings. This kind of intensive coordination is not only vital but essential, especially when previous attempts at community integration have led to staff injury or system breakdowns.

Currently, many of these bespoke inpatient services are delivered by independent sector providers, as NHS infrastructures may not always support such customisation. Once the patient has had sufficient interventions delivered within the inpatient EPC setup, discharge planning can then ensue. At this point, community-based EPC frameworks would be deployed for individuals requiring a high level of care and support.

https://www.shutterstock.com/image-photo/mentally-disabled-woman-second-companion-dog-1113194144

It is understandable that the costs involved in planning and structuring these settings for individuals requires a certain level of commitment, both in human as well as financial resources. Some of these settings can go upwards of million pounds in funding, to craft the necessary environment for continued rehabilitation. Whether the availability of these services will expand or diminish remains uncertain, especially in the face of funding constraints and ongoing pressures to reduce Continuing Health Care (CHC) expenditure.

Nonetheless, the 2024 Mental Health Act Reform has added urgency to the discussion. It has pushed the system to consider discharge planning more seriously for individuals with autism and intellectual disability who are otherwise detained indefinitely. EPCs—whether in community or inpatient form—are increasingly being seen as the bridge to a dignified life in the least restrictive environment.

The horizon of specialised care in this sector is within reach. It is our collective duty to embrace these evolving models, advocate for the necessary funding and infrastructure, and above all, champion the rights of individuals who might otherwise have no chance at community life. For our patients, this can mean the difference between living in a hospital setting with all its challenges, or looking out at the horizon from their own garden.

References

Pilling, S., et al. (2018). Developing services for people with complex needs: Lessons from Transforming Care. British Journal of Learning Disabilities, 46(3), 148-157. DOI: 10.1111/bld.12234

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group. (2021). Complex care commissioning policy. https://www.bnssgccg.nhs.uk/library/complex-care-policy/

NHS England (2022). National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. London: NHS England.

DHSC (2024). Mental Health Act Reform: Policy Implementation Plan 2024-2026. London: Department of Health and Social Care.

Author details

Dr Somya Pandey
Specialty Doctor in Psychiatry, Cygnet Hospital Harrow

Dr Azmathulla Khan Hameed
Consultant Psychiatrist – Autism and Intellectual Disability, Cygnet Hospital Harrow

Changing The Narrative: Celebrating Recovery in Long Term Care

By Dr Dheeraj Chaudhary

In rehabilitation psychiatry, we often work with patients whose journeys are long, complex, and sometimes disheartening. Chronic illnesses, risk histories, and prolonged hospital stays can make progress feel elusive. Amidst the regular and frequent crises and challenges of our practice, quieter stories of recovery often go unnoticed—but they are vital.

Every so often, we witness progress that reminds us of the potential for meaningful recovery—even in the most complex cases. These moments matter. They challenge assumptions, motivate teams, and inspire hope in patients and families alike. Sharing such success stories has value not just clinically, but educationally and organisationally.

One case stands out for me. A man in his late 40s with chronic schizophrenia and a serious forensic history was entirely disengaged from care. He spent most of his time in bed, was in poor physical health, with poorly managed diabetes, peripheral neuropathy and at risk of bed sores on regular body mapping. He had a long history of secure hospital admissions.

Due to an extended period of behavioural stability, I recommended a step-down and he was transferred to rehabilitation unit under my care. Initially, he showed little interest in engaging with rehabilitation. I offered full flexibility with his medication times. He accepted this. Perhaps he felt empowered by this choice—perhaps it signalled a mutual trust, with the possibility of hope being instilled by the step-down process. It may have given him a renewed sense of optimism, which changed the dynamic of the situation.

Gradually, he began coming out of his room, eating in the dining hall, interacting with others, attending his ward rounds and started utilising leaves off the ward. As his engagement increased we were able to expand his graded leave.

His psychosocial health improved along with his physical health - his diabetes became more stable, and his neuropathy improved. Some residual symptoms remained, as they often do in chronic psychosis. But they no longer dominated his life. He was able to manage his own activities of daily living, engage meaningfully with staff and peers, and take more ownership of his recovery.

We supported the re-establishment of family contact and strengthened therapeutic rapport. Working with the community team we found a supported accommodation that would accept him. After a slow, carefully managed transition, he was discharged—something we did not imagine possible when he first arrived.

This story, like many others in our field, may not fit the traditional definition of a ‘cure’, but it represents a successful rehabilitation journey. It is one that needs to be told. I am especially proud of this patient who surmounted incredible challenges and my team, who worked very hard to support his progress.

There are undoubtedly many success stories in rehabilitation psychiatry, but we do not hear about them often enough. As psychiatrists, we can be hesitant to speak about success—perhaps because progress is often slow, nonlinear, or incomplete. But this should not stop us. These stories matter because they highlight what is possible even in the most complex and enduring cases. Many of our patients have spent years in hospital, experiencing cycles of disengagement, risk, and deterioration. When one of them regains agency, reconnects with family, and takes steps back into the community, it is a remarkable achievement—no matter how modest or gradual.

Sharing success stories helps combat therapeutic pessimism. They validate the persistent efforts of staff, inspire hope in patients and families, and provide practical insights into what actually works—whether it is flexible care planning, early family engagement, or attention to physical health. They also challenge the assumption that some patients are beyond recovery, encouraging more inclusive service development. Just as importantly, they help reduce stigma by shifting the narrative from risk and long-term dependency toward growth, stability, and reintegration.

Not every patient journey will end in a successful discharge, but each step forward matters. Let us notice them, honour them, and let them shape the future of rehabilitation care. Sharing success is not just about feeling good—it is about learning, reflecting, and building better systems for those who need them most.

