Refocus on Recovery 2019

Expert workshops

Tuesday 3rd September 2019

8.00am	*Registration opens for Expert Workshops*		
	Facilitator	**Title**	**Room**
9.00am-12.00noon	Julie Repper	Workshop 1 - Co-Production	LT1
	Peter Bartlett	Workshop 2 - Mental Health and International Law	LT6
	Pesach Lichtenberg	Workshop 3 – Soteria Houses	LT7
	Michael Rowe and Helen Hamer	Workshop 4 - Strategies for Promoting Citizenship	LT8
	Stefan Rennick Egglestone	Workshop 5 - Designing Sensitive Digital Health Interventions	LT9

Refocus on Recovery 2019

Summary programme

Tuesday 3rd September 2019					
10.00am	*Registration opens*				Registration desk
1.00pm	Welcome: Robin Hood, Nottingham People's Choir, David Crepaz-Keay, Martin Orrell, Andy Long Keynotes: Natalie Drew Bold, Soumitra Pathare				LT2
3.00pm	*Refreshments, viewing of posters and exhibition stands*				
3.30pm-5.00pm	Parallel Session 1				
	Session 1.1 LT2	Session 1.2 LT5	Dialogical session LT4	Session 1.4 LT1	Session 1.5 LT6
5.15pm	Keynote: Mike Slade				LT2
6pm	*Drinks Reception (included in the registration fee)*				Central Gallery

Wednesday 4th September 2019				
9.00am	Keynotes: Alison Faulkner, Vicky Stergiopoulos			LT2
10.00am	Parallel Session 2			
	Session 2.1 LT2	Session 2.2 LT5	Session 2.3 LT4	Session 2.4 LT1
11.00am	*Refreshments, viewing of posters and exhibition stands*			
11.30am	Parallel Session 3			
	Session 3.1 LT7	Session 3.2 LT5	Session 3.3 LT4	Session 3.4 LT1
12.30pm	*Lunch, viewing of posters and exhibition stands* *Conference reflection session (12.30pm-1.30pm, Quiet room)*			
1.30pm	Wellbeing event – Clap Happy!			LT2
2.00pm	Keynotes: Joseph Leong Jern-Yi, Michael Rowe			LT2
3.00pm	*Refreshments, viewing of posters and exhibition stands*			
3.30pm	Parallel Session 4			
	Session 4.1 LT2	Session 4.2 LT5	Session 4.3 LT4	Session 4.4 LT1
5.00pm	*End of day*			
6.30pm	*Conference dinner (optional extra): meet at the registration desk for travel to Colwick Hall Hotel. Return time approximately 10.30pm.*			

Thursday 5th September 2019					
9.00am	Keynotes: Pesach Lichtenberg, Steven Allen				LT2
10.00am	*Refreshments, viewing of posters and exhibition stands*				
10.30am	Parallel Session 5				
	Session 5.1 LT7	Session 5.2 LT5	Dialogical session LT4	Session 5.4 LT1	Session 5.5 LT6
12.00noon	Debate: 'This house believes that there is no place for compulsion in a rights-oriented mental health system'				LT2
12.45pm	Closing remarks: Samson Tse				LT2
1pm	*Conference ends*				

Welcome to the *Refocus on Recovery 2019* conference

The aim of the conference is both to advance the field of recovery research and to create an international community of influence. The conference brings together leading researchers and people who use mental health services, their carers and informal supporters, mental health workers and professionals, and policy-makers and other stakeholders from across mental health services and wider systems. Our community has been meeting since 2010, and whether this is your first or fifth time at a *Refocus on Recovery* conference, you are hugely welcome!

The conference has four themes.

Theme 1: Mental health and human rights
Implementation and evaluation of QualityRights Toolkit initiatives. System transformation towards a focus on human rights. Strategic litigation and progressive jurisprudence. Advocacy and guardianship. The economic case for institutional transformation. Participatory politics. The impact of ethical frameworks on policy and practice. Rights of families, children and young people.

Theme 2: Supporting recovery through services
Theoretical foundations and first-in-field implementation of new approaches for individuals, family members, staff and systems. New frontiers, e.g. digital and machine learning approaches, innovations in acute mental health care. Process and outcome evaluations of effectiveness and economic evaluation of resource consequences for pro-recovery interventions, e.g. Recovery Colleges, Housing First, No Force First, personal ombudsperson, dialogical approaches, Soteria houses.

Theme 3: Supporting recovery through communities
What is 'community' in relation to recovery? Community asset mapping, community development and community connections. Services led by or with local communities. Changing roles and responsibilities between mental health / social care public sector and wider society. Co-production of services. Citizenship and inclusive societies. Insights from public mental health and 'dementia-friendly communities' initiatives about developing recovery-friendly communities.

Theme 4: Recovery and power
The limits and frontiers of the recovery 'movement'. Mental health in times of austerity. Popular resistance movements. Social inequality as a driver of 'mental ill-health'. Addressing stigma in society and services. Learning from Mad Studies and peer-led research. Theoretical foundations for, and evaluations of, peer-led and peer-run services. What recovery means for groups with low power, e.g. children, people with intellectual disabilities. Supporting recovery in resource-poor countries and marginalised populations.

We hope that you enjoy the conference!

2019 debate

At each Refocus on Recovery conference, we hold a debate on a globally topical issue. In 2019 our debate motion is:

> *This house believes that there is no place for compulsion in a rights-oriented mental health system*

The debate will be chaired by Samson Tse. Alison Faulkner and Peter Bartlett will speak for the motion, and John Copping and Vicky Stergiopoulos will speak against the motion.

New opportunity to join in with the debate
For the very first time, our debate session will be live streamed via YouTube with The Mental Elf. Conference attenders and anyone around the world will be able to watch the debate and submit and vote for questions.

To take part, please follow these steps:

1. Download the sli.do App or join online at **https://www.sli.do**
2. Use the event code **#RonR2019**
3. If you're not at the conference, you can watch the debate live at **https://elfi.sh/ronr2019-debate**
4. Before or during the debate, submit your question or vote for your favourite submitted question on sli.do

The most popular questions will be put to the debate panel. You can submit and vote for as many questions as you like, and the debate Chair will decide what questions are asked.

Please encourage your friends and colleagues who are not able to attend the conference to take part in the debate – it's free!

The 45-minute debate will take place at 12.00pm BST (midday) on Thursday September 5th. The time in other cities is:

Los Angeles	04:00 PDT
New York	07:00 EDT
Toronto	07:00 EDT
Rio	08:00 BRT
Rome	13:00 CEST
Kampala	14:00 EAT
Delhi	16:30 IST
Beijing	19:00 CST
Sydney	21:00 AEST

Acknowledgements and thanks

Refocus on Recovery 2019 is organised by the Recovery Research Team at the Institute of Mental Health in Nottingham. We are very grateful to our partners who have made the event possible:

- Institute of Mental Health (lead organisation)
- Nottinghamshire Healthcare NHS Foundation Trust
- School of Health Sciences, University of Nottingham
- Making Waves
- Mental Elf
- Mental Health Foundation
- ImROC
- World Health Organisation

The Scientific Advisory Board was responsible for scientific aspects:

- David Crepaz-Keay (Mental Health Foundation)
- Julie Hankin (Nottinghamshire Healthcare NHS Foundation Trust)
- Julie Repper (ImROC)
- Mike Slade (Chair) (Institute of Mental Health and School of Health Sciences, University of Nottingham)
- Nicola Wright (School of Health Sciences, University of Nottingham)
- Trude Klevan (University of Southeastern Norway)
- André Tomlin (Mental Elf)

The Local Organising Committee was responsible for logistics:

- Lou Rudkin (Chair) (Institute of Mental Health)
- Lee Edwards-Kelsall (Institute of Mental Health and School of Health Sciences, University of Nottingham)
- Ryan Knight (Nottinghamshire Healthcare NHS Foundation Trust)
- Matt Ramsey (Nottinghamshire Healthcare NHS Foundation Trust)
- Mike Slade (Institute of Mental Health and School of Health Sciences, University of Nottingham)
- Karen Sugars (Institute of Mental Health)

We thank all the volunteers (they're the ones in purple T-shirts!) who have helped with running the conference.

We are very grateful for the financial support we received from:

- Nottinghamshire Healthcare NHS Foundation Trust
- School of Health Sciences, University of Nottingham
- Institute of Mental Health

University of Nottingham
UK | CHINA | MALAYSIA

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

the institute of mental health
Nottingham
Research Excellence for Innovation

@instituteMH #RonR2019

Conference information

Need to know anything?
If you have any questions please go to the registration desk or just ask one of our volunteers – the helpful people in the purple conference T-shirts.

Finding your way around
Maps of the Conference Centre are on pages 3 and 4. The Conference Centre is on two floors – level 1 (main entrance) and level 0 (ground floor). There are lifts and stairs to move between levels. Fire exits are signposted within the building and on the Conference maps. Toilet locations are also shown on the Conference maps.

Refreshments
All refreshments will be served both on Level 0 and Level 1 at the times shown in the programme.

Cloakroom (Level 1 – close to registration desk)
Coats and luggage can be left in an un-staffed cloak-room (room LT3) throughout the conference. No liability is accepted for loss or damage.

Dialogical sessions (both in room LT4)
An opportunity to share your ideas, thoughts and reflections on the conference with others. Come to just one or to both sessions if wanted:
Tuesday 3rd September 3.30 – 5.00pm
Thursday 5th September 10.30am – 12.00pm
See also the description of the Quiet room (below).

Evening reception – Tuesday 3rd September, 6pm (Level 0)
Everyone is welcome to join us for a drinks and canapés reception in the Central Court (Level 0) on the evening of 3rd September. This is included in the conference registration fee, and you will have the opportunity for relaxed networking with colleagues.

Conference Dinner – Wednesday 4th September, Colwick Hall Hotel, Racecourse Road, Nottingham, NG2 4BH
The conference dinner is **not** included in the conference registration fee. Ask at the registration desk if you would like to confirm you have booked a ticket, or if you want to purchase a conference dinner ticket.
The Conference Dinner is being held at Colwick Hall Hotel, a magnificent Palladian style Georgian country house mansion which dates back to the 11th century and was the ancestral home of the famous poet Lord Byron. Meet at the registration desk at 6.30pm, to catch a coach from Chaucer Street just behind the conference centre. **The coach will leave promptly at 6.45pm.** For the return journey the coach will drop you off at Chaucer Street at approximately 10.30pm.

Quiet room (Level 1)
We recognise that a conference experience can be intense, especially for people new to academic conferences. If you need time out from the conference, there is a quiet room for some space and quiet. The room is open throughout the conference – feel free to use it whenever wanted. You can find the Quiet room near to the main entrance (see map). There is a facilitated session in the Quiet room to help you reflect on the conference experience, during the lunch break (i.e. 12.30pm-1.30pm) on Wednesday 4th September. Also consider going to one of the Dialogical sessions described above.

Prayer rooms
Prayer rooms are located in the DiCe Building, rooms 020 and 021. The DiCe building is a 7-8 minute walk from the Conference building and any delegates requesting use of the prayer room will be directed there by Nottingham Trent University staff at the main reception desk.

Banking facilities (Level 0)
Santander Bank is open Monday and Tuesday from 10 am – 6 pm and on Wednesday from 10 am until 5 pm. A cash point is also available in the Conference building (see map).

Certificate of Attendance
You can download a certificate of attendance from the conference website:
http://www.researchintorecovery.com/RonR2019

Certificates will be available to download until 5th October 2019.

Nearby restaurants and cafés

The Cornerhouse
Burton St, Nottingham NG1 4DB
https://cornerhousenottingham.co.uk/
This is a large complex very near the conference centre, with numerous restaurants including:

- **Wagamama**
- **TGI Fridays**
- **Nando's**
- **Rocket at Saltwater**
- **Turtle Bay**
- **Tamatanga**
- **Pizza Hut**
- **Subway**
- **Antalya**
- **Chiquito**
- **Bella Italia**

Creams
Trinity Place, Burton St, Nottingham NG1 4BJ, UK
+44 115 941 8333
www.creamscafe.com

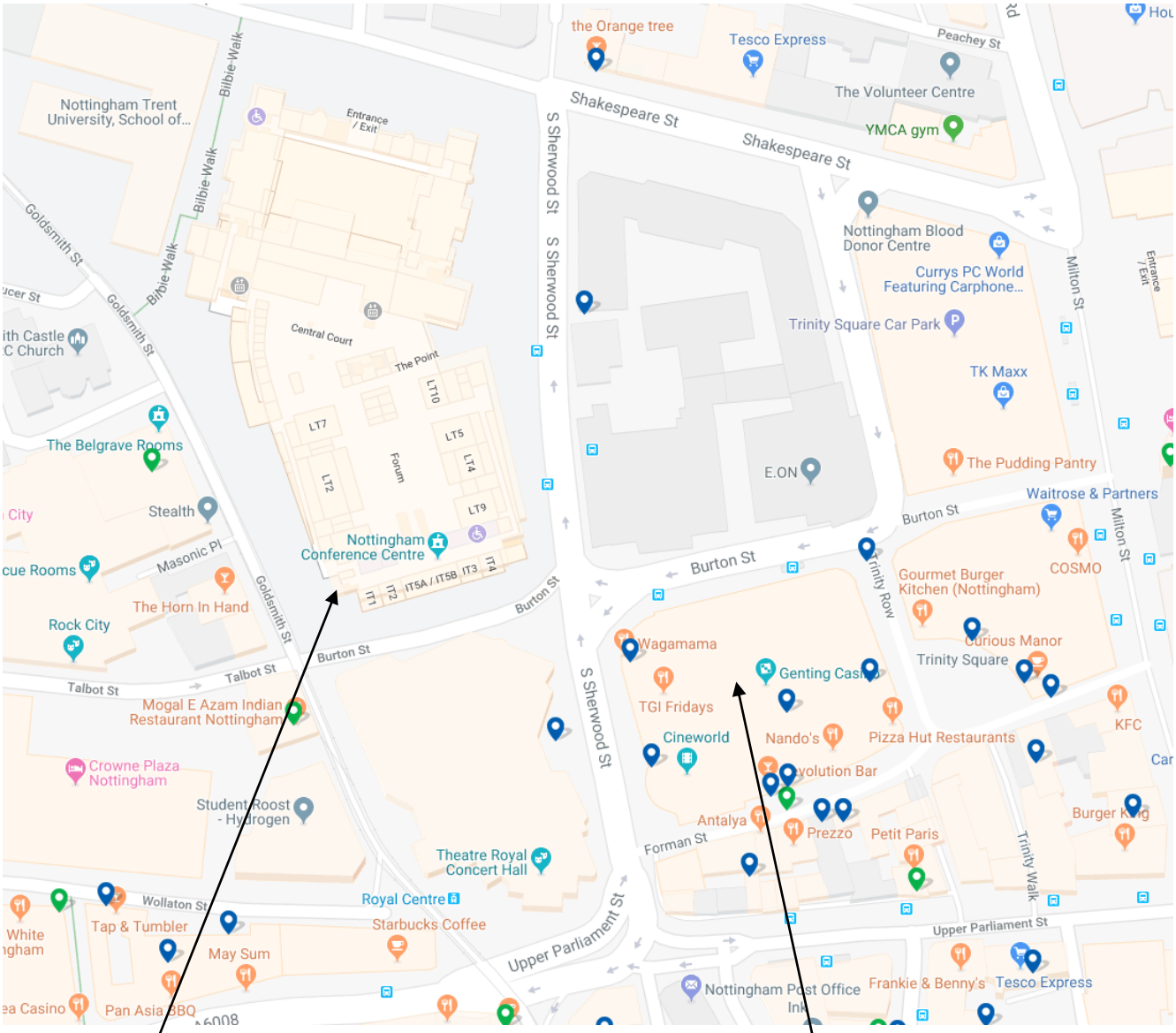
Marco Pierre White Steakhouse Bar and Grill
33 Wollaton St, Nottingham NG1 5FW, UK
+44 115 872 0602
www.mpwnottingham.com

Prezzo
21-23 Forman St, Nottingham NG1 4AA, UK
+44 115 941 4798
www.prezzorestaurants.co.uk

Tesco Express (small supermarket - will have inexpensive sandwiches, drinks etc)
2, 24-30 Shakespeare St, Nottingham NG1 4FQ, UK
+44 345 671 9329
www.tesco.com

Students Union Express (small supermarket - will have inexpensive sandwiches, drinks etc)
Goldsmith Street, Nottingham NG1 5JT