I strongly advocate for making space in our professional narratives to celebrate recovery—even partial, hard-won, and nonlinear recovery. These stories deserve to be recorded, shared, and reflected on. They remind us that our work makes a difference. Each successful transition from hospital to the community represents not just a clinical milestone, but a human achievement.

Incorporating success stories into teaching, case-based discussions, reflective practice sessions, CPD meetings, or newsletters like this one has value. It helps create a culture of learning, optimism, and shared responsibility. It is also a way of showing gratitude to our teams—who walk alongside these patients every day, often without recognition.

We not only need more successes in rehabilitation care, we also need to make it part of our regular clinical conversations.

On a personal note, I keep a 'hall of success' list on my office noticeboard which serves as a regular reminder of what is possible, and inspires me to keep aiming for more.

Author details

Dr Dheeraj Chaudhary
Consultant Forensic Psychiatrist,
Priory Healthcare

Rehabilitation, Supporting Anna to Have a Life Worth Living

Ros (Carer Perspective)

My husband Mark and I have lived for 20 years with our daughter Anna since bringing her back prematurely from university. We have all been profoundly affected by her psychosis, her treatment in the community, her stays in hospital and her medication. She has lost the possibility of a partner, a family, a career and we have lost that bright, musical daughter full of potential. She has become obese, inactive and understandably depressed and we have lived with levels of stress that were unimaginable before Anna became unwell.

Rehabilitation can never return Anna to her previous potential, but it could help her to gain a place in a supportive community, and take some control of her life. It could help her to engage with the people around her as an equal, learn that she has value and is not just a pawn in a benevolent, but highly controlling system.

Rehabilitation needs to be more than an offer of residential or community support that appears after years of deterioration. It has to be everyone’s business from EIP and CMHT to inpatient care, AOT and social care. It is about not allowing deficits to become the norm, not letting people become so unwell that they spend weeks combating voices, shouting in the night and attacking those around them. It is about addressing the trauma of being given a schizophrenia diagnosis, being sectioned and taken miles away from home. It is about all the things that we know make good care; continuity, compassion, seeing the whole person, and considering them in the context of their families and friends.

People need to be well enough to slowly acquire all the practical skills that 20 years of psychosis have destroyed; using a phone, cooking a meal, looking after one’s clothes, having friends, having a purpose, getting out of bed without prompting and taking responsibility for one’s medication. Then there need to be the difficult conversations around personal hygiene; how can someone who smells repellent even start to be accepted?

Given where we are, what could proper, tailored rehabilitation mean beyond the existing care of a good AOT, the support from social services that a Section 117 allocation provides and the community activities that we enable Anna to access?

It would have to be local, everything our daughter accesses is in our home city of York. It would have to be planned with us and her present team. It would have to acknowledge the very specific vulnerabilities of a woman who has previously been exploited financially and sexually. It would have to provide continuity. This is about planning for a lifetime. It would have to work with all of Anna’s family; particularly those of her generation, as we are ageing. The 24/7 Hubs that are being created could become an important part of Anna’s life, if she could build a trusted relationship with one and it’s activities and cafe.

Time is catching up with our family, I am in my late 60s and Mark in his 70s. Last year he had a major health scare. Am I optimistic about Anna’s future? Sadly not. York is a relatively expensive city and good supported accommodation appears to be in short supply. I am only too aware of the dire situation of the middle-aged sons of more than one friend from our carers’ group. They live totally unfulfilled lives, in squalor and largely under the radar of services. They are supported by ageing parents who open their sons’ letters in order to make sure they get their medication and attend the few appointments that they have. This tragic scenario haunts me, we have to create a city where this is not possible, and where the particular needs of a small section of our society are properly understood and everyone works to address them.

Medical Student Prize Winning Essay

Faculty of Rehabilitation and Social Psychiatry Essay Prize - How Best Can We Foster Hope and Maintain Optimism in Psychiatric Rehabilitation?

"Hope is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out." - Václav Havel

Introduction

In the landscape of psychiatric rehabilitation, hope emerges not as a luxury but as a fundamental therapeutic tool, one that can transform the trajectory of recovery for individuals with severe mental illness. Yet fostering genuine hope and maintaining realistic optimism remains one of the psychiatric field's most complex challenges. How do we kindle hope in someone who has experienced repeated hospitalisations, social rejection, and the crushing weight of psychiatric symptoms? How do we sustain optimism in the face of setbacks that feel insurmountable?

The answer lies in recognising hope and optimism as active, cultivatable processes rather than passive states of mind. Drawing upon Snyder's Hope Theory, hope comprises two essential elements: pathway thinking (the ability to generate routes toward valued goals) and agency thinking (the motivation and perceived capacity to pursue those routes) (Advances in Psychiatric Treatment, 2011). Optimism, meanwhile, represents a generalised expectation of positive outcomes that provides resilience during inevitable setbacks (Herth, 2011). Together, these constructs form the psychological bedrock upon which meaningful recovery is built.

This essay argues that fostering hope and maintaining optimism requires a fundamental reimagining of psychiatric rehabilitation, one that moves beyond traditional deficit-focused models toward a dynamic, person-centred approach that recognises everyone's inherent capacity for growth, meaning-making, and recovery (NICE, 2020).

The Transformative Power of Collaborative Partnership

The foundation of hope-centred rehabilitation begins with a radical shift in the therapeutic relationship itself. Rather than positioning clinicians as experts dispensing treatment to passive recipients, truly collaborative care planning establishes patients as co-architects of their recovery journey. This partnership model inherently communicates a powerful message: "Your voice matters, your goals are valid, and we believe in your capacity to shape your future."

Collaborative goal setting transforms abstract aspirations into concrete, achievable pathways. When a patient expresses the desire to "feel better," skilled clinicians work alongside them to unpack this goal into specific, measurable steps: perhaps attending social activities twice weekly, developing coping strategies for anxiety, or rebuilding relationships with family members. Each small victory becomes evidence of personal agency, strengthening both pathway and agency thinking through what research identifies as incremental "small wins" that build self-efficacy and motivation (Herth, 2011).

Motivational interviewing techniques amplify this process by eliciting patients' own motivations for change rather than imposing external pressures (Advances in Psychiatric Treatment, 2011). When individuals articulate their reasons for recovery in their own words, they develop ownership of the process. The clinician's role shifts from persuader to facilitator, asking questions like "What would need to change for you to feel this goal is worth pursuing?" or "Tell me about a time when you overcame a significant challenge." These conversations naturally evoke hope by connecting patients with their inherent strengths and previous successes.

The Revolutionary Impact of Peer Connection

Perhaps no intervention carries greater hope-fostering potential than authentic peer support. When someone struggling with mental illness meets another person who has navigated similar challenges and emerged with renewed purpose, the seemingly impossible suddenly becomes conceivable. Peer support operates on multiple levels simultaneously: it provides practical guidance, emotional validation, and living proof that recovery is possible.

Systematic research confirms that both structured peer-led groups and informal mentoring relationships significantly enhance hope, reduce isolation, and improve treatment engagement (Torous et al., 2021; BMC Medicine, 2024). But these statistics only hint at the deeper transformation occurring. Peer supporters serve as "recovery ambassadors," embodying the possibility of life beyond psychiatric symptoms. They normalise setbacks as part of the journey rather than evidence of failure, and they model resilience through their lived experience.

The power of peer connection extends beyond formal programmes. Creating opportunities for natural peer relationships to flourish, through shared activities, communal spaces, and group projects, generates organic hope networks. When individuals see others like themselves pursuing education, employment, relationships, or creative endeavours, their own sense of possibility expands exponentially.

Strengths-Based Transformation: From Deficit to Asset

Traditional psychiatric practice has long focused on pathology, symptoms, and deficits. While symptom management remains important, a strengths-based approach fundamentally alters the therapeutic landscape by anchoring interventions in patients' existing assets, talents, and capabilities. This shift from "What's wrong with you?" to "What's strong with you?" creates fertile ground for hope to flourish.

The Strengths Model exemplifies this approach by conducting comprehensive strengths assessments that identify not only clinical assets but also personal interests, cultural connections, spiritual resources, and social networks (Napa County, 2021; Rapp & Goscha, 2012). A patient who feels defined by their diagnosis of schizophrenia might discover recognition for their artistic talents, their loyalty as a friend, or their intuitive understanding of others' emotions. These strengths become the foundation for recovery goals and the evidence base for future success.

Strengths-based interventions inherently foster agency thinking by positioning individuals as experts on their own lives and resources. Rather than being recipients of treatment, patients become active participants who contribute their unique assets to the therapeutic process. This fundamental reframing cultivates self-efficacy and reinforces the belief that they possess the tools necessary for recovery.

Environmental Design as Hope Architecture

The physical environment profoundly influences psychological states, yet psychiatric settings have historically prioritised safety and efficiency over healing and hope. Emerging research from palliative care, architectural psychology, and trauma-informed design offers compelling insights for creating spaces that actively foster optimism and dignified recovery (Sagha Zadeh et al., 2018; Time, 2024; The New Yorker, 2021).

Environments that incorporate natural light, views of nature, comfortable seating areas, and personalisation opportunities communicate respect for patients' humanity and potential (Sagha Zadeh et al., 2018). When someone enters a psychiatric unit that feels more like a healing sanctuary than an institutional facility, their expectations about their own recovery journey begin to shift. The environment itself becomes a therapeutic intervention, conveying the message: "You deserve beauty, comfort, and dignity."

Privacy and control within therapeutic environments further enhance hope by allowing individuals to maintain autonomy and personal identity during vulnerable periods. Quiet spaces for reflection, areas for meaningful activities, and opportunities to display personal items help preserve the sense of self that psychiatric symptoms can erode. These environmental factors create the psychological space necessary for hope to take root and flourish.

Continuity as Hope's Lifeline

One of the most destructive forces to hope in psychiatric rehabilitation is fragmentation: the jarring transitions, communication breakdowns, and relationship ruptures that characterise poorly coordinated care systems. Conversely, continuity of care creates predictable pathways that sustain optimism even during difficult periods. Effective continuity extends beyond simple case management to encompass relationship continuity, informational continuity, and philosophical continuity. When patients work with consistent care teams who understand their history, respect their goals, and maintain therapeutic relationships across different levels of care, trust deepens, and hope is preserved during transitions.

Innovative continuity models, such as assertive community treatment teams and integrated care pathways, demonstrate how seamless coordination can dramatically improve outcomes (American Association of Community Psychiatrists, 2018; Herzog et al., 2023). These approaches recognise that hope is relational, and it develops and persists within therapeutic relationships that provide both challenge and support over time. Breaking these relationships unnecessarily fractures the very foundation upon which recovery is built.

Meaningful Activity: Hope in Action

Hope without action remains merely wishful thinking. Structured activity programmes encompassing vocational training, creative arts, physical wellness, and community engagement, provide essential opportunities for hope to become tangible reality. These programmes serve multiple functions: skill development, social connection, meaning- making, and evidence-gathering for future success.

Vocational rehabilitation programmes exemplify hope in action by connecting recovery goals with concrete life skills and community roles. When someone who has been unemployed for years due to mental illness successfully completes job training and secures meaningful work, their entire relationship with possibility transforms. They move from seeing themselves as a patient to recognising themselves as a contributing community member.