Locations of restaurants and cafés near Nottingham Conference Centre



Nottingham Conference Centre (venue for the conference)

The Cornerhouse

Refocus on Recovery 2019

Detailed programme

Tuesday 3rd September 2019					
10.00am	***Registration opens***				
1.00pm	**Chair: Marit Borg** **Welcome speeches:** Robin Hood Nottingham People's Choir David Crepaz-Keay (Mental Health Foundation) Professor Martin Orrell (Director, Institute of Mental Health) Andy Long (Deputy Vice Chancellor, University of Nottingham)				LT2
2.00pm	**Natalie Drew Bold** – WHO QualityRights: transforming services and promoting rights and recovery in mental health				
2.30pm	**Soumitra Pathare** – Peer support : an under-utilized resource in low-middle income countries				
3.00pm	***Refreshments*** ***Viewing of posters and exhibition stands***				
3.30pm-5pm	**Parallel Session 1**				
	Session 1.1 **LT2** *UPSIDES Study symposium* Chair: Jasmine Kalha	**Session 1.2** **LT5** *Recovery-Oriented Practice* Chair: Marianne Farkas	**Session 1.3** **LT4** Dialogical Session	**Session 1.4** **LT1** *Spirituality and Power*	**Session 1.5** **LT6** *Quantitative Studies* Chair: Mário César Rezende Andrade
	Richard Mpango Implementing formal peer support in a low-income setting: Preliminary results of UPSIDES qualitative research in Uganda	**Keren Wolstencroft** Bringing recovery and wellbeing into mental health service practice	A space to share your ideas, thoughts and reflections on the conference with others	**Matthew Aldridge** A Buddhist Āyurvedic approach to supporting recovery through services in the UK	**Siv Graav** Factors that may determine recovery from symptoms of depression without formal help: a quantitative approach
	Ashleigh Charles Modifications to mental	**Michaela Høj** Can a participatory		**Katja Milner** Experiences of spirituality	**Emilia Deakin**

	health peer support: systematic review	research inspired approach to further development and implementation of a recovery-oriented model facilitate recovery-oriented practice in public-sector services?		among adults with mental health problems: qualitative systematic review findings and the MISTIC framework	Using the social model of identity change to understand identity changes in recovery from psychosis
	Ramona Hiltensperger Organisational Readiness for UPSIDES peer support: materials, strategies and first experiences	**Sarah Brydges** Exploring views from service users upon an intervention designed to support recovery for men taking antidepressants, in a community pharmacy setting		**Rachel Waters** Producing the 'patient in recovery': pastoral power in the recovery approach	**Snigdha Dutta** Understanding pathways to resilience in undergraduate students: a theoretical approach
	Candelaria Mahlke Using Peer Support In Developing Empowering Mental Health Services: results from the pilot phase	**Hayley Thomas** Helping people see their progress		**Toni King** Using the recovery approach and participative action research to explore experiences of power and control in interactions between people who self harm and staff in community mental health services	**Mário César Rezende Andrade** Recovery assessment and associated factors in an outpatient sample of people with Schizophrenia in Brazil
	Jasmine Kalha Implementing peer support in public mental health facilities, Gujarat, India: Key reflections and challenges	**Kenneth Thompson** Recovery Fusion		**Emma Watson** Who has the knowledge and who's knowledge counts? Exploring power in the context of peer support	**Fiona Ng** The role of self-identified recovery and diagnostic status on outcomes in borderline personality disorder: A mixed-

					methods study
		Kenneth Thompson Using Peer Supports In Crisis Settings			**Linda Nesse** Recovery in co-occurring substance use and mental health problems: A cross-sectional study with residents in supported housing in Norwegian cities
		Marianne Farkas A social media program to promote recovery: inspiring hope and community			
5.15pm	**Mike Slade** – Multiple perspectives on recovery				**LT2**
6.00pm	***Drinks Reception (included in the registration fee)***				**Central Court (Level 0)**

Wednesday 4th September 2019				
9.00am	**Chair: Simone Arbour** **Alison Faulkner** – The 'inconvenient complications' of peer support in mental health		LT2	
9.30am	**Vicky Stergiopoulos** – Improving housing and recovery outcomes for persons experiencing homelessness and mental health challenges		LT2	
10.00am- 11.00am	**Parallel Session 2**			
	Session 2.1 **LT2** *CHIME and REFOCUS* Chair: Gianfranco Zuaboni	**Session 2.2** **LT5** *Sport and mental health* Chair: Alan Pringle	**Session 2.3** **LT4** *Citizenship* Chair: Phil Morgan	**Session 2.4** **LT1** *Coaching* Chair: Nick Dent
	Lyn Williams CHIME to Care – improving collaborative care planning in practice using improvement methodology	**Adam Benkwitz** Enhancing mental health through sport: methodological reflections on two community projects	**Lisa Archibald** Wellbeing manifesto	**Keren Wolstencroft** Can coaching promote an orientation to wellbeing for people who are experiencing mental illness or psychological distress?
	Ingo Tschinke Introducing recovery as complex intervention to mental health nursing home care	**Marit Borg** Recovery on the football pitch	**Phil Morgan** Do Future Studies have a role in promoting citizenship for people with mental health challenges?	**Dagmar Narusson** Coaching for recovery in Estonia
	Elidh Brown Connecting community through participatory budgeting and chime	**Alan Pringle** Notts County FC, mental health and recovery	**Daniel Cockle** Supporting recovery through communities	**Thomas Nordahl Christensen** Vocational recovery for persons with severe mental illness participating in individual placement and support and cognitive remediation: Results from a randomized controlled trial
			E S Rogers Lives in the community: dimensions of community	

			involvement of people with psychiatric disabilities	
11.00am	***Refreshments*** ***Viewing of posters and exhibition stands***			
11.30am- 12.30pm	**Parallel Session 3**			
	Session 3.1 **LT7** *Peer Support Work* Chair: Simone Arbour	**Session 3.2** **LT5** *Recovery in the Global South Symposium* Chair: Ursula Read	**Session 3.3** **LT4** *Human rights* Chair: Toni King	**Session 3.4** **LT1** *Qualitative Studies* Chair: Trude Klevan
	T Sreekanth Need for peer support recovery model for prisoners with common mental illness and substance use disorder in India	**Ursula Read** The right to live in the community": meanings of and resources for community inclusion in urban and rural Ghana	**Nada Al-Attar** Barriers to recovery in the Kingdom of Saudi Arabia	**Fiona Ng** The stages and processes of recovery in borderline personality disorder: A qualitative study of lived experience
	Gemma Dorer Enabling recovery: an evaluation of a co-produced peer led intervention	**Grace Ryan** "Nothing about us without us" in global mental health: Rhetoric or reality?	**Antoine Baleige** Using the QualityRights toolkit to promote human rights in mental health services - application to a French psychiatric sector in the suburbs of Lille	**Trude Klevan** It is kind of like a separate language
	Nikita Adams Is it feasible for peer specialist to work in child and adolescent units?	**Clement Bayetti** The Re-covering Self: a critique of the recovery-based in India's mental health care	**Inger Kari Nerheim** Looking for the curve ball	**Fadia Gamieldien** Recovery from severe mental illness: a South African perspective
	Simone Arbour Using peer support to enhance	**Rochelle Burgess** Talking 'bout a revolution:	**Angela Figueiredo** Family members as partners of care: an	**Frank Keating** The meaning of recovery for African and Caribbean men: An

	the transition from hospital to community	mental health recovery and cries for social change in Colombia	experience report of empowerment on community mental health services in Brazil	intersectionalities approach
		Norha Vera San Juan Meaning of recovery for Latin American service users and their carers		**Jyotsna Jain** A qualitative study: parents of persons with schizophrenia: planning after them
12.30pm	***Lunch*** ***Viewing of posters and exhibition stands*** ***Conference reflection session (Quiet room, 12.30pm-1.30pm)***			
1.30pm	Wellbeing event – Clap Happy!			LT2
2.00pm	**Chair: Stefan Rennick-Egglestone** **Joseph Leong Jern-Yi** – How personal recovery stories help spread the peer support movement in Singapore			LT2
2.30pm	**Michael Rowe** – Citizenship and Mental Health			LT2
3.00pm	***Refreshments*** ***Viewing of posters and exhibition stands***			
3.30pm- 5.00pm	**Parallel Session 4**			
	Session 4.1 **LT2** *NEON Study Symposium* Chair: Stefan Rennick-Egglestone	**Session 4.2** **LT5** *Democracy, Relationships and Recovery Symposium* Chair: Gary Winship	**Session 4.3** **LT4** *Mental health crisis care* Chair: Lene Falgaard	**Session 4.4** **LT1** *Narratives research* Chair: Heike Bartel
	Joy Llewellyn-Beardsley The characteristics of mental health recovery narratives	**Geoff Dennis** Slough – an enabling town	**Nicky Fitchett** My Wellbeing Plan, a co-produced collaborative approach to care and crisis planning	**Sam Robertson** Using lived experience to develop a personal narrative workshop programme in order to aid mental health recovery

	Stefan Rennick-Egglestone A change model for the impact of mental health recovery narratives	**Natasha Berthollier** Alternatives to admission – a new form of Therapeutic Community	**Jonas Fisker & Andreas Hoff** Return to work after sick leave with depression, anxiety or stress	**Anneliese de Wet** "For different clients it will be different": Interviews with service users, service providers and carers regarding the meaning of mental health recovery in the South African context
	Fiona Ng How do recovery narratives generate hope and connectedness?	**Vanessa Jones** Co-creation for recovery in the psychiatric hospital	**Claire Rotheram** The Life Rooms: does a non-clinical response to mental distress work?	**Heike Bartel** Poetry and recovery? Poems on male eating disorders
	Caroline Yeo "Whose VOICES are they anyway?" The curation of mental health, madness and recovery story collections	**Gary Winship** Chaos and recovery	**Jacob Beale** The Retreat; the role of lived experience in a drop in mental health crisis service	**Simone Arbour** Recovery and adolescents: leveraging lived experience as a driver of adolescent mental health research
	Adaresh Bhogal Practical considerations for mental health recovery narrators	**Kleopatra Psarrakis** Therapeutic Communities as a social movement	**Corrine Hendy & Mark Pearson** Qualitative Study of Open Dialogue working with people and their support network in crisis in Nottinghamshire Healthcare Foundation Trust	**Dimitar Karadzhov** Recovering at the extremes of disadvantage: a transatlantic, qualitative investigation of the experience of mental health recovery in the context of homelessness
	Ada Hui Institutional injustice: learning through the recovery narratives of marginalised communities	**Rex Haigh** Modified therapeutic communities for the future	**Katie Brown** Safety and Support Plans: the challenge of meaningful care plan co-production in a secure setting	**Louise Canacott** How do women with a diagnosis of borderline personality disorder, detained in secure and locked services perceive recovery? A grounded theory

	James Roe How can recorded recovery narratives find a place in mental health practice?			
5.00pm	***End of day***			

Conference dinner at Colwick Hall Hotel (optional extra)

6.30pm	*Meet at the registration desk for travel to conference dinner*
10.30pm (approx.)	*Arrive back at conference venue*

Thursday 5th September 2019					
9.00am	**Chair: Gabrielle Richards** **Pesach Lichtenberg** – Soteria: the final frontier of deinstitutionalization				LT2
9.30am	**Steven Allen** – The role of strategic litigation in pursuing human rights-compliant reform of mental health services				LT2
10.00am	***Refreshments*** ***Viewing of posters and exhibition stands***				
10.30am -12.00noon	**Parallel Session 5**				
	Session 5.1 **LT7** *Education* Chair: Karen Machin	**Session 5.2** **LT5** *Structured interventions* Chair: Laurie Hare Duke	**Session 5.3** **LT4** Dialogical session	**Session 5.4** **LT1** *Arts and mental health* Chair: Auden Pederson	**Session 5.5** **LT6** *Compulsion* Chair: Vicky Stergiopoulos
	Abigail Harris An evaluation of the extent to which Leicestershire Recovery College is accessible to and promotes good recovery outcomes for the local community	**Margaret Hendriks** The use of a structured program to support, empower and promote recovery in persons with mental health issues	A space to share your ideas, thoughts and reflections on the conference with others	**Audun Pederson** Art and culture as recovery tools	**Sarah Markham** Challenging epistemic injustice at state level in the context of the Independent Review of the MHA 2018
	Karen Machin Learning together: “The course that lives up to its title”	**Laurie Hare Duke** Development and feasibility evaluation of a social connectedness intervention		**Kristin Berre Ørjasæter** Experiencing small positive moments through participation in performing arts	**Candelaria Mahlke** A co-produced mental health worker training for acute wards to reduce violence and involuntary treatment
	Toby Brandon & Alisdair Cameron Teaching Mad Studies: a possible route to knowledge democracy	**Lorenzo Pelizza** Implementation of Individual Placement and Support in an Italian		**Kristin Berre Ørjasæter** Performing arts as a free-zone that supports recovery processes	**Andrew Hider** “I don’t want to come off my CTO”: the impact of psychological factors in

		Department of Mental Health			the operation of Section 17a of the Mental Health Act
	Joanna Fox A first person narrative: The potential of Acceptance and Commitment Therapy to improve wellbeing at work	**Pau Dotor** Providing a range of supports for individuals with mental health conditions who have contact with the Criminal Justice System		**Nastaran Doroud** Living Well; Supporting recovery through an innovative photo-voice program	**Vicky Stergiopoulos** Implementing a trauma-informed intervention for female survivors of gender-based violence: lessons learned in a large urban centre
12.00noon	**Debate: 'This house believes that there is no place for compulsion in a rights-oriented mental health system'** **Chair: Samson Tse** **For the motion: Alison Faulkner, Peter Bartlett** **Against the motion: John Copping, Vicky Stergiopoulos**				**LT2**
12.45pm	**Closing remarks – Samson Tse**				
1.00pm	**Conference ends**				

SPEAKERS WELCOMING YOU TO NOTTINGHAM

Image courtesy of Visit Nottinghamshire

Robin Hood
Ade Andrews is Robin Hood for the 21st century. An ambassador for Sherwood Forest, VisitNotts and VisitBritain, his Robin Hood Town Tour is Nottingham's leading attraction and Ade is guest speaker at the National Tour Guiding Conference this year.
#RobinHood
@EzekialBone
www.ezekialbone.com

Nottingham People's Choir
Funded by the Institute of Mental Health (IMH), the Nottingham People's Choir was formed in 2013 as an initiative to promote mental health. It is not a condition of Choir membership that people have used mental health services, yet recruitment of members takes place within a local NHS mental health trust. The group, located in Nottingham, is facilitated by a professional choir leader who is experienced in working with people with mental health problems with the support of a mental health nurse.

The Choir meets weekly during school term-times; it meets during the day time as there are a number of community choirs meeting locally in the evenings. It was thought that meeting during the day, would enable people who do not work to attend and during school term-time to enable parents to attend. The venue is provided pro bono by the Nottingham Royal Concert Hall in the city centre by an arrangement with the local authority. The Choir has a steering group that comprises mainly Choir members with representatives from the local authority, the venue, the IMH, and the local NHS trust.

David Crepaz-Keay is Head of Empowerment and Social Inclusion for the Mental Health Foundation. He has led the development, delivery and evaluation of many self-management and peer support across England and Wales. he has been a technical advisor to the World Health Organisation on empowerment issues, chaired a WHO working group on developing indicators of involvement, and has spoken and written widely on involvement, empowerment, self-management and peer support. He is an editor of the Journal of Mental Health Training, Education and Practice and sits on technical advisory groups for the Forces in Mind Trust (mental health research), NHS England and NHS Improvement (mental health payment systems), and is currently a senior advisor to Public Health England (mental health campaign).
With over thirty years of involvement as first a user of mental health services and later as a campaigner, he is also an advocate of service user voices being included in mental health service planning and delivery.

David was a Commissioner for Patient and Public Involvement in Health (2003-2007). The Commission (CPPIH) was created to give the public a voice in decisions that affect their health, and the health of the local. He was a founder member of the English national survivor user network (NSUN) and co-developed and facilitated the Welsh Mental Health Form (2014-2018).

Before working in mental health, David wrote economic models at HM Treasury of models of underground water systems for the water industry. He is also a qualified cricket umpire.

Martin Orrell is Director of the Institute of Mental Health, a partnership between the University of Nottingham and Nottinghamshire Healthcare NHS Foundation Trust, and also Head of the Division of Psychiatry and Applied Psychology at the University of Nottingham.

He has published over 300 academic papers and is Editor of the journal Aging & Mental Health.

Andy Long has been Deputy Vice-Chancellor and Provost at the University Nottingham since July 2018, taking the executive lead on strategic and operational planning and academic resources. Prior to this he served as Pro-Vice-Chancellor in Engineering at the University.

His research is on composite materials, in particular analysis and development of manufacturing processes for aerospace, automotive and renewable energy applications. This work has been supported by numerous research awards from research councils, UK government and industry. Most recently he was Director of the EPSRC Future Composites Manufacturing Research Hub, leading a consortium including 10 UK universities and 22 companies. In 2006 he was awarded the Institute of

Materials, Minerals and Mining Rosenhain Medal for distinguished contribution to materials science, and in 2014 he was elected a SAMPE Fellow for significant contributions in materials and process engineering technology.

WORKSHOPS

Expert Workshop 1: Co-Production

Facilitator: Julie Repper

Julie Repper is Director of ImROC. ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. Julie is also joint editor of the Journal of Mental Health and Social Inclusion and recently retired from being Recovery Lead at Nottinghamshire Healthcare Trust.

Julie has extensive experience of working as a nurse, manager, researcher and lecturer in mental health services; she has also been a Trustee of various voluntary sector groups, sits on a number of national committees and uses mental health services herself.

It is all of these experiences that drive her belief in the need to improve services and offer more recovery focused support. She strives to work across boundaries and with whole systems - including people who use services, health, social care and third sector providers, commissioners and academic institutions - to support collaborative approaches to facilitating recovery.

Abstract:
This workshop will provide a forum to discuss and develop ideas about co-production.

Participants will:

- Increase their understanding of coproduction at different levels of organisations and systems
- Explore the potential benefits and challenges
- Share experiences and ideas about ‘what works.
- Practice coproduction
- Co-produce ‘good practice guidelines’ for successful co-production

The workshop will begin by exploring the questions that participants have about co-production and provide a presentation about the meaning, facilitation and benefits of co-production drawing on examples of co-production at different levels. Participants will work in small groups to share their experiences and the challenges that they have encountered. All participants will work in mixed groups to practice co-production and observe their experience. These co-production groups will focus on developing guidance for facilitating effective co-production.

Expert Workshop 2: Mental Health and International Law

Facilitator: Peter Bartlett

Peter Bartlett is Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law in the School of Law at the University of Nottingham and the Institute of Mental Health in Nottingham. He has advised mental health law reform in Bosnia and Herzogovina, Armenia, Serbia, Georgia and Lesotho, and in 2013-15 was the expert advisor for the House of Lords Committee on the implantation of the Mental Capacity Act 2005. He has published extensively on human rights law and mental health/capacity/disability.
His open access publications may be found at
http://eprints.nottingham.ac.uk/view/people/Bartlett=3APeter=3A=3A.html

Abstract
Policymakers and people with lived experience of mental distress talk about human rights a lot, but what is it that we mean? Do our expectations fit with the content of the international standards and structures of human rights law? And what is this 'new paradigm' of human rights that we hear about?

In this workshop, we will –

- Distinguish between every-day and legal meanings of 'human rights'
- Explore the way human rights are enforced, both nationally and internationally
- Using the European Convention on Human Rights (ECHR) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD), explore two different visions (the 'old' and 'new' paradigms) of what human rights means for people with mental health problems, psychosocial disabilities, or learning disabilities
- Explore the way in which key elements of recovery interact with the CRPD, including the right to community living, the right to equality before the law (and legal capacity), the right to health, the right to be free from violence, exploitation and abuse, and the right to liberty.

Expert Workshop 3: Soteria Houses

Facilitator: Pesach Lichtenberg

Pesach Lichtenberg M.D. is a Jerusalem psychiatrist and associate professor of psychiatry at the Hebrew University in Jerusalem. After many years during which he served as the director of a closed psychiatric inpatient ward, he left in 2016 in order to establish the first Soteria home in Israel. He opened a second one in 2017, also in Jerusalem. Since then the model has been recognised by the Israeli Ministry of Health, and similar homes have begun to be established elsewhere in the country.

Abstract

Soteria houses in Israel have catalysed a change in the delivery of psychiatric care for people in states of extreme cognitive and emotional distress, such as psychosis and suicidal depression. Instead of being hospitalized in an institution, with the attendant ills of stigma, passivity, alienation and marginalization, the individual joins a therapeutic community in a well-staffed home in a residential neighbourhood. The emphasis is on emotional support, honest communication, empathy and recovery. Decisions are shared, including about medication. Where possible, the primary support group becomes a part of the process.

In this workshop, through presentations, open theoretical discussions, and small work group activities, we will explore and deepen our appreciation for the following areas:

- A brief history of the Soteria approach and its variants
- The potential of Soteria homes for changing the paradigm for the delivery of acute psychiatric care
- The distinction between mental health and illness
- An approach to establish meaningful rapport with people in extreme mental states
- The proper role of medication in providing care

Expert Workshop 4: Strategies for Promoting Citizenship

Facilitators: Michael Rowe and Helen Hamer

Michael Rowe, Ph.D., is a medical sociologist and Professor of Psychiatry at the Yale School of Medicine. His main areas of study, research and writing are citizenship, an applied framework for full social inclusion and participation, mental health outreach and homelessness, peer studies, and medical humanities. He is the author of many peer-reviewed articles, book chapters and other publications, and of six books, including Citizenship and Mental Health, Crossing the Border: Encounters Between Homeless People and Outreach Workers, Classics of Community Psychiatry and The Book of Jesse: A Story of Youth, Illness and Medicine.

Helen Hamer is an independent nurse consultant with extensive years of experience in both physical and mental health settings, teaching and supervising clinical staff and peer workers, delivering workshops that promote social inclusion and working with people on their journeys of recovery. Her research interests are in citizenship; social justice; rights; inclusion; mental health law and procedural justice; and modelling the consumer-clinician alliance to promote research that directly informs practice. She also has experience in leading and facilitating systems change to increase integration across primary and secondary care systems. She holds an honorary academic/research role at PRCH Yale University, Connecticut and has since supported and facilitated the development and delivery of the Citizenship Project in Aotearoa New Zealand.

Abstract

'Citizenship,' a way of thinking about the social inclusion and participation of people with psychiatric challenges, has been developed at the Yale Program for Recovery and Community Health in the U.S. from the late 1990s on, and has since been taken up in other countries. Using presentation, small and large group activities, and 'citizenship exercises, the objectives of this workshop are to:

- Convey the 'what' and 'why it matters' of citizenship and mental health to service users, practitioners, and others.
- Review and discuss the application of citizenship principles in mental health systems of care and outside them, including financial empowerment, citizenship-oriented care, community building, and more.
- Question, challenge, and discover how citizenship might work in different settings and countries, and the ways in which cross-national citizenship, already underway, can benefit users of services and supports, and enhance their valued roles in their communities and countries.

The workshop will be participatory, with a minimum (but enough) presentation and background information to give participants a firm foundation in citizenship ideas and practices.

Expert Workshop 5: Designing Sensitive Digital Health Interventions

Facilitator: Stefan Rennick Egglestone

Stefan Rennick Egglestone is a Senior Research Fellow in the School of Health Sciences at the University of Nottingham, and the coordinator for NEON, a five-year programme of work looking at whether recovery stories can be of benefit to people experiencing psychosis. Stefan has an interest in both mental health and interaction design research; his PhD considered the question of tailoring self-management technologies to the homes and motivations of stroke survivors. He will present a workshop on methods for designing digital interventions which take account of the needs of the individual, and which support an individual in making a meaningful recovery.

Abstract

Information and communications technologies are established as a mechanism for supporting people living with a range of health conditions, but evaluations show that drop-out rates are high, and users rarely complete a "course" of "treatment". I would argue that design of digital health interventions often underestimates the challenging personal and social settings in which technologies are used.

This workshop is designed to provide a rapid primer for those interested in how to design digital health interventions that are sensitive to needs and motivations of individuals.

- We will consider selected examples of methods which have been developed to generate an "empathic" understanding of the needs and motivations of digital health technologies.
- We will consider how these methods might be applied to real examples provided by workshop attendees.

KEYNOTE SPEAKERS
(in order of the programme)

Natalie Drew Bold is a Technical Officer with the Mental Health Policy and Service Development team in the department of Mental Health and Substance Abuse at the World Health Organization. As part of her work she supports countries to reform national policies, plans and laws and services in line with the UN Convention on the Rights of Persons with Disabilities and other international human rights standards. In addition, she oversees the WHO QualityRights Project, which builds capacity of national stakeholders to understand and promote human rights and recovery approaches in mental health.

Title of talk: WHO QualityRights: Transforming services and promoting rights and recovery in mental health

Abstract: WHO QualityRights is an initiative which aims to improve access to good quality mental health and social services and to promote the rights of people with psychosocial disabilities throughout the world. The initiative works in the following areas: capacity building to combat stigma and discrimination and promote human rights and recovery; creating community based mental health services and supports that respect and promote human rights and a person centered, recovery approach; supporting civil society movements and empowering people with lived experience to conduct advocacy and influence policy making; reforming policy and law in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.

Soumitra Pathare MD MRCPSych PhD is a Consultant Psychiatrist and Director of Centre for Mental Health Law and Policy at the Indian Law Society, Pune, India. His primary interests are in the areas of mental health policy, scaling up mental health services, rights-based care and legislation.
He is Project Director of SPIRIT Hub (2017-2022) a collaborative initiative scaling up and evaluating 3 universal suicide prevention interventions in a cluster randomised controlled trial. He is currently involved in scaling up Atmiyata across Mehsana district, Gujarat (2013-2019) with a population of 1 million. Atmiyata is a project to improve access to mental health services in rural areas, by training and mentoring women leaders of micro-credit self-help groups to provide basic psychological interventions and access to social benefits for a defined rural population. He was the Principal Investigator of QualityRights Gujarat project (2014-2016) which implemented the WHO QualityRights program in 6 public mental health facilities in Gujarat. He has served as a WHO consultant in many low and middle-income countries assisting in developing mental health policy and drafting and implementing mental health legislation. He has provided technical assistance to the Ministry of Health and Family Welfare, Government of India in

drafting India's new Mental Health Care Act 2017, which takes a rights-based approach to mental health care and provides for publicly funded universal mental health care.

Title of talk: Peer Support: an under-utilized resource in Low-middle income countries

Abstract: Over the past decade, peer support has become part of mental health service provision in high income countries. However, it relatively little used in mental health systems in low and middle income countries. This is surprising, given the huge deficit of mental health professionals in these countries. Challenges to implementing peer support in routine mental health services in low resource settings will be discussed using the presenter's experience of setting up and sustaining a peer support program in a mental hospital in India.

Mike Slade is Professor of Mental Health Recovery and Social Inclusion at University of Nottingham and Chair of the European Network for Mental Health Service Evaluation (ENMESH). His main research interests are recovery-focused and outcome-focused mental health services, including Recovery Colleges, lived experience narratives, peer work, identity, citizenship, wellbeing, needs assessment and developing measures, e.g. INSPIRE, Camberwell Assessment of Need, Threshold Assessment Grid. He has written over 270 academic articles and published 11 books, including Personal Recovery and Mental Illness (2009), Partnering for Recovery in Mental Health (2014), Positive Psychotherapy for Psychosis (2017) and Wellbeing, Recovery and Mental Health (2017). His free booklets include Making Recovery a Reality (2008), REFOCUS: Promoting recovery in community mental health services, 2nd edition (2011), 100 Ways to Support Recovery, 2nd edition (2013), The empirical evidence about recovery (2015) and The Business Case for Recovery (2017), all downloadable at researchintorecovery.com

Title of talk: Multiple perspectives on recovery

Abstract: Research about recovery has matured. In the past decade, study designs have moved beyond individual stories to incorporate mixed-methods approaches. There is a greater emphasis on theory-driven programmatic work, informed by lived experience but also including randomised controlled trials, systematic reviews and replication studies. An example is the REFOCUS Study. The next phase of development will involve three journeys of change for recovery research.

First, to go wider. The focus of research is slowly broadening from symptoms and treatments to citizenship and society. Examples include Individual Placement and Support for work, Recovery Colleges for education (RECOLLECT Study) and Housing First for home. New areas of research include social connectedness (CIVIC Study) and spirituality (MISTIC Study).

Second, to go further. Lower-resource countries and regions are often still dominated by hospital-based, clinician-led mental health systems. The UPSIDES Study is cross-culturally modifying, implementing and evaluating peer support work in lower-resource settings.

Third, to go deeper. Engaging with the disruptive innovation at the heart of recovery will require institutional transformation. This involves the development of new perspectives about, and use of, lived experience of ‘mental ill-health’. Emerging approaches include more use of recovery stories (NEON Study), trauma-informed support, Mad Studies and human rights.

Information on all named studies is at: researchintorecovery.com/research

Alison Faulkner is a freelance survivor researcher and trainer in mental health with over 25 years' experience of working in mental health research and consultancy. Alison has worked for most of the major UK mental health charities, including the Mental Health Foundation, NSUN (The National Survivor User Network), Mind and Together for Mental Wellbeing. She managed the user-led 'Strategies for Living' programme from 1997 to 2002, one of the first user-led research projects in the UK. Currently she is working part-time with Professor Diana Rose at King's College, London on a ground breaking project: EURIKHA, which seeks to capture and understand the knowledge contributions of service users and survivors across the globe. Alison has personal experience of mental distress and using mental health services, including inpatient care, medication, psychotherapy, A&E and crisis services. She was awarded her PhD in 2017 by City University, London on the role and value of experiential knowledge in mental health research.

Title of talk: The 'inconvenient complications'* of peer support in mental health

Abstract: This talk will address issues of power and empowerment, privilege and disadvantage in relation to current conceptualisations of peer support. What is the meaning of peer support - in all of its 'inconvenient complications'? What are the risks and possibilities for peer support in the UK in the 21st century, after years of austerity which have eroded its very foundations - at the same time as seeing a growth in peer support-as-intervention incorporated within mainstream services? Can we forge a bridge between these divided paths? The presentation will draw upon a number of sources of survivor research and activism as well as the mainstream research on peer support.

** This phrase borrowed from the following paper:*
Jones, N. and Kelly, T. (2015) Inconvenient Complications: On the heterogeneities of madness and their relationship to disability. Chapter Three in Madness, Distress and the Politics of Disablement, ed. Spandler, Sapey and Anderson. London: Policy Press.

Vicky Stergiopoulos is a Clinician Scientist, the Physician-in-Chief at the Centre for Addiction and Mental Health and Professor and Vice Chair, Clinical and Innovation, in the Department of Psychiatry at the University of Toronto. Her clinical and research activities focus on the development and evaluation of interventions to address the needs of people who are homeless and those who make frequent use of mental health services. She has a great interest in the redesign of our health system for the purpose of system improvement, in partnership with service users.

Title of talk: Improving housing and recovery outcomes for persons experiencing homelessness and mental health challenges

Abstract: Homelessness is a concern and a priority for many jurisdictions, and homeless and vulnerably housed people experience a high prevalence of physical and mental health challenges compared to the general population. The evidence on interventions to improve housing, health and recovery outcomes for homeless and vulnerably housed people with mental health challenges will be discussed, focusing on Housing First, recovery-oriented approaches, and additional interventions and supports to promote recovery for different populations**.**

Joseph Leong Jern-Yi has been working at the Institute of Mental Health (Singapore) since 2000. After obtaining his Certified Psychiatric Rehabilitation Practitoner (CPRP) in 2004, he also did his clinical fellowship at UCLA with Distinguished Professor of Psychiatry Robert Paul Liberman in 2009.

He was Deputy Chief of Community Psychiatry at the Institute of Mental Health working with Community Partners to build connections, capacity and capability. He shares his expertise in Psychiatric Rehabilitation and Recovery as an Expert Advisor to start up several Non-Governmental Organisations (NGOs) such Club HEAL, Caregiver Alliance, Hougang Care Center and St Andrew's Nursing Home. He also serves on the Board of the Singapore Association for Mental Health. He is the current President for the Association for Psychiatric Rehabilitation (Singapore).

For his contributions, he was given the Healthcare Humanity Award 2011 by the President of Singapore and the Distinguished Public Service Star Award in 2013 by the Singapore government.

Title of talk: How personal recovery stories help spread the Peer Support Movement in Singapore

Abstract: Joseph Leong Jern-yi first shared at the World Association of Social Psychiatry (WASP) Jubilee Congress in London November 2014 on the start of the Peer Support Specialist Movement in Singapore. He will now share the development the last 5 years and suggest that the Peer Support Movement is more like The Starfish and the Spider as a recovery movement spread by social media, mental health blogs and several peer run self-help groupings with Non-Government Organisations (NGOs), charities and religious organisations.