Creative and expressive activities offer different but equally powerful pathways to hope (St David's Center, 2024). Art therapy, music programmes, writing groups, and drama activities provide outlets for processing difficult experiences while creating something beautiful and meaningful. These programmes demonstrate that psychiatric symptoms need not define or limit human creativity and expression.

Staff as Hope Agents: The Cultural Revolution

Perhaps the greatest untapped resource for fostering hope lies within the attitudes, beliefs, and behaviours of rehabilitation staff themselves. When clinicians genuinely believe in patients' capacity for recovery and consistently communicate high expectations, they become powerful hope agents. Conversely, therapeutic pessimism, however well-intentioned, can extinguish fragile hope with devastating efficiency (Repper et al., 2018).

Recovery-oriented training programmes demonstrate remarkable potential for transforming staff attitudes and practices (Repper et al., 2018). These initiatives educate clinicians about the science of hope, recovery principles, and the profound impact of their own expectations on patient outcomes. Staff who understand their role as hope facilitators approach their work with renewed energy and purpose.

Creating organisational cultures that support staff hope and resilience proves equally crucial. Clinicians working in environments characterised by burnout, cynicism, and resource scarcity struggle to maintain their own optimism, let alone foster it in others. Investing in staff wellbeing, providing adequate resources, and celebrating recovery successes creates positive feedback loops that benefit both providers and patients.

Self-Management: Internalising Hope

The ultimate goal of hope-fostering interventions involves helping patients develop independent capacity for maintaining optimism and generating pathway thinking. Self-management strategies provide individuals with portable tools for navigating setbacks and sustaining motivation throughout their recovery journey.

Techniques such as future positive imagery help patients envision and work toward meaningful life goals beyond symptom management. Gratitude practices shift attention from deficits to assets, while strengths journaling helps individuals recognise and build upon their personal resources (Herth, 2011). These interventions empower patients to become their own hope agents, reducing dependence on external support systems while building internal resilience.

Recovery planning tools that individuals can personalise and update independently further enhance self-management capacity. When patients learn to identify their own early warning signs, effective coping strategies, and support resources, they develop confidence in their ability to navigate future challenges successfully.

Integration and Implementation: Making Hope Systematic

Transforming individual hope-fostering interventions into systematic, organisation-wide approaches requires thoughtful integration and sustained commitment. Services that successfully embed hope and optimism into their culture demonstrate several common characteristics: clear recovery-oriented philosophies, comprehensive staff training, patient involvement in service development, and systematic outcome measurement.

Implementation begins with organisational leadership that champions recovery principles and allocates resources accordingly. This includes funding for peer support programmes, environmental improvements, staff training, and activity programmes (NICE, 2020).

Successful integration also requires recognising that hope and optimism manifest differently across cultural, ethnic, and socioeconomic contexts. Interventions must be culturally responsive, acknowledging diverse sources of strength, meaning, and connection. This might involve incorporating spiritual practices, cultural traditions, family systems, or community resources that resonate with individuals' backgrounds and values.

Conclusion: The Future of Hope-Centred Rehabilitation

The question posed by this essay demands more than technical answers. It requires a fundamental commitment to seeing beyond psychiatric symptoms to recognise the whole person, complete with dreams, strengths, relationships, and possibilities for growth.

The strategies outlined here: collaborative partnership, peer connection, strengths- based approaches, healing environments, continuity of care, meaningful activities, staff development, and self-management, work synergistically. Within these systems, optimism becomes self-reinforcing as small victories build toward larger achievements, setbacks transform into learning opportunities, and individuals rediscover their capacity for agency and meaning making.

Rehabilitation specialists have the extraordinary privilege of witnessing human resilience in action. Every person who progresses from acute psychiatric crisis to community integration represents a triumph of hope over despair, possibility over limitation. The challenge lies not in creating hope from nothing, but in recognising the seeds of hope that already exist within each individual and nurturing the conditions for their growth.

The future of psychiatric rehabilitation belongs to those who dare to believe that recovery is not only possible but probable when the right supports, relationships, and opportunities align. By making hope and optimism central therapeutic targets rather than pleasant side effects, rehabilitation is transformed from a series of treatments into a journey of rediscovery, empowerment, and renewed possibility.

In closing, fostering hope and maintaining optimism in psychiatric rehabilitation requires nothing less than a revolution in how human potential is conceptualised in the face of mental illness. It demands that we move beyond managing symptoms to facilitating transformation, beyond reducing deficits to cultivating strengths, and beyond providing services to building partnerships. When we succeed in this endeavour, we do more than improve clinical outcomes, we restore faith in the fundamental human capacity for growth, recovery, and hope itself.

References

1. AdvancesinPsychiatricTreatment.(2011).Hopein psychiatry.*Advancesin Psychiatric Treatment*.
2. AmericanAssociationofCommunityPsychiatrists.(2018).ContinuityofCare Guidelines. *Community Psychiatry*. Available at: communitypsychiatry.org
3. BMCMedicine.(2024).Theeffectiveness,implementation,andexperiencesof peer support. *BMC Medicine*.
4. Herzog,D.B.,etal.(2023).Long-termefficacyofacontinuity-of-caretreatment model. *The British Journal of Psychiatry*.
5. Herth,K.(2011).Determinants,self-managementstrategiesandinterventions for hope in psychiatric rehabilitation. *Social Science & Medicine*.
6. NapaCounty.(2021).TheStrengthsModelPractice Guidelines.*NapaCounty Mental Health Division*.
7. NationalInstituteforHealthandCareExcellence.(2020).Rehabilitationfor adults with complex psychosis (NG181). *NICE*.
8. TheNewYorker.(2021).WhatShouldHangontheWallsofaHospital?
9. Rapp,C.A.,&Goscha,R.J.(2012).*TheStrengthsModelofRecovery-Oriented Practice*. Department of Health Victoria.
10. Repper, J., et al. (2018). Recovery-oriented training programmes for mental health professionals: a systematic review. *ScienceDirect*.
11. Sagha Zadeh, R., et al. (2018). Environmental Design for End-of-Life Care. *Journal of Pain and Symptom Management*.
12. St David's Center. (2024). Architecture, Design, and Children's Mental Health.
13. Time. (2024). Healing Amid Nature: Montage Health Ohana Center.
14. Torous, J., et al. (2021). A systematic review and meta-analysis of group peer support for mental health recovery. *BMC Psychiatry*.