References:

1. Social inclusion: the Singapore story in community mental health development, psychiatric rehabilitation and recovery, Asia Pacific Journal of Social Work and Development, 26:2-3, 167-177, DOI: 10.1080/02185385.2016.1218793 by Shih Ying Gun & Joseph Jern-Yi Leong (2016)

2. The Starfish and the Spider The Unstoppable Power of Leaderless Organizations by Ori Brafman and Rod A. Beckstrom (2006)

3. Shattered We HEAL 2 – Peer Recovery Movement in Singapore: from one man to many Peer Support Specialists (2016) https://www.straitstimes.com/singapore/theres-no-shame-in-mental-illness

Michael Rowe Ph.D., is a medical sociologist and Professor of Psychiatry at the Yale School of Medicine. His main areas of study, research and writing are citizenship, an applied framework for full social inclusion and participation, mental health outreach and homelessness, peer studies, and medical humanities. He is the author of many peer-reviewed articles, book chapters and other publications, and of six books, including Citizenship and Mental Health, Crossing the Border: Encounters Between Homeless People and Outreach Workers, Classics of Community Psychiatry and The Book of Jesse: A Story of Youth, Illness and Medicine.

Title of talk: Citizenship and mental health

Abstract: Citizenship as an applied framework for the social inclusion and full participation in society of people with mental health challenges has gained some familiarity in 'mental health circles' in recent years. Still, many questions remain about its definition, its deployment in practice, and its outcomes. This talk will explore and attempt to answer the following questions:

- What does citizenship mean in relation to mental health and mental health care and where did it come from?
- Doesn't citizenship exclude people as well as include them, and isn't it thought of mainly in terms of its legal aspect? If so, why not simply take what it has to offer and add it to recovery, social inclusion, and other person-centered approaches?
- What has been 'done' with citizenship—what applications of it have been made and what research on it has been done in and outside of mental health practice and systems of care?
- Where is citizenship going and why does it deserve the attention of people who are interested in innovative and empowering ideas, practices, and supports in community mental health.

Pesach Lichtenberg M.D. is a Jerusalem psychiatrist and associate professor of psychiatry at the Hebrew University in Jerusalem. After many years during which he served as the director of a closed psychiatric inpatient ward, he left in 2016 in order to establish the first Soteria home in Israel. He opened a second one in 2017, also in Jerusalem. Since then the model has been recognised by the Israeli Ministry of Health, and similar homes have begun to be established elsewhere in the country.

Title of talk: Soteria: the Final Frontier of Deinstitutionalization

Abstract: Soteria is a recovery-based model which seeks to replace the hospital ward with a therapeutic community. The fundamental departure from dominant biomedical approaches to acute psychiatric distress is that extreme emotional and cognitive states, such as psychosis and suicidality, are treated not as neurophysiological aberrations, but rather as human

experiences requiring humane responses. We have established two Soteria homes in Jerusalem, and more are planned elsewhere in Israel. In our homes, the staff, mostly non-professionals and including many people with lived experience, strives to be with the person in her or his suffering, and not merely to suppress symptoms. We minimize hierarchy and boundaries, while cultivating open and honest communication. We also work intensively with families using Open-Dialogue-inspired approaches. Our dependence on pharmacological interventions is reduced.

What we began in 2016 as a semi-underground service funded by philanthropy and out of pocket payments has since acquired governmental recognition under the newly-minted category “stabilizing houses”. Subsequently such houses have begun sprouting elsewhere in Israel and are challenging the institutional paradigm for acute psychiatric care. Our ultimate goal is to establish the Soteria model as the first-line approach for people unable to remain in their homes and requiring round-the-clock care.

Steven Allen is Campaigns Director of the Validity Foundation, formerly the Mental Disability Advocacy Centre (MDAC), headquartered in Budapest. He leads the organisation's advocacy initiatives before regional and international bodies including the United Nations, Council of Europe, European Union and African Commission, and also served as interim Executive Director between 2017-18. He is an MPhil/PhD candidate at the University of London pursuing research on legal institutions which restrict or deny legal agency and holds an LLB (Hons) from the same.

Title of talk: The role of strategic litigation in pursuing human rights-compliant reform of mental health services

Abstract: As an international NGO (non-governmental organisation), Validity uses strategic litigation to promote, protect and defend the human rights of persons with intellectual and psychosocial disabilities. In this talk, Validity’s Co-Executive Director Steven Allen will discuss the need for grounding reforms of mental health systems in human rights standards; the way in which strategic litigation can be used to catalyse momentum for reform; and key developments jurisprudential developments in Europe and Africa.

Refocus on Recovery 2019 Debate

This house believes that there is no place for compulsion in a rights-oriented mental health system

Chair: Samson Tse

Samson Tse is Associate Dean (Undergraduate Education) of Faculty of Social Sciences and Professor of Mental Health in Department of Social Work and Social Administration at The University of Hong Kong. He has expertise in examining the complex mechanisms of recovery from severe and persistent mental illness like bipolar disorder and gambling disorder. He has served in government, and non-government organization advisory committees in New Zealand, Singapore and Hong Kong. Samson has presented to groups around the globe about issues he is passionate about: Living beyond disability and improving service users' experience. He was also the Co-Chairperson of the Programme Committee of the International Conference on Recovery-oriented Services and Policy Planning in Mental Health in 2018.

For the motion: Alison Faulkner, Peter Bartlett

Alison Faulkner is a freelance survivor researcher and trainer in mental health with over 25 years' experience of working in mental health research and consultancy. she has worked for most of the major UK mental health charities, including the Mental Health Foundation, NSUN (The National Survivor User Network), Mind and Together for Mental Wellbeing. She managed the user-led 'Strategies for Living' programme from 1997 to 2002, one of the first user-led research projects in the UK. Currently she is working part-time with Professor Diana Rose at King's College, London on a groundbreaking project: EURIKHA, which seeks to capture and understand the knowledge contributions of service users and survivors across the globe. Alison has personal experience of mental distress and using mental health services, including inpatient care, medication, psychotherapy, A&E and crisis services. She was awarded her PhD in 2017 by City University, London on the role and value of experiential knowledge in mental health research.

Peter Bartlett is Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law in the School of Law at the University of Nottingham and the Institute of Mental Health in Nottingham. He has advised mental health law reform in Bosnia and Herzogovina, Armenia, Serbia, Georgia and Lesotho, and in 2013-15 was the expert advisor for the House of Lords Committee on the implantation of the Mental Capacity Act 2005. He has published extensively on human rights law and mental health/capacity/disability.

Against the motion: John Copping, Vicky Stergiopoulos

John is a carer. His HealthWatch describes him as an influential member of a regional social enterprise of active mental health carers. An NHS approved service improvement leader, his career specialism was quality improvement and change management. He has worked for years with the College Centre for Quality Improvement (CCQI) unit of the Royal College of Psychiatrists and led joint-working with mental health commissioners and providers. He worked extensively with academics as one of the consultants contracted to facilitate knowledge transfer from universities into small companies. He recently completed a post-graduate course in heritage conservation and now practices in that field, with hopes of becoming perfect!

Vicky Stergiopoulos is a Clinician Scientist, the Physician-in-Chief at the Centre for Addiction and Mental Health and Professor and Vice Chair, Clinical and Innovation, in the Department of Psychiatry at the University of Toronto. Her clinical and research activities focus on the development and evaluation of interventions to address the needs of people who are homeless and those who make frequent use of mental health services. She has a great interest in the redesign of our health system for the purpose of system improvement, in partnership with service users.

Parallel Session 1
Tuesday 3rd September
3.30pm-5.00pm

Parallel Session 1.1
Theme: UPSIDES Study Symposium
Room: LT2

Richard Mpango
Implementing formal peer support in a low-income setting: Preliminary results of the UPSIDES qualitative research in Uganda

Introduction
Through the Brain Gain I and II projects initiated by the Butabika Link in Kampala, Uganda became the first low-income country to establish a formal peer support programme for people with lived experience of mental health conditions. The aim of this study is to identify factors that either facilitate or hinder implementation of peer support based on the Ugandan experience, to help inform the development of a conceptual framework for an international programme of implementation research on peer support called UPSIDES.

Methods
Focus groups and interviews were conducted with key stakeholders at Butabika National Referral Hospital in Uganda. Four focus group discussions (FGDs) were held, with eleven participants each; two with Peer Support Workers (PSWs), one with Psychiatric Nurses (n=11) and one with Psychiatric Clinical Officers (PCOs). Two hospital managers and one policy maker also participated in key informant interviews. Both focus group discussions and interviews were conducted in English, audio-recorded, transcribed, and coded by hand for thematic analysis.

Results
A number of key themes and sub-themes were identified, across the following areas: (1) Institutional readiness; (2) Economic constraints; (3) Knowledge base; (4) Attitudes; and (5) Practices. The general ethos of peer support as a recovery-oriented intervention focused on empowerment of people with lived experience was described by many as a strength, but also a potential source of conflict between PSWs and the clinical staff responsible for mental health care. Participants generally expressed enthusiasm for peer support and felt it should continue at Butabika, but also raised practical concerns regarding sustainability in a low-resource setting.

Discussion
The Ugandan experience indicates that for clinical services developing a peer support programme, it is particularly important to address the organisational culture, staff attitudes and support for peer support workers, for example through training, clarifying roles, ensuring adequate resourcing, and developing peer networks.

Ashleigh Charles
Modifications to mental health peer support: systematic review

Introduction
Peer support involves people with lived experience of mental health problems helping others to recover from mental health problems. PSW roles are being implemented in several countries internationally, with modifications to fit the local context. There is no framework to inform modifications of the PSW role to address local contextual and cultural aspects. Addressing this knowledge gap will inform implementation in diverse setting. The aim of this review was to characterise modifications to mental health peer support work when implemented in different settings. The objectives were to develop a typology of types of modifications and to characterise the rationales for these modifications.

Methods
A systematic review and narrative synthesis was conducted. The search strategy identified

15,300 unique publications, and 39 publications were included with only one from a low-resource setting. Planned and unplanned modifications to PSW, and the rationales for these modifications were analysed, producing a typology of modifications and rationales for these modifications.

Results

Planned adaptations were reported in 22 (56%) studies, unplanned adaptations in 10 (26%) and both planned and unplanned adaptations in 7 (18%). Six modifications were identified: role expectations; initial training; type of contact; role extension; workplace support for peer support workers; and recruitment. Five rationales for modifications were identified: to provide best possible peer support; to best meet service user needs; to meet organisational needs, to maximise role clarity; and to address socio-economic issues.

Conclusions

The typology and rationales for PSW modifications can be used to inform implementation of peer support work in a range of settings. Considering each identified modification as a candidate change will lead to a more systematic consideration of whether and how to modify the approach to peer support to different settings. Understanding modifications needed for PSW implementation in low-resource settings is an important future research focus.

Ramona Hiltensperger

Organisational Readiness for UPSIDES Peer Support: Materials, Strategies and First Experiences

Introduction

Peer support has shown promising results as a recovery-oriented intervention for persons with mental illness in a number of countries. The international multicenter study UPSIDES will scale-up peer support interventions at six sites in Africa, Asia and Europe. One of the biggest challenges for implementation of peer support in mental health institutions is lack of organisational readiness. This presentation will outline how context- and culture-specific strategies to promote organisational readiness across UPSIDES study sites will help to ensure successful and sustainable implementation of the UPSIDES peer support intervention.

Method

Overall strategies and materials for promoting organisational readiness were developed based on information from scientific literature, focus group discussions, local advisory board meetings and expert consultations. Further local adaptations for each UPSIDES study site were made to account for cultural appropriateness.

Results

An overview of developed UPSIDES materials and strategies for promoting organisational readiness for peer support will be given and, as an example, the local adaptations for the UPSIDES study site in Ulm, Germany, will be presented.

Discussion

The unique cultural background, as well as different levels of peer support experience at each of the UPSIDES study sites influenced the organisational readiness materials and strategies. Long-term approaches for preparing and training employees at all levels of the organization are crucial for successful and sustainable implementation of peer support in mental health services.

Candelaria Mahlke

Using Peer Support In Developing Empowering Mental Health Services: Results from the pilot phase

Introduction

To strengthen the recovery-focus in mental health, Peer Support interventions have shown promising results in a variety of different settings. The UPSIDES project developed a training and intervention based on the core aspects of recovery and Peer Support, considered relevant for each country and setting, and locally adaptable components, following a framework for cultural adaptation. During the UPSIDES core training, the upcoming Peer Support Workers learn how to draw on their lived experience and how to support others in

their personal recovery. The training and intervention will be piloted at each UPSIDES recruiting site (Germany, India, Israel, Tanzania, and Uganda).

Method

The UPSIDES pilot phase takes place in a sample of high- middle- and low-income countries. An overview of the Peer Support training and intervention is given. Data will be collected from the participants of the UPSIDES training, the service users in the intervention and local stakeholders from each study site. A mixed-method approach, comprising focus groups, questionnaires, and interviews will be used to evaluate the pilot phase and to further amend the training and intervention to the different cultural contexts.

Results

The core modules of the UPSIDES Peer Support Training, as well as an overview about the development of the USPDIES Peer Support intervention are given. Results from focus groups, questionnaires, and interviews will be presented.

Discussion

Implications from the training development and pilot phase will be discussed in relation to the need to modify the Peer Support training and intervention to best fit the different global contexts.

Jasmine Kahla

Implementing peer support in public mental health facilities, Gujarat, India: Key reflections and challenges

The legal and policy framework in India has under-utilised peer support as a form of mental health care and treatment. Peer support was introduced within six public mental health facilities in Gujarat, within the broader framework of QualityRights intervention from 2014-2016. This was the first structured intervention of peer support applied within public mental health care systems in India. This intervention was able to impact Gujarat State policy as it continues to provide financial support to peer support since June 2016. This paper will describe the context and impact of peer support as an intervention within mental health care through the lens of an implementation research team. It will describe the process of peer support implementation in six facilities, focusing on the methodology of the intervention process. It will further describe challenges faced during the process by the implementation team. The paper will also describe key lessons learned in the process of implementation which have impact on policy and practice of mental health care from a recovery perspective. It will briefly describe the scope for improvement in implementation through (i) Using Peer Support in Developing Empowering Mental Health Services (UPSIDES) consortium and (ii) changes in the legal framework that support rights of persons with disabilities.

Parallel Session 1.2
Theme: Recovery-Orientated Practice
Room: LT5

Keren Wolstencroft

Bringing recovery and wellbeing into mental health service practice

Introduction

Despite advances in our understanding of what mental health systems and services can do to enhance wellbeing outcomes for people seeking support, it has been challenging to operationalise new knowledge at the practice level. This presentation will share findings from a recently published study which assessed consumer and staff perspectives about the implementation and value of a practice approach developed in Australia (1). The Collaborative Recovery Model (CRM) is a person-centred strengths-based coaching model, purposely designed to assist translation of recovery and wellbeing oriented knowledge into service practice.

Methods

The setting was a large Australian community-managed mental health organisation. The study involved a cross-sectional analysis of consumer (n = 116) and staff practitioner (n = 62) perspectives.

Results
Findings revealed that staff and consumers perceived that the key practice elements were being implemented at a high level and that the practices were perceived as being important or very important for assisting recovery. Significant moderate correlations were found between the extent that practice elements were valued and the level at which they were applied. Higher levels of implementation were associated with higher ratings of session helpfulness.
Discussion Points
Despite challenges, recovery and wellbeing oriented knowledge and evidence, are translatable to real world mental health service settings. Factors that may have assisted translation in the study setting. The importance of an approach being valued by both staff and consumers as responsive and relevant to people's lives. The combination of recovery knowledge, an orientation to wellbeing, and the inclusion of coaching methods; as a practical solution for delivering on new and evolving demands.
Reference
1. Wolstencroft KE, Deane FP, Jones CL, Zimmermann A, Cox M. Consumer and staff perspectives of the implementation frequency and value of recovery and wellbeing oriented practices. International Journal of Mental Health Systems. 2018;12(1).

Michaela Høj
Can a participatory research inspired approach to further development and implementation of a recovery-oriented model facilitate recovery-oriented practice in public-sector services?

Introduction
Studies indicate that implementation of a recovery-oriented practice is challenging. This study therefore investigates if a participatory research inspired approach to implementation of a recovery-oriented model, called RENEW-DK, can facilitate a more recovery-oriented practice in two public sector services in Denmark.
Methods
Narrative interviews with ten professionals from a mental health centre and an employment centre were analysed through a Science and Technology Studies perspective.
Results
Findings demonstrate that, despite a rigorous process of contextualising the model in a one-year long implementation and development phase, professionals experience RENEW-DK to be challenging due to the dissonance in values and intentions between the model and the two employment contexts. In their practice, they therefore continue to shape the boundaries of RENEW-DK in accordance with organisational requirements and professional beliefs. Thus, for example in regard to practicing network meetings, practice did not change profoundly towards becoming more recovery-oriented. Nevertheless, professionals did describe to have changed their perceptions in regard to being more appreciative of how a strength-based approach and working with a broader perspective of the service users might be a valuable approach.
Discussion
The study calls to attention the importance of acknowledging dissonances between intentions in models, and values and structures in organisations. Furthermore, it presents perspectives in regard to how supervision might be used as a valuable approach to make explicit when professionals' practices are conforming with earlier practices instead of changing towards becoming more recovery-oriented.

Sarah Brydges
Exploring views from service users upon an intervention designed to support recovery for men taking antidepressants, in a community pharmacy setting.

Introduction
Help seeking can support recovery in depression, yet typically men limit help-seeking in depression. Additionally many men have poor social-support networks, which can hinder metal health recovery. Academics advocate a gender sensitive approach to developing

services to support men. Peer support services, particularly with male peers, and task focused services have been beneficial and acceptable to men in depression recovery.
An healthcare field men under utilise for recovery is community pharmacy, yet the pharmacy profession is seeking to better support those with depression. This research is about implementing an first in a field service for men treating depression with antidepressants. The specific question is to appraise the methodology of the prototype intervention with three key components; peer support interactions including a feedback loop, asynchronous communication via video messaging, and a community pharmacy setting.

Methods

12 men taking antidepressants, and 4 pharmacists were interviewed before and/or after they modelled the service. Male peers either proposed a question, and gave feedback upon reply (peer 1) or replied to a question (peer 2). Data was transcribed and analysed using thematic analysis.

Results:

Key themes were:
Confidentiality: key barriers on service and video messaging were around confidentiality, and this was linked to wanting to keep things in during depression.
Altruism, Reflection and Focus: Altruism, being heard, and self-reflection were benefits for peer 2. Opportunity to reflect on concerns, and focus upon specific issues, were key benefits to peer 1.
Setting: The setting was accessible. Some commented in a trust in NHS systems, with comparisons made to social media.
Asynchronous communication. This was a barrier for some, hindering peer interactions, yet others felt it avoided the service being time dependent, increasing its accessibility.

Discussion

Implementation would require further development in line with medical research council guidance on developing a complex intervention.

Hayley Thomas
Helping People See Their Progress

Background

Within inpatient learning disability settings there is a risk that care may be disempowering due to a lack of balance between proactive supportive, skill building and reactive interventions. Progression through an individual's care pathway alone through prescribed clinical treatment is often not enough to facilitate long term change and maintenance of community skills. Building Better Lives is a novel framework that delivers active support (Mansell, Elliott, Beadle-Brown, Ashman & Macdonald., 2002) and progression through key areas ("looking after me", "working together", "looking after where I live", "the community and me," and "living together"). These domains are incorporated into primary prevention of PBS plans, supporting the integration of the principles of active support and positive behavioural support (Allen, James, Evans, Hawkins & Jenkins., 2005).

Aim

Our service aimed to create a co-produced incentive plan that actively engages clients to work through their care pathway whilst also encouraging maintenance of skills developed using their chosen incentives.

Procedure

Research has indicated that the use of meaningful incentives can increase engagement (Houghton et al., 2008) and so incentives are co-produced. Building Better Lives goals are co-produced and used to formulate a service user led incentive plan.

Outcomes

The intervention has resulted in an improvement in engagement with and perceived focus on functional goals for inpatient treatment alongside traditional clinically focused outcomes such as symptoms and challenging behaviour Service users are engaged in their plans and are making progress to complete their incentives. This has meant that there is an increased engagement in activities, and overall well-being. There has also been a more consistent approach used by the MDT to ensure a direct focus on progression, since the system

populates MDT paperwork alongside more traditional clinical outcome measures.

Kenneth Thompson
Recovery Fusion

Introduction
Significant cultural and philosophical differences often exist between a recovery philosophy and the traditional medical model approach to care. Similarly, misunderstandings often exist between clinical/medical staff and peer staff. These two philosophies appear to be at opposite ends of the spectrum, and resist joining forces. RI International believes that bridging the gap between these two disciplines poses the greatest impact for faster, more positive clinical outcomes, an approach which we refer to as "Recovery Fusion". This session will discuss the efforts being made by the company to overcome some of the traditional barriers often encountered when agencies attempt to adopt a more recovery-based approach to care.

Methods
The session will include a review of the multi-pronged efforts undertaken by RI International to bridge these two disciplines including continual staff training, creation of unique job descriptions, the deployment of operational structures and practices that support collaboration, and the use of continuous quality improvement practices.

Results
60% of the current workforce is comprised of persons with lived experience, and peers play an equal role to clinical/medical staff in the treatment and care of the individual. Peers are embedded in every treatment team, on every shift, and often outnumber the clinical/medical staff in certain settings. Clinical and operational infrastructure support the inclusion of peers at all level of treatment decision-making.

Discussion
This session will briefly review the history of the recovery movement and subsequent inclusion of peers into the workforce, with emphasis on the future trajectory of this model given the increased use of peers in all treatment settings and the mounting body of research supporting enhanced outcomes when peers are embedded in treatment teams.

Kenneth Thompson
Using Peer Supports In Crisis Settings

Introduction
Expansion of a peer workforce most often means hiring persons with lived experience into least-restrictive settings such as outpatient care. The use of persons with lived experience in acute inpatient and/or crisis settings is less common due to reservations about using some of the least (traditionally) trained staff in the highest levels of care. RI International operates nearly fifteen crisis centres across the U.S. and peers comprise the majority of the staffing.

Methods
The crisis centres utilize a "Peer First, Peer Last" philosophy of care which has transformed the face of crisis care as we know it. This means that when a guest is being admitted to the unit, a peer is the first person he/she has contact with. At times this peer has been a patient at the centre him or herself and can walk the guest through what to expect as they prepare for admission. Likewise, a peer is the last person the guest interacts with at discharge. On a typical six-person shift, four of the six staff are peers. Unique positions such as that of a "Milieu Specialist" are utilized to maintain the therapeutic environment.

Results
The substantial use of persons with lived experience in crisis settings has resulted in decreased incidents of violence towards self/others, decreased physical holds, and decreased seclusion and restraints.

Discussion
Discussion will encourage an open dialogue and knowledge exchange about the strengths and limitations of using peers in crisis settings.

Marianne Farkas
A Social Media Program to Promote Recovery: Inspiring Hope and Community

Introduction
Recovery promoting services focus on hope, wellbeing, and interpersonal connections, for example, which represents a major shift away from the more pathology- and symptom-oriented models of services of the past. There has been a growing effort to develop e-mental health interventions to support clinicians delivering services, however, none of these interventions specifically fosters community inclusion and recovery of people in mental health recovery (MHR), based on a vision of hopefulness (Ben-Zeev et al., 2012; Lal & Adair, 2014; Tal & Torous, 2017). The aim of this project was to create a recovery–oriented virtual community for individuals living with mental illnesses. "Recovery 4 US" is now available via both a smartphone application for iOS and Android platforms through the corresponding "app store", and web browser. The program content is modeled on the principles of Photovoice as a community based participatory action research methodology (Catalani & Minkler, 2010) and other work done at the Center for Psychiatric Rehabilitation,(e.g. Russinova et al. 2014; Russinova et al., 2018). "Recovery 4US" includes three main components: 1) daily receipt of a hope-inspiring message, paired with a corresponding visual image; 2) creation and viewing of recovery-oriented Photovoice works; and 3) attendance of community events initiated by members of the "Recovery 4US"community who live in close proximity to each other.
Method
Recovery4US was developed and tested, with the full inclusion of people in MHR, using step-wise iterative testing in 4 phases: 1. content development; 2. mobile usability; 3. desktop usability testing and 4. 3 month prototype pilot. 1. 11 people, including 6 in MHR, used a 3-round Delphi consensus process, to select and evaluate hope-inspiring quotes; 2. 5 people in MHR, used the app and provided feedback to specific questions. 3. 5 in MHR used the website, answering the same questions as used in Phase 2; 4.11 in MHR were given smartphones for 3 months to use the app.

Parallel Session 1.3
Dialogical session
Room: LT4

A space to share your ideas, thoughts and reflections on the conference with others.

Parallel Session 1.4
Theme: Spirituality and Power
Room: LT1

Matthew Aldridge
A Buddhist Āyurvedic Approach to Supporting Recovery through Services in the UK

Introduction
Developing new and better interventions for supporting recovery is a top priority for health providers in the UK. Mindfulness-based, compassion-focused and other Buddhist-derived interventions for mental health have become increasingly valued, and there are many who would prefer interventions that more closely resemble traditional Buddhist approaches. Over the past decade in Sri Lanka an approach to supporting recovery has been developed called "Buddhist Āyurvedic Counselling and Psychiatry" (BĀCP) - a new subject area in Buddhist studies grounded in ancient texts which have endured over 2000 years since 400 BCE.
The three main aims of this research were:
• To identify BĀCP theory and treatment methods
• To identify the existing evidence-base for BĀCP
• To model BĀCP process and outcomes for provision in England
Methods
The three main methods used in this research were:
• Constructivist grounded theory
• Literature review of randomised controlled trials (RCTs)
• Review of practice-based evidence

Results
According to BĀCP, mental health problems arise within the operation of processes such as memory, intellect, patience and perceptions. Through recognising the associations between the various psychophysical factors, recovery can be supported in a holistic way. BĀCP includes four main therapeutic approaches: physical, behavioural, mental and cognitive therapy. There are no published Randomised Controlled Trials (RCTs) on BĀCP protocols but some small scale RCTs have been conducted on Āyurvedic treatment methods for mental health (included within BĀCP). Initial delivery of BĀCP in England followed a protocol collaboratively developed with international experts in Sri Lanka, and 20 mental health service users gave positive feedback.
Discussion
Currently an 8-week group programme delivering BĀCP is being developed collaboratively with the SLaM Recovery College. Alongside service user feedback, service evaluation will include standard clinical outcome measures (e.g. CORE-OM) and physical observations (e.g. BMI). BĀCP has potential as a new approach to supporting recovery through services in the UK.

Katja Milner
Experiences of spirituality among adults with mental health problems: Qualitative systematic review findings and the MISTIC framework

Introduction
Spirituality, in both religious and non-religious forms, is an important component of mental health care and recovery. Research demonstrates that many people using services would like to have their spiritual needs addressed within mental healthcare services. However a 'religiosity gap' exists in the difference in the value placed on spirituality and religion by professionals compared with service users, often resulting in people's spiritual needs being neglected within clinical practice. Reasons for this include a lack of understanding about the complex ways people connect with spirituality within contemporary society. A better understanding of spirituality and mental health from the perspectives of people who experience mental health difficulties could help to bridge the 'religiosity gap' and promote engagement between mental health service users and clinicians.
Methods
A summary of findings will be reported from a qualitative systematic review of the experiences of spirituality amongst people with mental health difficulties. An electronic search of seven databases was conducted along with searching bibliographies and forward-referencing of all eligible studies, hand-searching journal contents pages and expert consultation.
Results
Thirty-eight published qualitative research studies were identified which met the inclusion criteria. A thematic synthesis of the study findings identified six key themes: Meaning-making, Identity, Service-provision, Talk about it, Interaction with symptoms and Coping, giving the acronym MISTIC.
Discussion
This study is the first qualitative systematic review to explore the experiences of spirituality among adults with mental health difficulties and offers a framework for developing holistic, strengths-focussed and person-centred approaches to mental health care. This can be utilised to aid understanding and address people's spiritual needs within healthcare practice by integrating the spiritual dimension as part of a holistic approach towards care.

Rachel Waters
Producing the 'patient in recovery': pastoral power in the recovery approach

Introduction
My study investigates how recovery is practised in mental health services through the in-depth analysis of interactions between professionals and service users. I draw on Foucauldian concepts, and discursive psychology to explore how power is exercised by professionals and service users in their interactions to produce, maintain or resist recovery.

Methods
The study was ethnographic and was carried out in three mental health services in South Wales. I observed and recorded meetings between professionals and service users, interviewed staff and service users and made general observations at the services.
Results
Recovery was understood as happening through a combination of psychological, pharmaceutical and other treatments in combination with service users' efforts at self-management, goal attainment and control of symptoms. The service users I observed could be divided into 'recovering' and 'non-recovering', these categorisations were expressed by staff and service users, and were usually in agreement. Staff drew on a pastoral power model which included monitoring, expressing care for, persuading, inducing, and praising service user's efforts to be self-managing, autonomous and responsible. 'Recovering' service users worked with professionals to jointly construct themselves as trying hard, motivated, future-oriented and as taking responsibility for their recovery. The 'non-recovering' service users rejected the pastoral model of care, and resisted, adapted and rejected recovery discourse, preferring different approaches, complete independence from services or contested goals for recovery. Some service users did not understand recovery as relevant and/or possible for them.
Discussion
The techniques employed by service users and staff within a recovery framework, to transform service users into autonomous, self-managing, independent citizens can be seen in individual interactions in mental health services. The implications of these findings for service users, professionals and mental health services will be discussed.

Toni King
Using The Recovery Approach And Participative Action Research To Explore Experiences Of Power And Control In Interactions Between People Who Self Harm And Staff In Community Mental Health Services

Introduction: This PhD study will be 6 months into its development by September. It proposes to explore the experiences of people who self harm and come into contact with community mental health services. The number of people who self define as matching this description is increasing, whilst their experience of receiving support from mental health services is variable and at times poor. Staff working in this area often experience conflict and powerlessness in managing their duty of care to the individual, the needs of the service and their own internal responses. This can reduce the quality of care provided and impact on the wellbeing of staff. The Recovery Approach highlights the need and impact of redressing power imbalance within individual and system wide interactions. This study's intention is to draw the lived and professional experience together to examine the meaning and pertinence of power and control within the clinical interaction.
Method: Participatory Action Research and discourse analysis are the indicated methods at this time.
Results: N/A (not commenced)
Discussion: This works aims to contribute unique knowledge about the experience of power and control in the clinical interaction between people who access and people who work within mental health services. It specifically focusses on people who self harm and community staff, exploring their experiences and impact on the wellbeing of both actors. It is intended that this work would enable the development of a set of principles / framework for staff and people who access services in order to ensure the most sensitive and efficacious experience of power within the clinical encounter. This outcome would be a valuable contribution to the recovery agenda, through improving the recovery of those accessing services and the resilience and wellbeing of staff within them

Emma Watson
Who has the knowledge and who's knowledge counts? Exploring power in the context of peer support

This presentation will explore how peer workers describe and experience power in their

roles. This is based on qualitative research, which included interviews with 18 peer support workers in Nottinghamshire NHS Foundation Trust. Peer support relationships are often described as mutual relationships, where power is shared and both people are the experts in their own experiences. However when peer workers are employed in helping roles, the role of power demands further exploration. Peer workers describe their experiences of simultaneously feeling powerful and powerless within peer support relationships, and within the wider context of mental health systems. Therefore power within peer support cannot be understood as static or one-dimensional. Given that power is deeply connected to knowledge, the authority that a peer worker has often depends on who they are relating to and whether their lived experience is valued as a form of knowledge. The presentation will explore the different forms of power and how these relate to peer support, as well how the context of mental health services affects the power that peer workers feel they hold.

Parallel session 1.5
Theme: Qualitative Studies
Room LT6

Siv Graav
Factors that may determine recovery from symptoms of depression without formal help: a quantitative approach

Introduction
The scientific foundation of recovery models is mainly based on qualitative studies. Previous research points to the need for more quantitative evidence. The recovery from untreated depression is an overlooked area of research and there is a need for studies using high-quality population-based studies. It is also recommends to focus on the role of social networks and social interactions in the process of recovery. This research project address the recovery processes of persons who recover without formal help or support. The goal of the study is to identify the personal and social conditions that may determine recovery.