Mental Health Act Reform: Rehabilitation Psychiatry Perspective

Dr Hina Tahseen, Vice-Chair, Faculty of Rehabilitation and Social Psychiatry

The Mental Health Act 2025 represents the most significant reform in over 40 years, with implementation beginning this year. For rehabilitation psychiatry, these changes bring both opportunities and challenges that warrant careful consideration.

The "Serious Harm" Threshold in Practice

The new requirement for "serious harm" as a detention threshold presents particular complexities for rehabilitation settings. Unlike acute presentations, rehabilitation patients often demonstrate gradual deterioration patterns - progressive self-neglect, slow nutritional decline, or increasing vulnerability to exploitation.

These cumulative harms may not meet an immediate "serious" threshold but lead to significant disability if untreated. Clear documentation of deterioration trajectories becomes essential, helping tribunals and commissioners understand why continued treatment remains necessary despite the absence of acute crisis.

The challenge lies in articulating risk that manifests over months rather than days, while maintaining the therapeutic optimism central to rehabilitation practice.

Autism and Learning Disability: Navigating Complexity

The Act's provisions preventing detention solely for autism or learning disability align with ethical best practice but introduce diagnostic challenges. Many rehabilitation patients present with diagnostic complexity - autism with possible psychosis, learning disability with trauma-related symptoms, or neurodevelopmental conditions obscured by years of institutional care.

These reforms necessitate:

- Comprehensive developmental histories and functional assessments
- Stronger collaboration with specialist neurodevelopmental services
- Clear documentation of co-occurring mental disorders
- Investment in appropriate community alternatives

The potential positive outcome could be long-overdue development of specialist community services, reducing inappropriate admissions while ensuring those with genuine mental health needs receive appropriate treatment.

Three-Month Reviews: Balancing Legal Requirements with Clinical Reality

The shift to three-month initial Section 3 periods increases tribunal frequency significantly. Rehabilitation recovery typically follows extended trajectories - engagement and assessment (months 1-3), treatment optimisation (months 4-6), skills development and reintegration (months 7-12 and beyond).

Demonstrating meaningful progress at three months, when therapeutic relationships are just forming, requires careful framing. Breaking rehabilitation into clear phases with specific, measurable goals helps tribunals understand where patients sit within their recovery journey. Regular reviews might also help identify systemic barriers earlier, particularly accommodation delays that prevent timely discharge.

The administrative burden cannot be understated - more tribunals mean more reports, more hearings, more clinical time diverted from direct patient care.

Section 117 Aftercare: Systemic Accountability

The strengthened Section 117 provisions highlight a longstanding rehabilitation challenge - patients ready for discharge but awaiting appropriate accommodation. The reformed Act's emphasis on least restrictive options provides stronger grounds to challenge these systemic failures.

Effective approaches include:

- Explicit documentation of discharge readiness dates
- Clear specification of required support packages
- Regular multi-agency meetings with documented actions
- Escalation pathways when aftercare provision stalls

Whether strengthened duties translate to actual provision remains to be seen. Historical experience suggests legal frameworks alone rarely solve resource problems.

Community Support Beyond CTOs

Tighter CTO criteria require reimagining community support structures. Traditional reliance on CTOs to bridge the hospital-community gap must give way to more collaborative approaches:

- Graduated Section 17 leave programmes with clear progression markers
- Crisis planning that patients genuinely co-produce
- Assertive outreach models with rapid response capability
- Peer support networks and recovery colleges
- Transitional accommodation with flexible support levels

These alternatives require investment and innovation. The risk is that without CTOs as a safety net, services become more risk-averse, potentially prolonging admissions.

Nominated Persons: Respecting Choice

The nominated person provisions offer particular value in rehabilitation, where family relationships may be complex or fractured after years of illness. Patients choosing supportive professionals or peers over relatives who may not understand their recovery journey represents genuine progress in respecting autonomy.

Implementation requires careful consideration of capacity fluctuations, safeguarding requirements, and practical processes for nomination and review.

Workforce Implications

These reforms demand significant workforce adaptation:

- Training on new legal frameworks and documentation requirements
- Administrative support for increased tribunal activity
- Time for comprehensive assessments and formulation
- Skills development in collaborative care planning
- Understanding of autism and learning disability presentations

Without additional resources, these requirements risk overwhelming already stretched services.

Critical Success Factors

Successful implementation depends on several factors beyond services' direct control:

Community capacity: Without genuine alternatives, reforms risk creating impossible tensions between legal requirements and clinical reality.

Funding alignment: Legal duties must match resourced provision, particularly for Section 117 aftercare and specialist placements.

Culture change: Moving from risk-averse practices to positive risk-taking requires system-wide support.

Data systems: Capturing rehabilitation outcomes meaningfully requires sophisticated approaches beyond simple admission/discharge metrics.

Opportunities Worth Pursuing

Despite challenges, these reforms could drive positive change:

- Greater clarity about therapeutic purpose could strengthen rehabilitation's identity
- Regular reviews might reduce drift and maintain recovery focus
- Stronger patient voice aligns with rehabilitation's collaborative ethos
- Section 117 strengthening might finally address placement delays
- Requirements for community alternatives could generate investment

Questions for Consideration

As implementation proceeds, key questions emerge:

- How will services manage diagnostic uncertainty at the autism/mental health interface?
- Can meaningful therapeutic progress be demonstrated in three-month cycles?
- Will strengthened Section 117 duties translate to actual provision?
- What CTO alternatives prove effective and sustainable?
- How do we balance autonomy with protection for fluctuating capacity?

Moving Forward

The reformed Act asks rehabilitation services to be clearer about therapeutic purpose, more ambitious about community alternatives, and more rigorous in justifying continued detention. While challenging, these requirements could strengthen rehabilitation psychiatry's role in modern mental health services.

Success requires honest dialogue about resource gaps, creative problem-solving around community support, and commitment to maintaining therapeutic optimism despite systemic constraints. The reforms won't solve rehabilitation's challenges overnight, but they might catalyse conversations and changes that are long overdue.

Colleagues' experiences during early implementation will prove invaluable. Sharing both challenges and innovations through professional networks will help shape practical responses to these significant reforms.

Quality Improvement and Education Spotlights

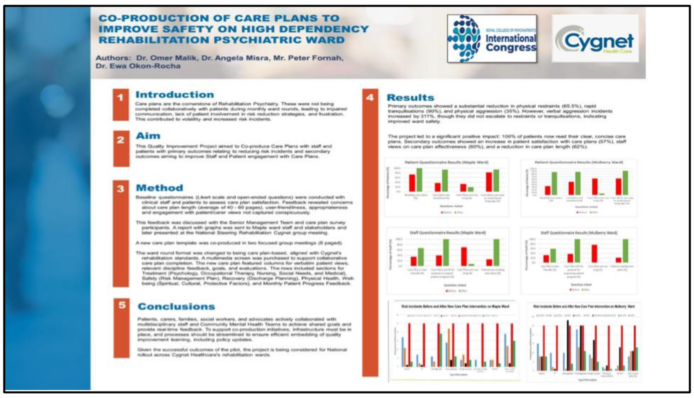
Below are brief highlights from recent quality improvement and education work presented as posters. We welcome short 'how we did it' write-ups for future issues.

Co-production of Care Plans to Improve Safety on a High Dependency Rehabilitation Ward

Dr Omer Malik, Dr Angela Misra, Mr Peter Fornah, Dr Ewa Okon-Rocha (Cygnet Churchill Hospital, London)

This quality improvement project set out to co-produce care plans with patients and staff, aiming to reduce risk incidents and improve engagement. Baseline questionnaires highlighted concerns about care plan length and user-friendliness. A new, concise care plan template (8 pages) was co-produced and embedded into ward routines.

Reported outcomes included reductions in seclusion, rapid tranquillisation and physical aggression, alongside improved accessibility of care plans and a substantial reduction in care plan length. The project has been considered for wider rollout.



CO-PRODUCTION OF CARE PLANS TO IMPROVE SAFETY ON HIGH DEPENDENCY REHABILITATION PSYCHIATRIC WARD

Authors: Dr. Omer Malik, Dr. Angela Misra, Mr. Peter Fornah, Dr. Ewa Okon-Rocha

1 Introduction

Care plans are the cornerstone of Rehabilitation Psychiatry. These were not being completed collaboratively with patients during monthly ward rounds, leading to impaired communication, lack of patient involvement in risk reduction strategies, and frustration. This contributed to volatility and increased risk incidents.

2 Aim

This Quality Improvement Project aimed to Co-produce Care Plans with staff and patients with primary outcomes relating to reducing risk incidents and secondary outcomes aiming to improve Staff and Patient engagement with Care Plans.

3 Method

Baseline questionnaires (Likert scale and open-ended questions) were conducted with clinical staff and patients to assess care plan satisfaction. Feedback revealed concerns about care plan length (average of 40 - 60 pages), user-friendliness, appropriateness and engagement with patient/carer views not captured conspicuously.

This feedback was discussed with the Senior Management Team and care plan survey participants. A report with graphs was sent to Maple ward staff and stakeholders and later presented at the National Steering Rehabilitation Cygnet group meeting.

A new care plan template was co-produced in two focused group meetings (8 paged).

The ward round format was changed to being care plan-based, aligned with Cygnet's rehabilitation standards. A multimedia screen was purchased to support collaborative care plan completion. The new care plan featured columns for verbatim patient views, relevant discipline feedback, goals, and evaluations. The rows included sections for Treatment (Psychology, Occupational Therapy, Nursing, Social Needs, and Medical), Safety (Risk Management Plan), Recovery (Discharge Planning), Physical Health, Well-being (Spiritual, Cultural, Protective Factors), and Monthly Patient Progress Feedback.

4 Results

Primary outcomes showed a substantial reduction in physical restraints (65.5%), rapid tranquilisations (90%), and physical aggression (35%). However, verbal aggression incidents increased by 311%, though they did not escalate to restraints or tranquilisations, indicating improved ward safety.

The project led to a significant positive impact: 100% of patients now read their clear, concise care plans. Secondary outcomes showed an increase in patient satisfaction with care plans (57%), staff views on care plan effectiveness (60%), and a reduction in care plan length (62%).