Methods
In this project we use data from The Health Study in Nord-Trøndelag (HUNT), Norway`s largest collection of health data from the general population (https://www.ntnu.edu/hunt). Data is obtained in four waves (ten years apart), the first was carried out in 1984-1986 and the last wave will be completed in the autumn 2019. The data from HUNT was collected by means of questionnaires, which includes for example a symptom depression scale and a variation of questions regarding personal and social conditions. We will investigate personal and social conditions among adults that recovered from symptoms of depression without formal help using data from HUNT wave 3 (2006-2008) and 4 (2017-2019).

Results
This project is a part of a lager study that is under development. We will be presenting our preliminary results.

Discussion
This project will contribute to the research area of recovery, describing factors that may determine the likelihood of remission. We expect that these results will be essential for planning future society and help services.

Emilia Deakin
Using the Social model of identity change to understand identity changes in recovery from psychosis

Introduction
Redefining and rebuilding a positive sense of identity has been recognised as a key process in personal recovery. Literature on identity change and psychosis has focused on the all-encompassing nature of illness identity. The applicability of dominant models of identity to people who have experienced psychosis has also been questioned. The UNFOLD study aims to identify processes involved in developing an identity as a ‘person in recovery’, and how recovery from mental ill health may unfold over time.

Methods

The social identity approach, and corresponding model of identity change (SIMIC) provide a framework for understanding the processes involved in identity change and recovery. Social identity maps will be used to visually represent and assesses changes to participants' social identity. Smartphone data will also be used to examine interaction with members of social groups and levels of wellbeing. The qualitative arm will investigate whether social identity processes are part of the experience of recovery from psychosis. The qualitative arm will investigate whether social identity processes are part of the experience of recovery from psychosis.

Results

A framework will be presented for understanding change to social identity in recovery from psychosis

Discussion

The SIMIC model shows that the negative effect on wellbeing can be reduced by certain social factors. The ability to take on new relationships following a life changing transition can be a way for an individual to protect themselves against this. The model describes how belonging to multiple identities prior to life transition is important because they can provide a basis for forming new group identities after life transition. They may also provide a basis for maintaining some of the relationships over the period of the transition.

Snigdha Dutta

Understanding Pathways to Resilience in Undergraduate Students: A Theoretical Approach

Introduction

Rising prevalence of depression, anxiety, and suicide in university students in the U.K. highlights the need for building resilience and promoting young adults' mental well-being. To create effective evidence-based resilience promoting interventions, it is important to understand and contextualise the development and evolution of resilience in higher education settings. The study's aim is to test a novel multi-faceted theoretical model of resilience, based on an ecological framework. Well-established individual, familial, and social risk and protective factors are hypothesised to predict the development of resilience processes in university students. The role of cognitive reappraisal is hypothesised to be the potential underlying mechanism leading to the development of resilience processes. Moreover, demographic characteristics (e.g., gender and ethnicity) are hypothesised to impact the relationship between these risk and protective factors in developing resilience.

Methods

A 2-phase longitudinal study has been conducted, and data has been collected from undergraduate students via a self-administered online survey. Structural equation modelling will explore the data and test the hypothesised model's predictive validity.

Preliminary Findings

A final dataset comprising of responses from two time-points from 362 undergraduate students has been obtained (mean age 20.7 years; 79.7% females; 36.9% first year students; 81.4% white British). Further analysis is ongoing to examine the hypothesised models using structural equation modelling on Mplus.

Conclusion

The study is the first to test an ecologically-based theoretical model of resilience processes for undergraduate students to contextualise the process of their development and trajectories. Understanding this process over time may allow for the development of sensitive and theoretically-driven interventions in higher education settings.

Mário César Rezende Andrade

Recovery assessment and associated factors in an outpatient sample of people with Schizophrenia in Brazil

Introduction

Personal Recovery is increasingly driving the policies for people with severe mental illness. In Brazil, despite recent advances in community mental health care, the adoption of a Recovery-oriented approach remains in early stages. This study aimed to assess the level of

Recovery and its association with clinical measures in a Brazilian sample of people with schizophrenia.

Methods

This cross-sectional study comprised a non-probabilistic sample of 104 people with schizophrenia receiving outpatient care in a university psychiatric centre. Personal Recovery was measured using the Brazilian short-version of the Recovery Assessment Scale (RAS), comprising 24 items with a five-point Likert scale, distributed into five domains. The following clinical measures were also used: the Self-Assessment of Occupational Functioning Scale (SAOF); the general psychopathology, positive and negative dimensions of the Positive and Negative Syndrome Scale (PANSS); the Calgary Depression Scale for Schizophrenia; the Independent Living Skills Survey (ILSS) and the Clinical Global Impression (CGI). The mean scores of RAS domains were compared using ANOVA for repeated measures and clinical measures associated with RAS total score were identified using linear multiple regression. Significance level was $p<0.05$.

Results

The mean total sum score of RAS was 85.8 (S.D.=1.1) and the mean score was 3.9 (S.D.=0.04). RAS domains with the highest scores were “Goal/success orientation” and “Reliance on others”, while the domain “Not dominated by symptoms” presented the lowest score. A lower score in the Calgary Depression Scale and a higher score in the occupational functioning measure (SAOF) were the only variables associated with a higher level of Recovery.

Discussion

Despite cultural differences, our general findings were similar to those from international literature. Like in previous studies, a higher level of Recovery was associated with a self-rated clinical outcome, in this case, occupational functioning, and with lower affective symptoms, as measured by Calgary Depression Scale.

Fiona Ng

The role of self-identified recovery and diagnostic status on outcomes in borderline personality disorder: A mixed-methods study

Introduction

Personal recovery in mental health is described as a process, with individuals as experts of their own experience. Whilst the majority of research focuses on symptom reduction, an individual’s perception of their recovery may differ from clinical accounts of outcome. This study aimed to explore outcome differences in individuals with lived experience of borderline personality disorder (BPD) based on three different criteria - diagnostic status, self-identified recovery status, and combined diagnostic and self-identified recovery status.

Methods

This mixed-methods study consisted of survey responses from 349 individuals with lived experience of BPD. BPD symptoms and self-identified recovery status was used to understand differences in personal and clinical recovery outcomes. Personal definitions of recovery were thematically analysed to understand what constitutes recovery in BPD.

Results

Self-identified recovery status had a significant main effect on personal and clinical recovery outcomes, whilst diagnostic status had an effect on clinical recovery only. Using a clinical screening measure, 90% of individuals met criteria for BPD, whilst 79.1% self-identified with being not recovered. There was concordance between diagnostic and recovery status in 75.4% of individuals, with a minority of individuals who did not meet criteria and self-identified with being recovered (3.2%). Diagnostic status was predicted by age, relationship status and score on Mental Health Inventory–5, yet no variables were predictive of self-identified recovery status. Individual definitions indicated recovery could take on two definitions, recovery as self-management or recovery as not possible.

Discussion

An individual’s self-identified recovery status and views on recovery have important implications for understanding outcomes in individuals with lived experience of BPD. There is a need to gain understanding of an individual’s perspective within clinical practice settings

in order to holistically understand the needs of individuals and progress in recovery.

Linda Nesse

Recovery in co-occurring substance use and mental health problems: A cross-sectional study with residents in supported housing in Norwegian cities

Introduction

Recovery and quality of life are currently emphasized on a policy level for services working with persons who experience co-occurring substance use and mental health problems. This includes supported housing and connected services. There is, however, a scarcity of knowledge about residents' self-reported recovery and quality of life, as well as aspects of everyday life which may have an impact on how life is perceived, such as support from staff. The current study aims to map and explore self-reported recovery, quality of life and support from staff with residents in supported housing as respondents.

Methods

A cross-sectional survey study was conducted between August and November 2018. The study was carried out at 21 supported housing sites in six cities across Norway, with a total of 104 participants. The study is part of a research project based at the Center for Mental Health and Substance Abuse, University of South-Eastern Norway (USN), in collaboration with the Norwegian University of Life Sciences (NMBU). Recovery was measured employing the Recovery Assessment Scale revised (RAS-R). Quality of life was assessed with the Manchester Short Assessment of Quality of Life (MANSA) and single items on positive and negative affect. Support from staff was measured with the Brief INSPIRE.

Results

Descriptive findings from the study will be presented, along with results on the associations between recovery, quality of life and support from staff.

Discussion

Implications for practice and the recovery-orientation of housing and connected supports for persons with co-occurring problems will be discussed.

Parallel Session 2
Wednesday 4th September
10.00am – 11.00am

Parallel session 2.1 **Theme: CHIME and REFOCUS** **Room: LT2**
Lyn Williams **CHIME to Care – Improving Collaborative Care Planning in Practice using Improvement Methodology**
Introduction Within Leicestershire Partnership NHS Trust, a twelve month project was established as a quality improvement programme to understand and address concerns about the gaps in recovery orientated practice and improve how we work with service users and carers through collaborative care planning. The project aims were to find ways of routinely improving our approach when constructing collaborative care plans. ***Methods*** The Recovery and Collaborative Care Planning programme was initially co-produced by a small programme team who had knowledge and experience in delivering recovery orientated services. Collaborative academic advisory oversight has been in place throughout the programme of work. Expertise has also been contributed by clinical staff. However, the real strength to this project has been the involvement of service users and carers with lived experience and their growing leadership input. The lynchpin of the project is a monthly learning and improvement group using strengths based collaborative World Café methodology. This has developed into a community of practice, co-produced with service user and carers. ***Results*** Through the café, we have applied CHIME to changing conversations to become more collaborative. Developing a shared understanding about recovery has been informed and underpinned by masterclasses which has utilised the CHIME conceptual framework. The group has developed guidance on recovery and collaborative care planning that is co-produced with service users and carers. We have designed and launched a recovery based module with De Montfort University. 75 places have already been offered to qualified healthcare professionals. ***Discussion*** Session evaluations evidence the value of the project. Exploration of the potential for applicability within physical health services is underway. An evidence base was been needed to design this work so as to engage with staff in thinking differently about collaborative care planning supported by skilful strengths based conversations. This programme has delivered that to date.
Ingo Tschinke **Introducing Recovery as complex intervention to Mental Health Nursing home Care**
Introduction Recovery in psychiatric organizations isn't very widespread in mental health system in Germany. Most of the psychiatric workers have heard about it, but because of the structure of the mental health system and the domination of the bio-psychosocial model, training for Recovery such as the REFOCUS Training isn't available. The goal of our project was an introduction of Recovery as a complex intervention to Mental Health Nursing home Care. ***Methods*** We translated the REFOCUS Workbooks and presented them in three Focus Groups. The Members of these Focus Groups were Leading Managers and Owner of Mental health Nursing home care services. After the transcription of the text, the analysis was made with MaxQ Data, the Data was reduced by the method of the qualitative content analysis by Udo

Kuckartz.

Result

In the result the REFOCUS Program was accepted as a workable and meaningful instrument for the Training of Mental Health nurses in the ambulatory services. In Addition some aspects were added to support Recovery in practical use and to implement Recovery as complex intervention in organisational change.

Discussion

The German health system is fractionated and dominated by the medical viewpoint of the bio-psychosocial model. Through the Recovery Training of mental health nurses in community services and mental health hospitals a change of the Health system could be achieved as a bottom up systems.

Elidh Brown

Connecting Community through Participatory Budgeting and CHIME

Introduction

Elidh and Holly reflect on their shared learning journey in relation to participatory budgeting (PB). Through these reflections and the co-creation of a joint presentation Elidh and Holly share how we position our work connecting people and communities in Moray, in a different way, to realise recovery and wellbeing through community empowerment, using PB and CHIME to overcome barriers and tackle stigma.

Methods

Through reflection we have identified 5 key changes/shifts, and offer three concluding reflections regarding Participatory Budgeting (PB), CHIME and stigma as a persistent barrier. Through PB, people and communities in Moray are recognised as assets. Stakeholders make decisions that shape the PB process. More people experience positive outcomes from participating in the co-creation of solutions for and with their own communities.

Results

Initially, coproduction was aspirational rather than realised, with capacity building and mutual exchange with partners required to make this possible. Greater public involvement came, but at what cost? PB can be, but is not necessarily, strength-based. Co-creation and co-production require specific methods and take time. Peer champions co-facilitated deliberation workshops, shifting the balance of power. Together we held the space for peers to come together and collaborate. Partners and stakeholders worked together explicitly embedding CHIME methodology into the PB process, through the co-produced Applicant Toolkit, Funding Criteria, Stakeholder Deliberation, Voting and Celebration events. Participatory budgeting is a meaningful mechanism for taking recovery back into communities in Moray. CHIME supports multiple stakeholder identities. People taking part connect and begin to transcend traditional boundaries and divides. Stigma remains a persistent barrier. More people and communities require resources and support to be engaged in the participatory budgeting process.

Discussion

Through shared reflection with Elidh, Holly articulated the following question: Can CHIME be used as a mechanism or tool for taking recovery back into communities? Discuss.

Parallel Session 2.2
Theme: Sport and Mental Health
Room: LT5

Adam Benkwitz

Enhancing Mental Health through Sport: Methodological Reflections on Two Community Projects.

Introduction

As the practice and discourse of mental health recovery evolves, increasing appreciation has been given to personal recovery and now social recovery. It therefore follows that we need initiatives that enhance levels of social capital, positive social identities and social inclusion

within the community, not just within mental health services. These initiatives must bring people together in ways that allow them to feel that they have ownership of any new social infrastructures and use evidence-based frameworks to evaluate them. One context that has been given some consideration is the use of community sport. This paper therefore contributes to the steadily growing literature in this area by exploring the specifics of two different mental health football projects, through the utilisation of the personal and social recovery frameworks that have been established within the 'mainstream' mental health evidence base.

Methods

Both studies were underpinned by a relativist ontology and a constructionist epistemology, however one adopted an ethnographic approach whilst the other used semi-structured interviews. Both studies gathered data from participants in the projects as well as those who delivered the sessions.

Results

Participants were considerably positive about both projects, and data suggested a strong adherence to the empirically based CHIME personal recovery framework. In terms of alignment with the social recovery concepts, the data was particularly robust in supporting active citizenship processes, but more work is required to explore the contextual impact of poverty and employment, and the role that sport can potentially play.

Discussion

Specifically, this paper shall reflect on the differing methodological approaches and how each can offer opportunities to explore what personal or social recovery might mean for participants in these 'community sport for mental health' related contexts, whilst still offering an appreciation of participants' lived experiences.

Marit Borg
Recovery on the Football Pitch

Introduction

The first Norwegian street soccer team started in 2012. There is great variation of team organization, from being a part of a premier league team (NPL), to NGO's and other initiatives. This study was a part of a collaboration between the University of South-Eastern Norway (USN), Center for Mental Health and Substance Abuse, and the Norwegian Football Foundation. The objective was to study recovery-experiences in four street football teams, where the players struggled with mental health and substance abuse issues.

Methods

This qualitative study had a collaborative approach involving people with lived experiences in the research process. A competence group participated in all steps of the research. Data were developed in focus group interviews with 50 participants. There were two interviews at each site. Through collaborative thematic analysis, three main themes were identified.

Results

The themes were 1. The football team as a safe place. The team was a safe arena for friendship and belonging, for meaningful activity and general meaning in life. The team was a helpful place for trying things out and taking chances. 2. A place here you can be yourself. The team constituted a unique community, where the players could support each other through sharing, giving and taking boast and feeling welcome. 3. Best follow-up system. Being a player in the team made services more accessible. People from services were at trainings and matches. This helped the players in various ways, like sorting out finances and practicalities, finding work and re-establishing family links.

Discussion

The study reveals a variety of recovery-pathways. Being a part of the team created a supportive community and a feeling of belonging and giving opportunities to contribution as well as commitment. Being a player offered meaning and partnerships, in general and with services. The teams created a nurturing environment.

Alan Pringle
Notts County FC, Mental Health and Recovery

Can there be a more prominent symbol for a community than their local football club?

Recent years have seen the development of mental health interventions being delivered in football clubs across the country. One of the most successful clubs in this field has been Notts County FC whose Football in the Community programme has spent more than ten years developing and delivering mental health programmes for many parts of the community.

These include programmes aimed at primary school age children, people with dementia, adolescents and men with mental health problems, refugees and women with mental health problems. Evaluation of many of these programmes has been developed and carried out in conjunction with the University of Nottingham.

This presentation outlines the way Notts County are working to implement recovery ideas in their programme delivery including the club being developed as a venue for Notts Healthcare Trust's Recovery College.

Parallel Session 2.3
Theme: Citizenship
Room: LT4

Lisa Archibald
Wellbeing manifesto

Big Psychiatry (our medical-led mental health and addiction system) was created around 200 years ago in an historical moment that established the construction of madness as an illness. The new profession led a medicalised, institutional and coercive system, where even the best intentions led to routine harm and poor outcomes.