5 Conclusions

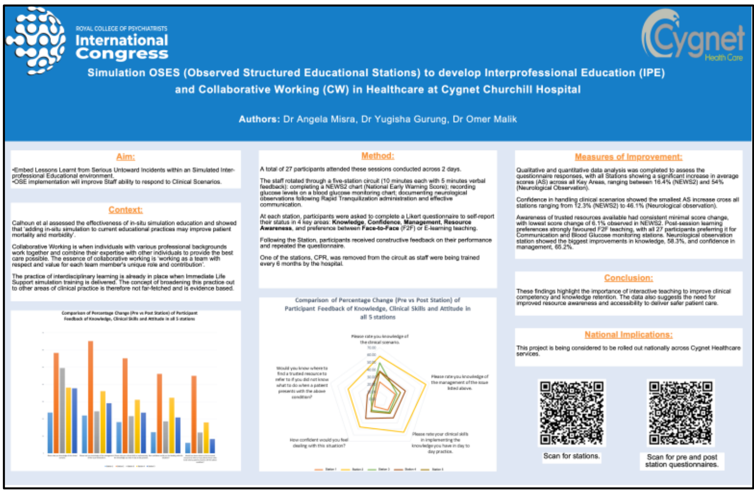
Patients, carers, families, social workers, and advocates actively collaborated with multidisciplinary staff and Community Mental Health Teams to achieve shared goals and provide real-time feedback. To support co-production initiatives, infrastructure must be in place, and processes should be streamlined to ensure efficient embedding of quality improvement learning, including policy updates.

Given the successful outcomes of the pilot, the project is being considered for National rollout across Cygnet Heathcare's rehabilitation wards.

Simulation OSES to Develop Interprofessional Education and Collaborative Working

Dr Angela Misra, Dr Yugisha Gurung, Dr Omer Malik (Cygnet Churchill Hospital)

An in-situ simulation programme ran across five stations (NEWS2, blood glucose monitoring, neurological observations post-rapid tranquillisation, communication and others) with pre- and post-session Likert measures. Across all stations, average scores improved (reported range 16.4% to 54%), and face-to-face teaching was strongly preferred.



Simulation OSES (Observed Structured Educational Stations) to develop Interprofessional Education (IPE) and Collaborative Working (CW) in Healthcare at Cygnet Churchill Hospital

Authors: Dr Angela Misra, Dr Yugisha Gurung, Dr Omer Malik

Aim:

•Embed Lessons Learnt from Serious Untoward Incidents within an Simulated Inter-professional Educational environment.
•OSE implementation will improve Staff ability to respond to Clinical Scenarios.

Context:

Calhoun et al assessed the effectiveness of in-situ simulation education and showed that 'adding in-situ simulation to current educational practices may improve patient mortality and morbidity'.

Collaborative Working is when individuals with various professional backgrounds work together and combine their expertise with other individuals to provide the best care possible. The essence of collaborative working is 'working as a team with respect and value for each team member's unique role and contribution'.

The practice of interdisciplinary learning is already in place when Immediate Life Support simulation training is delivered. The concept of broadening this practice out to other areas of clinical practice is therefore not far-fetched and is evidence based.

Method:

A total of 27 participants attended these sessions conducted across 2 days.

The staff rotated through a five-station circuit (10 minutes each with 5 minutes verbal feedback): completing a NEWS2 chart (National Early Warning Score); recording glucose levels on a blood glucose monitoring chart; documenting neurological observations following Rapid Tranquilization administration and effective communication.

At each station, participants were asked to complete a Likert questionnaire to self-report their status in 4 key areas: **Knowledge**, **Confidence**, **Management**, **Resource Awareness**, and preference between **Face-to-Face** (F2F) or E-learning teaching.

Following the Station, participants received constructive feedback on their performance and repeated the questionnaire.

One of the stations, CPR, was removed from the circuit as staff were being trained every 6 months by the hospital.

Measures of Improvement:

Qualitative and quantitative data analysis was completed to assess the questionnaire responses, with all Stations showing a significant increase in average scores (AS) across all Key Areas, ranging between 16.4% (NEWS2) and 54% (Neurological Observation).

Confidence in handling clinical scenarios showed the smallest AS increase cross all stations ranging from 12.3% (NEWS2) to 46.1% (Neurological observation).

Awareness of trusted resources available had consistent minimal score change, with lowest score change of 6.1% observed in NEWS2. Post-session learning preferences strongly favoured F2F teaching, with all 27 participants preferring it for Communication and Blood Glucose monitoring stations. Neurological observation station showed the biggest improvements in knowledge, 58.3%, and confidence in management, 65.2%.

Conclusion:

These findings highlight the importance of interactive teaching to improve clinical competency and knowledge retention. The data also suggests the need for improved resource awareness and accessibility to deliver safer patient care.

National Implications:

This project is being considered to be rolled out nationally across Cygnet Healthcare services.

Scan for stations.

Scan for pre and post station questionnaires.

Latest Research in Rehabilitation and Social Psychiatry

Introduction

Over the past six months, significant research has advanced our understanding of evidence-based rehabilitation models, psychosocial interventions, and the social determinants shaping recovery outcomes. This section highlights five major research contributions that signal important directions for rehabilitation and social psychiatry practice.

1. Global rehabilitation models for complex psychosis: A new systematic review

A comprehensive 2025 systematic review examined 24 high-quality studies of mental health rehabilitation models across high-, middle-, and low-income countries, identifying seven distinct approaches to supporting people with complex psychosis in their recovery. Rather than establishing one superior model, the evidence reveals that multiple rehabilitation approaches—ranging from strengths-based case management to intensive case management to psychosocial rehabilitation—produce meaningful gains in specific domains when aligned with local contexts and individual needs.

Key Finding: Recovery-oriented, person-centered models with goal-setting, family involvement, and flexibility for local implementation consistently demonstrated better outcomes for social functioning, self-efficacy, and community integration. Notably, approximately two-thirds of individuals in UK inpatient rehabilitation and over 40% in supported accommodation achieved expected progression along the care pathway when services prioritized recovery orientation.