Despite the closure of the old psychiatric hospitals and the addition of some community support services, Big Psychiatry still sits at the hub of our mental health and addiction system, where it shapes the world view and draws on most of the available resources. Its medical lens and expensive, narrow interventions focus on symptom reduction and short-term risk rather than holistic wellbeing and long-term outcomes. New Zealand led the world by taking the first significant steps in the transformation from Big Psychiatry to Big Community (a multi-sector, community-led wellbeing system) in the 1990s and 2000s, through the closure of the large psychiatric hospitals and growth in community support services.

However, in the last decade a crisis has developed from persisting inequality, loss of leadership, lack of investment in Big Community and a complex, inflexible and fragmented system. There is widespread public concern about levels of distress and suicide, especially among Māori and youth. Many people cannot access help until they are in a deep crisis. People who use services are poorly served, with increasing rates of coercion, traumatising crisis interventions and a paucity of comprehensive responses. We must restart the journey to Big Community and resist pressure to pour more resources into the current obsolete model.

Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress and addiction has open access to a comprehensive range of responses.

The Wellbeing Manifesto was conceived by Mary O'Hagan, a lived experience advocate, and former mental health commissioner with a long-held interest in system transformation. It was refined at a PeerZone seminar in November 2017 and through further consultation with Māori, Pasifika people, health promotion experts, mental health professionals, mental health system leaders and people with lived experience.

Phil Morgan
Do Future Studies have a role in promoting citizenship for people with mental health challenges?

Introduction

People with mental health challenges face exclusion and discrimination as citizens. Attempts to promote peoples' rights have been long standing but progress has been slow (Ponce and

Rowe, 2018; Slade et al., 2017; Vervliet et al., 2017). This presentation will argue it is important to not just explore citizenship in the present but also pay attention to future impacts to promote citizenship for people with mental health challenges.

Methods

This workshop examines citizenship, mental health, and future studies.

Results

Due to advances in technology society is rapidly changing and new ideas of citizenship are emerging (Harari, 2017, Isin and Nielsen, 2008; Isin and Ruppert, 2015). Future Studies explores the potential impact of developments within technology (Pino, 1998) and offers a practical approach to encourage constructive hope about social challenges (Davidson, 2017; Ojala, 2015). In Western society citizenship is conventionally viewed as the relationship between the individual and state and the rights and responsibilities of each. They are based on social norms which can exclude and sustain oppression (Ponce and Rowe, 2018). It is argued that critiques of citizenship can surface challenges to existing power structures (Atterbury and Rowe, 2017; Isin and Nielsen, 2008; Vervliet et al., 2017). Central to promoting citizenship for people with mental health challenges is amplifying the voices of people with mental health challenges, co-producing approaches, and allying to the wider disability struggle and identity politics; (Rowe and Davidson, 2016; Slade et al., 2017).

Discussion

This raises questions on how the voices of people with mental health challenges can be heard in these discussions. Future studies have been used to discuss feminist futures (Bergman et al, 2014; Gunnarsson-Östling et al., 2012). This workshop raises the question could a similar approach lead to discussions supporting inclusive future citizenship for people with mental health challenges?

Daniel Cockle

Supporting Recovery through Communities

Our presentation is focused on the work that the Recovery Team at Kemple View do in building links and partnership working in the community. These links build communities for our patients in a setting outside of the hospital. Community partners range from Burnley football club to the Canal and River Trust and Red Rose Recovery. The opportunities that these projects have provided have supported patients to move on in their Recovery and create connections in the local community. This has meant that the step to discharge has been much smoother in regards to support networks and meaningful relationships.

Much of the work that is done by the Kemple View recovery team involves taking positive risks. A prime example of this is the community boxing session that is available to our patients. This is been fantastic in improving physical health but also demonstrates the importance of keeping yourself busy and connecting with other people in an environment outside of the hospital.

The Kemple View recovery team also works collaboratively with the patients. This co-production element means that patients take on a role of responsibility that empowers them and gives them a focus to succeed.

E. S. Rogers

Lives in the community: Dimensions of community involvement of people with psychiatric disabilities

Introduction

In the US (as well as other countries) de-institutionalization has enabled individuals with psychiatric disabilities to live in the community however, research suggests that they continue to experience loneliness and social isolation (Toner, Fabisch, Priebe, & Klug, 2018; Mann, et al., 2017) and lack social connections and community engagement (Rowe & Pelletier, 2012). While interventions have been developed and tested to increase participation in normalized residential, employment and educational settings (e.g., Gulcur, Tsemberis, Stefancic, & Greenwood, 2007; Drake & Bond, 2014), fewer interventions have addressed community participation. A fuller understanding of the community lives of individuals with psychiatric disabilities is needed to optimize efforts to increase the

community participation of this population.

Methods

We will describe the results of two initiatives at the Center for Psychiatric Rehabilitation pertaining to community participation: 1) a multi-faceted survey undertaken to document both the objective and subjective aspects of community participation among a cohort of individuals with serious mental illness. A total of n=302 participants in mental health programs engaged in a one-time, face-to-face interview that queried them in detail about their community lives; 2) results about the community goal setting process and outcomes embedded in the testing of a new peer-led intervention designed to enhance community participation among individuals with psychiatric disabilities – the Bridging Community Gaps Photovoice (BCGP). As part of the BCGP program we systematically assist participants to explore and set self-determined, SMART (Specific, Measurable, Attainable, Relevant and Timely) goals that are informed by Community Asset Mapping (Minkler, Wallerstein, & Wilson, 2008).

Results

From the survey of community participation, we will describe results pertaining to the objective types and frequency of community activities. We will describe subjective indicators as well including psychological sense of belonging, loneliness, perceptions of neighbourhood acceptance, and perceptions of social support. In addition, we will describe what individuals report as being their "closest and most important" communities and how those communities are related to psychological sense of belonging and perceived loneliness. Results that examine differences in community participation by various demographic characteristics and clinical characteristics will also be presented. Secondly, we discuss interim findings from the testing of the BCGP intervention, including the challenges to assist participants to explore and set attainable community participation goals. In addition, we will report on common goals set by study participants and we will illustrate with the Photovoice pieces they have created as part of the intervention. Photovoice is a powerful technique that enables participants to represent their community goals through both photographs and accompanying narratives.

Discussion

We will discuss how reported results comport with extant research and our current understanding of the community lives of individuals with psychiatric disabilities. In addition, we will discuss implications for services and practice in terms of reducing social isolation and improving the community lives of individuals with serious mental illness.

Parallel Session 2.4
Theme: Coaching
Room: LT1

Keren Wolstencroft

Can coaching promote an orientation to wellbeing for people who are experiencing mental illness or psychological distress?

Introduction

New knowledge and societal demands are requiring significant shifts in how mental health service providers think about the purpose and aims of service, and innovation in terms of how they can enact these shifts.

Method

The aim of this presentation is to explore the case for the utility of coaching to deliver on these demands. We note the increasing reference to its application in mental health care.

Results

The potential of coaching as a form of mental health support may lie in its ability to facilitate the agency of people to know and act on what matters, relative to their environment.

Discussion

Within the coaching field, coaching is typically pitched in terms of facilitating personal growth, learning and development, each of which appear relevant for people seeking support

to ‘grow and live beyond the effects of mental illness’. However, there are prevalent statements and inferences attesting to its unsuitability for people with a mental health diagnosis. For example, coaching is described as being: for individuals, groups and organisations who do not have clinically significant mental health issues or abnormal levels of distress (APS IGCP, 2015). Much of the argument for this kind of positioning is based on distinctions about the wellness or functioning of people attending coaching versus counselling/therapy or distinctions about the aims and focus of each. What this presentation proposes is that if the focus of mental health services is purposed to improve recovery and wellbeing; and incorporate notions of empowerment, hope, purpose meaning and responsibility - then such distinctions may be flawed. Present distinctions may not be well-informed and at worst may be an example of the type of othering that can be experienced by people living with and experiencing mental illness - particularly in relation to notions of autonomy and potential for self-determination.

Dagmar Narusson
Coaching for Recovery in Estonia

Introduction

The aim of this study is to determine aspects of the application of the key principles and practices of coaching for recovery in the mental health client work process in Estonia. The personal recovery orientation in mental health practice demands a shift in attention to enhancing health and well-being and a change in engagement style. Recovery coaching is one of the practices, which contribute to the development of the goal-focused and change-focused thinking in the recovery and facilitates hope and self-empowerment. Mental health practitioners in Estonia have gained experience in using co-vision group coaching. Coaching for recovery with clients has been lacking in Estonian mental health. In 2018 the first “Coaching for Recovery” training for mental health practitioners in Estonia took place. This course has been taught in Nottingham for over 10 years and has provided an excellent opportunity to be at the forefront of a new project with MH staff in Estonia. The course is an introduction to the principles of coaching skills, takes place over two consecutive days, and combines theory with practice. Illustrating how the brain elicits answers when effective communication, powerful questions, and the Grow Model technique are incorporated results in choices, options, and outcomes. This abstract summarizes the study which was carried out from Oct 2018 until March 2019, and focused on finding out how coaching for recovery principles has been integrated into practice among the participants of the course in three different mental health settings: (1) special rehabilitation-focused closed schools, (2) in mental health community housing and (3) in open mental health centers and in a recovery college.

Methods

The semi-structured interview focused on integrating coaching elements (1) in practitioners’ personal life, (2) indirect client work, (3) in staff reciprocal support practice and organizational culture. Audio-recorded interviews (up to 1,5 hours long) were transcribed. Interview texts were coded by using the MAXQDA qualitative analysis program. Coded data were analyzed based on the principles of thematic analysis.

Results and Discussion

Key practice elements of coaching which have been integrated show a shift (1) in rapport, such as being more respectful and (2) in conversations, such as asking powerful questions. In addition, practitioners have learned to focus on the “difference that has made the difference”. They have effectively integrated the coaching elements into everyday activities.

Thomas Nordahl Christensen
Vocational recovery for persons with severe mental illness participating in individual placement and support and cognitive remediation: Results from a randomized controlled trial

Introduction

Individual Placement and Support (IPS) seems an effective vocational intervention for people with severe mental illness to obtain vocational recovery. However, the effects of IPS

has not been demonstrated in a Danish welfare model and it has been suggested that the vocational effects can be further enhanced by supplementing IPS with cognitive remediation and work-related social skills training (IPSE).

Methods

The trial was an investigator-initiated randomised, three-group parallel, assessor-blinded, multisite trial. 720 participants with severe mental illness were recruited from early intervention teams (OPUS teams) or community mental health services in three Danish cities and were randomly assigned to receive IPS (N=243), IPSE (N=238), or SAU (N=239) from November 2012 to February 2016. The primary outcome was number of hours in competitive employment or education during the 18-month follow-up. This was analysed with a proportional odds model. Analysis was by intention to treat.

Results

During the 18-month follow-up, the IPSE group on average worked or studied 488 hours compared with 340 hours in the SAU group (OR 1.76, 95% CI 1.15-2.67, p=0.005). The difference between IPS versus the SAU group was 411 vs. 340 hours (OR 1.53, 95% CI 1·02-2·31, p=0·018). We found no differences between groups in symptoms, social- or cognitive functioning, which also indicates that there were no adverse effects of the intervention. Significantly higher satisfaction with treatment was found in the two experimental groups compared with SAU. Results from 30 months follow-up and the cost-effectiveness of the interventions will be presented.

Discussion

IPS and IPS supplemented with cognitive remediation and work-related skills training can be implemented in a Danish welfare model and demonstrate vocational effects in a Danish context.

Parallel Session 3
Wednesday 4th September
11.30am – 12.30pm

Parallel Session 3.1
Theme: Peer Support Work
Room: LT7

T Sreekanth
Need for Peer Support Recovery Model for Prisoners with common Mental Illness and Substance Use Disorder in India

Introduction
The prevalence of mental health problems in prisons is three to five times higher than that of the general population. Mental health professionals in the correctional setting in India are few. There is a need to develop a recovery model where peers and prison staff can be used as resources for identifying and providing supportive services to prisoners with common mental health and addiction.

Methodology
Systematic review of peer-support interventions in the prison to understand the models used across the world in the area of prisoner's mental health was conducted. Further key informant interviews with mental health professionals (n= 3), prison officials (n = 3) and the forensic psychiatry team (n = 2) was conducted to formulate a programme of conducting a peer support recovery programme for prisoners with common mental health disorder and substance use in the Central Jail at Bengaluru, India.

Results
The peer support recovery programme developed for feasibility testing had in three phases. Phase1: Training peers (convicted prisoners) and staff of prison in mental health promotion, common mental health problems and substance use, identification of persons with common mental health problems, basic supportive skills and methods of referral. Phase 2: Conducting mental health promotion in different barracks in the prison by peers and staff. Phase 3: Identification and provision of mental health services to prisoners with 6 months follow up to assess, number of cases identified, number people referred, improvement in clients' symptoms, coping and wellbeing, satisfaction and challenges of the trainers and the end users.

Conclusion
In keeping with the social work principles of human rights and social justice, the implementation of this programme would help bring about a change in the mental health care delivery system in the prison (social change), through social empowerment of the peer counsellors for improving the well-being of the prisoners.

Gemma Dorer
Enabling Recovery: An Evaluation of a Co-produced Peer Led Intervention

Introduction
Research demonstrates the positive impact of peer mentorship across a range of contexts. Building upon this, Peer Support Specialist (PSS) roles have been incorporated into NHS mental health services. Although models of PSS interventions vary, good outcomes have been shown for PSS led psychoeducational groups. Several factors have been considered to explain this however the research is in its infancy.

Objectives
To evaluate a PSS and NHS practitioner co-produced "Enabling Recovery" group that supports service-users' recovery, whilst providing pathways for appropriate transition from mental health teams. The evaluation set out to assess how the attendees experienced the group and the impact of the group on subsequent contact with services.

Methods

The sample included 23 service-users (f.10, m.13) with a range of mental health conditions. The design involved a content analysis of focus groups and group evaluation forms; an assessment of direct and indirect contacts made in the three months prior, and following, the group; and a record of the number of discharges and referrals made following the group.

Results

Group content and social contact were rated as most helpful and cognitive demands and paperwork as least helpful. Number of direct and indirect contacts significantly reduced, four attendees were discharged due to improved mental
health and 17 began accessing third-sector/community organisations

Conclusions

This paper adds a novel contribution to the PSS literature, offering support to the utility of co-produced PSS interventions in an NHS setting. Findings suggest that PSS and NHS Practitioner co-produced group interventions are effective in reducing service demand and increasing service-user satisfaction.

Nikita Adams

Is it feasible for peer specialist to work in child and adolescent units?

Introduction

This local service evaluation explored the feasibility of the development of the Young Peer Specialist role and offering Recovery Education on an Adolescent Unit in Dorset.

Methodology

A survey of the staff attitudes were conducted at the beginning of the project and at 18 months. We also completed reflect accounts exploring our journey of co-producing the project, including key areas of development, learning, and feedback from young people and parents.

Background

Whilst peer specialists and peer support workers have been established in adult mental health services (IMROC 2017) the development of peers in child and adolescent units had limited exploration in the literature. The peer support literature for young people focuses on supporting transitions to adult services (Lambert et al., 2014; Oldknow et al., 2014). Therefore, this local service development project was established. It was co-produced working with the Lead for Recovery Education, staff from the adolescent inpatient unit, peer specialists from Dorset Mental Health Forum, and young people who had expressed an interest in peer work who had been inpatients on the unit.

Results

Two cohorts of interested young people were trained and peers have been working in to the unit for two years. The staff survey demonstrated that the attitude of the staff group had shifted from one of concern to peers being seen as an integral part of the recovery process.
Young people, parents and staff reported the benefits of having peer specialists on the unit and the hope that it inspires. There was significant learning in regards to recovery education. Young people didn't want a structured educational framework in which to explore their recovery and through co-production flexible approaches were developed.

Discussion

It is feasible for peer specialist to work in child and adolescent units. Recovery Education needs significant adaptation to be relevant to young people. There is significant learning to be shared, including aspirations for the future.

Simone Arbour

Using Peer Support to Enhance the Transition from Hospital to Community

Introduction

Transition from an inpatient hospital stay back into community life can be difficult for individuals with severe mental illness. Social isolation can considerably hinder this process. Peer support has the potential to minimize the impact of isolation and can instill hope. The purpose of the present study was to implement this type of peer support through a transitional discharge program. In this program Peer Support Specialists (PSS) leverage their lived experience to support individuals to improve the transition from a specialized

mental health hospital into the community.