Implication: Rehabilitation efficacy depends less on prescriptive fidelity to a single model and more on embedding core biopsychosocial principles—multidisciplinary support, individualized goals, activities of daily living skills, and community engagement—with cultural and contextual responsiveness.

2. Peer support validated globally for severe mental illness

A landmark 2025 international randomised controlled trial (615 participants across Germany, Uganda, Tanzania, Israel, and India) confirmed that structured peer support significantly improves social inclusion, empowerment, and hope among people with severe and long-standing mental health conditions. Participants receiving the UPSIDES peer support intervention showed measurable improvements in social inclusion and empowerment, with larger effects in those who received three or more sessions.

Why This Matters: Social isolation is identified as a key driver of mental ill health. By validating peer support's effectiveness across diverse cultural and economic contexts, this research positions peer support as an essential, scalable, and cost-effective component of recovery-oriented mental healthcare globally. The finding carries particular significance for resource-constrained settings where professional workforce shortages challenge traditional service delivery.

Implication: Peer support moves beyond an ancillary service to a core intervention within comprehensive mental healthcare pathways, with potential to advance recovery- and rights-based approaches to mental health globally.

3. Consensus on Psychosocial Interventions for Functional Recovery in Schizophrenia (2025)

In June 2025, eight leading experts in psychiatry and psychology convened to synthesize evidence on psychosocial interventions driving functional recovery (employment, education, social integration, quality of life) in schizophrenia. The panel identified four domains of functional impairment—intrinsic (symptoms, cognition, insight), behavioral (nonadherence, substance use), comorbid (depression, defeatist beliefs, isolation), and societal/contextual (stigma, poverty, lack of family support)—and mapped evidence-based interventions to each.

Strongest Evidence for Functional Gain:

Intervention	**Effect & Outcomes**	**Status**
Cognitive Remediation	d=0.29 (cognition), d=0.22 (functioning); real-world gains in employment, social relationships, independent living	EPA-endorsed; combines best with vocational training
Supported Employment (IPS model)	40–55% job placement; 50%+ reduction in hospitalizations vs. traditional rehab	NICE, APA, EPA recommended
Family-Focused Interventions	50–60% relapse reduction; improved adherence, functioning, QoL	Level 1 evidence
Cognitive Behavioural Therapy for Psychosis (CBTp)	Small-to-medium symptom reduction; relapse prevention; reduced self-stigma	APA, NICE, EPA-endorsed
Psychoeducation	Reliable relapse/rehospitalization reduction; improved adherence	Guideline-endorsed

Critical Gap: Despite robust evidence, these interventions remain systemically underutilized due to workforce shortages, training gaps, resource constraints, and therapeutic nihilism. The panel emphasized that functional outcomes achievable through integrated, measurement-based care remain far below actual practice.

Implication: Rehabilitation progress hinges not on developing new interventions, but on embedding evidence-based practice into routine care, overcoming organizational and cultural barriers to implementation, and shifting expectations toward recovery as a realistic, measurable goal.

4. Mental Health Stigma: Evidence and Gaps (2025 Scoping Review)

A 2025 analysis of 448 studies (294 quantitative, 154 qualitative) mapped the consequences of mental health stigma across health, service use, psychosocial, economic, and structural domains. Across all domains, stigma and discrimination correlate with poorer outcomes: reduced help-seeking, lower employment, family avoidance, housing barriers, and discriminatory laws.

Critical Finding: While stigma is consistently associated with adverse outcomes, causal evidence remains limited. Most studies (56%) employ cross-sectional designs, precluding causality claims. More importantly, the review highlights a key distinction often blurred in practice: stigma (negative attitudes) ≠ discrimination (harmful behaviors). Effective interventions must target behavior change and structural barriers, not just public education about attitudes.

Regional Evidence Gaps: Evidence clusters in North America, Northern/Western Europe, and Eastern Asia. Substantial underrepresentation in low- and middle-income countries (e.g., no studies from Central America, Central Asia, or Oceania) limits generalizability and leaves practice in these regions under-evidenced.

Implication: For rehabilitation and social psychiatry, this research underscores that addressing stigma through structural change—employment support, accessible housing, inclusive policies, service user involvement in policy—is more impactful than attitude campaigns alone. Social determinants of health (poverty, housing, discrimination) emerge as central drivers deserving equal emphasis with clinical interventions.

References

- Houngbedji N, Dalton-Locke C, Hughes A, Killaspy H, et al. Mental health rehabilitation models for people with complex psychosis: a systematic review. BMC Psychiatry. 2025;25:812. doi:10.1186/s12888-025-07174-8
- Puschner B, Nakku J, Hiltensperger R, et al. Effectiveness of peer support for people with severe mental health conditions in high-, middle- and low-income countries: multicentre randomised controlled trial. Br J Psychiatry. 2025;(Published online June 27). doi:10.1192/bjp.2025.10299
- Tandon R, Barch DM, Buchanan RW, et al. Psychosocial interventions and functional recovery in schizophrenia—realizing opportunities today. J Clin Psychiatry. 2025;86(4):JCP.hfrecachi2505. Published online December 17, 2025. doi:10.4088/JCP.hfrecachi2505
- Kågström A, Guerrero Z, Aliev AA, et al. Mental health stigma and its consequences: a systematic scoping review of pathways to discrimination and adverse outcomes. eClinicalMedicine. 2025;89:103588. doi:10.1016/j.eclinm.2025.103588

Disclaimer

Please note that the Faculty of Rehabilitation and Social Psychiatry newsletter is intended for our membership. The content is provided by contributors and does not necessarily reflect the views, position, or policy of the College. The Royal College of Psychiatrists does not provide any endorsements or assume any responsibility for the accuracy, completeness, or suitability of the content provided.