Method

The Transitional Discharge Program was piloted on three adult psychiatric units within a hospital in Ontario, Canada. Service users who expressed social isolation and lived locally, were invited to participate in the program (N=16). Each participant received up to 12 peer support sessions over a span of 3 months that began while the service user was still in hospital and continued up until approximately six-weeks post-discharge. Each session lasted approximately 1 hour and consisted of activities of the participants' choosing based on pre-identified recovery goals. Activities encompassed both instrumental support such as locating and providing rides to community resources and emotional support such as supportive discussions. The INSPIRE and Recovery Assessment Scale were used to examine the impact of the program pre- and post-participation.

Results

A preliminary analysis of data suggests that perceptions of peer support (INSPIRE) were significantly better following participation in the Transitional Discharge Program (p=.006). Personal recovery (RAS) scores for 50% of participants increased after the program.

Discussion

Findings suggest that spending time with a PSS improves perceptions of support and personal recovery. The experiential knowledge shared by PSS can help service users gain a more positive outlook outside clinical settings, enhancing their outcomes, thereby positively influencing transition from hospital.

Parallel Session 3.2
Theme: Recovery in the Global South Symposium
Room: LT5

Ursula Read
"The right to live in the community": meanings of and resources for community inclusion in urban and rural Ghana

Introduction
Ghana is signatory to the UN Convention on the Rights of Persons with Disabilities which describes the right to live independently in the community. However, there is little exploration of what this means and how this might be achieved in particular contexts. Notions of community as a locus of support which can be mobilised around shared values is seldom interrogated. This study aims to:
• Explore how independence, community, support and inclusion are conceptualised in rural and urban locations
• Identify resources for and barriers to social inclusion to inform policies and interventions

Methods
Research employs participatory and ethnographic methods including: community mapping and key informant interviews; participatory groups, observation and in-depth interviews with persons with experience of mental illness and family members.

Results
Community is widely perceived as providing a sense of belonging and obligations for support. However, there are fears of community breakdown and decline in solidarity. Inequalities may exacerbate social exclusion with a rise in homelessness, particularly in urban areas. Community-based mental health services have expanded but lack resources. Costs of treatment and limited support can leave families struggling to provide care. Despite increases in NGOs and advocacy groups, these are unevenly distributed and driven by donor funding.

Discussion
Whilst Africa inspires nostalgic reveries of communal support, rising costs of living, unemployment and precarity, as well as stigma, threaten the ability of persons with mental health problems to live meaningful lives in the community. Despite increases in community-based services and advocacy in Ghana, fragmentation and intermittent funding limit their capacity to provide consistent support. Furthermore, emphasis on vulnerability and protection can preclude opportunities for participation. The emergence of persons with experience of mental health issues as advocates suggests new promise for representation and inclusion but requires resources and efforts to include the most disadvantaged to avoid widening inequalities.

Grace Ryan
"Nothing about us without us" in global mental health: Rhetoric or reality?

Introduction
The 2018 Lancet Commission claims that global mental health is undergoing a "transformational shift" toward an ethic of "nothing about us without us". Yet global mental health has also come under scrutiny for failing to meaningfully engage people with lived experience of mental health conditions in research, policy and service delivery in low- and middle-income countries (LMICs). In this presentation, we review the current state of the literature on the involvement of people with lived experience in LMICs and share experiences of co-production from the Butabika National Referral Hospital in Uganda.

Methods
We conducted a rapid review of primary research published between June 2017 and December 2018, across eight electronic databases. We included primary research conducted in LMICs using any kind of study design, so long as it reported on the involvement of people with lived experience in mental health policy, services or research.

Results

We identified ten studies from nine countries across Asia, Africa and Europe. The majority were qualitative and conducted as part of a situation analysis, pilot study or other formative research. Few reported the results of efforts to improve involvement. Three reported on involvement in mental health policy and planning, three on involvement in mental health services or capacity-building of service providers, and three on involvement in treatment decisions. Upon further consultation with the corresponding author, an additional study was identified as having involved people with lived experience in data collection.

Discussion

The rapidly increasing number of studies published on involvement of people with lived experience suggests the field of global mental health may indeed be at the early stages of a transformational shift. However, the effects of this shift are not yet apparent in most LMICs. Resource limitations are important barriers to involvement in LMICs, which must be addressed in future calls for funding.

Clement Bayetti

The Re-covering Self: a critique of the recovery-based in India's mental health care.

This paper critiques recent initiatives for deploying the Recovery Model in the Indian sub-continent. It traces the history and growth of the model, and questions its applicability for mental health care in the Indian sub-continent. The authors argue that mental health professionals in this region are at the crossroads of a familiar past: either to uncritically import and apply a Euro-American 'recovery' model or re-configure its fundamental premise such that it is embraced by the majority Indian population. The paper proposes a fundamental re-thinking of existing culturally incongruent 'Recovery Models' before application in India's public mental health and clinic settings. More crucially, policy makers, clinicians and researchers need to reconsider the local validity of what constitutes 'recovery' for the very people who place their trust in State mental health services. This critical reappraisal, together with essential cultural ly-sensitive research, is germane to prevent yet again the deployment of culture-blind programs and practices. Addressing these uncontested issues has profound implications for public mental health in the Global South.

Rochelle Burgess

Talking 'bout a revolution: Mental health recovery and cries for social change in Colombia

Introduction

The application of mainstream recovery models in the global south is facing increasing scrutiny, with scholars arguing its limits in contexts where long-wave socio-structural dynamics shape everyday life. This paper contributes to these debates through an analysis of the experiences of internally displaced men with mental distress living in Colombia.

Methods

As part of a participatory action research project to design a locally relevant mental health intervention, men internally displaced by the Colombian conflict (n=17) completed focus groups (n=2) and life-history interviews in 2017 and 2018. Data was analysed using thematic network analysis.

Results

Findings identified that men's understandings of recovery and experiences of wellbeing were driven by structural violence, stigma linked to their status as victim, and failed social support structures. Men articulated that their individual projects of recovery were directly linked to the need for social change at two levels. First – change that led to reduced state corruption and better functioning systems of support. Second – change that enabled their family networks to have meaningful shifts in their wellbeing and social circumstances.

Discussion

Men in our study signal the need to re-imagine models of recovery in post-conflict settings. Findings highlight the importance of support that considers the impact of political instability on personal projects of growth linked to the promotion of long-term mental wellbeing. Implications for future interventions are discussed.

Norha Vera San Juan

Meaning of Recovery for Latin American Service Users and Their Carers

Background and aim

Research about recovery has taken place mainly in high-income countries. Cultural understandings of recovery are thought to be central for the adequate development of mental health services. This study aims to gather an understanding of Latin American mental health service users and informal carers' notion of recovery from severe mental problems.

Method

Qualitative in-depth interviews were conducted with 41 services users and their carers in Santiago, Chile and Sao Paulo, Brazil. Data was analysed applying framework analysis to identify common themes and patterns in participants' responses.

Results

The ten main themes about recovery identified in the interviews were: Recovery and Economy; Clinical Recovery and Services; Love; Personal Recovery; Recovery and Interactions or Sense of Belonging; Recovery and Knowledge; Religion and Spirituality; Respect, and Complaints or Opposite of Recovery. At the same time, salient cultural values and contextual characteristics which influence recovery were identified, such as high number of stressors in every-day life, lack of leisure time and machismo.

Conclusions

There was some overlap between these themes and exiting literature about recovery from high-income countries. However, emphasis on topics within themes was different. This study's findings highlight the importance of taking the individual's context into account in the process of restoring wellbeing after mental problems. The Individual's personal struggles and the social barriers they face were found to be an equally important part of the recovery process.

Parallel Session 3.3
Theme: Human Rights
Room: LT4

Nada Al-Attar
Barriers to recovery in the Kingdom of Saudi Arabia

Introduction

Mental ill-health presents a global challenge, complicated by the fact that cultural beliefs and behaviours associated with mental ill-health can stand between people experiencing difficulties and their treatment. Furthermore, there is an absence of recovery research in the Kingdom of Saudi Arabia (KSA). This study considers potential barriers to mental health care, treatment and subsequent recovery arising from lay beliefs/ cultural beliefs of mental illness and distress in KSA.

Objectives

To explore people's experiences of mental ill-health in KSA, in particular barriers to treatment and subsequent recovery of the effects and the influences of stigma, spiritual and religious factors.

Methods

Qualitative interview study using a narrative inquiry research method, incorporating critical narrative analysis, to gather and analyse respondents' experiences and accounts.

Findings

Key themes concerning access to mental health care in KSA were the influence and importance of faith healers as a mental health resource and cultural artefact in: widespread stigmatisation; socio-economic problems, including financial and social issues; psychological distress and mistrust or suspicion of medical assistance; the lack of belonging and absence of family assistance and support and family relationships and support.

Conclusions

Findings suggest that in KSA, a culturally-tailored approach that takes account of religious/traditional elements as well as modern/conventional western medical treatment may optimise recovery outcomes in Saudi residents accessing mental health care.

Antoine Baleige

Using the QualityRights toolkit to promote human rights in mental health services - application to a French psychiatric sector in the suburbs of Lille

Introduction

Following the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) in 2006, mental health services must transform toward informed consent, instead of security and compulsory care. Based on the CRPD, the World Health Organization (WHO) QualityRights program has been promoted as a practical tool to operate such a transformation. The citizen psychiatry experiment of psychiatric sector 59G21, initiated 35 years ago in the eastern suburbs of Lille, France, is a comprehensive mental health service within the city. The service implemented a largely open practice system, recognized by the WHO as an example of good mental health practices in the European community and of comprehensive psychiatry services in the city, and as a result works closely with a WHO Collaborating Centre. We conducted a QualityRights evaluation of the service to verify its compliance with the UN CRPD and point towards further improvements.

Method

A multidisciplinary team composed of users, families and professionals visited all sites in sector 59G21 for a three-day observation. 35 interviews with users, carers and professionals, in situ observations and document review were conducted. Five main themes, broken down into 116 criteria, were investigated and rated by the team.

Results

Out of 116 criteria, 87 were evaluated as Fully Completed, 22 as Partially completed, 3 as Initiated realization, and 0 as Not initiated. 4 were Not applicable.

Discussion

The QualityRights evaluation and 10 recommendations formulated allow for an efficient targeting of areas of improvements and aligned with the sector's own evaluation process. The French citizen psychiatry approach applied in the 59G21 psychiatric sector seems in accordance with the modern direction given by the CRPD. As such, it can be used to prove that mental health care compliant with the CRPD is possible, and to enrich the list of possibilities for transforming practices. We will present the main QualityRights results and future transformation of the service based on results from the evaluation.

Inger Kari Nerheim

Looking for the curve ball

Introduction

In The Pathfinder Project (two hospital regions and 27 communities in south-western Norway) the issue of ownership to one's life as a prerequisite of recovery led us on to civil rights and the human rights convention CRPD. The discussion happened in a series of planning workshops and 10 classes of Peer Support Training over 3 years. We began with the CHIME article by M. Leamy et.al, as well as input from Ashcraft, L., Anthony, W, Johnson, G and others. WHO's papers on Quality Rights have also been inspirational. All the workshops and classes brought into the process a large body of experience. Results have been promising: Awareness of autonomy and civil rights among volunteers in recovery and Peer Support workers is strong. There are great insights on mutual respect between help seekers and help givers as an important element in healing the treatment systems. The community level is moving in the same direction. Part of the specialist MH/A services are making a shift towards recovery support with peer workers. In spite of a fermenting process Peer Support is still a "research question". Autonomy and civil rights are not the main mind-sets. Service users have the same issues as before. What are the necessary change makers in creating MH/A services which truly respect the citizen?

Methods

The presenters will bring forward in a dialogue the state of our discussion in our region as of August 2019, with a short overview of the value bases and the action choices, which we believed would result in changes. Some paradoxes will be presented. We will then ask the participants to join in a game changing exercise, based on their own successes, or failures.

Short formulations on quick serves/curve-balls or policy decisions/revolts which have worked, will be much appreciated. The results will be sent to the participants.

Angela Figueiredo

Family members as partners of care: an experience report of empowerment on community mental health services in Brazil

Introduction

This Project aims to increase the autonomy, empowerment and protagonism in family members who are also caregivers of mental health service users. It is associated to the Research Nucleus on Mental Health Public Politics of the Federal University of Rio de Janeiro- Brazil (NUPPSAM/ UFRJ) and has been functioning since 2011. The project also intends to educate about mental health subjects and to create a host space where caregivers can exchange their life experiences, which can facilitate the work overload relief through a support and mutual help network, helping them to develop a recovery process.

Methods

An experience report from the project's last five years will be presented. Through those years, partnerships have been established with some community mental health services in Rio de Janeiro, where some activities have taken place, such as family groups and associations support and meetings with the professional staff in order to comprehend and to promote the caregiver's role in the services. Other activities are promoted among the community, such as the Meeting Cycle, which focus on health education, sharing of experiences and the expansion of protagonism, and the annual Family Members as Partners of Care Congress, which seeks to reach new caregivers and to strengthen the relation with the ones who already attend the project, promoting the dialogue of relevant themes to our mental health reality.

Results

The project activities contribute to reduce the family members and caregiver's work overload. Their participation also promotes the possibility of sharing experiences towards the care and their recovery and empowerment among our mental health community services.

Discussion

With this project, we aim to contribute to our public health reality and the development of recovery, strengthening the caregiver's relations with the services and also with the community, including the university and the production of knowledge.

Parallel Session 3.4
Theme: Qualitative Studies
Room: LT1

Fiona Ng

The stages and processes of recovery in borderline personality disorder: A qualitative study of lived experience

Introduction

Recovery in borderline personality disorder (BPD) has been described using clinical and personal recovery perspectives. The possibility of symptom remission in BPD is well documented in longitudinal studies. Yet the perspectives of service users and comparisons between individuals at varying stages of recovery have been minimally explored. There is a need to understand the lived experiences of individuals with BPD at different points of recovery to develop a model to describe stages and processes.

Method

The narratives of 14 individuals who reported having a diagnosis of BPD were analysed using qualitative interpretative phenomenological analysis. Individuals were at opposite ends of the recovery continuum and grouped as recovered (self-identified with being recovered and no longer meeting diagnostic criteria) or not recovered (not recovered and meeting criteria).

Results

Recovery in BPD was described as an ongoing and fluctuating journey, which occurred

across three stages; 1) Being Stuck, 2) Diagnosis, and 3) Improving Experience; and involved four recovery processes; 1) Active Engagement in the Recovery Process, 2) Hope, 3) Treatment, and 4) Meaningful Activities and Relationships. There were differences between individuals in the recovered and not recovered group, particularly in the extent to which individuals had progressed through the improving experience stage.

Discussion

Recovery in BPD is a non-linear, ongoing process, facilitated by the interaction between clinical and personal aspects to facilitate growth. Whilst clinical aspects are targeted through specialist clinical interventions, greater consideration is required in monitoring an individual's personal motivation, hope and engagement in relationships and vocational activities, may be required within clinical practice for a holistic recovery approach.

Trude Klevan

It is kind of like a separate language

Introduction

Over the past years, policies and research have emphasized the importance of having people with lived experiences, often referred to as peer support workers, in mental health and substance abuse services. Peer support workers use their lived experiences as their foremost source of knowledge in their daily work. Thus, lived experiences are acknowledged and recognized as knowledge. The purpose of this study was to explore this experience-based knowledge as a phenomenon and, furthermore, how peer support workers understand and draw on this knowledge base in their daily work.

Methods

The qualitative study had an explorative and collaborative design. Researchers with diverse backgrounds were involved in planning and conducting the study. Focus group interviews were used as means for generating data. Data were analysed following the procedures of a hermeneutic, collaborative content analysis.

Results

Five main themes were generated through the analysis: 1) Experienced-based knowledge is processual, 2) It all comes down to being a fellow human being, 3) A dynamic bridge builder, 4) Real involvement, 5) Yet a long way to go.

Discussion

Experience-based knowledge is knowledge in-the-making. It is made and remade though new experiences and partnerships with others and in continuous reinterpretation of former experiences. As such, a timely question to pose is whether and how standard mental health services are prepared and ready to include this knowledgebase as part of their practices. Furthermore, the study reveals that there seems to be drawn a clear distinction between those who are expected to use experience based knowledge in their job and those who are not. This study emphasises the need to discuss potential implications of the tendency to polarise experienced-based knowledge and professional knowledge as two incompatible contradictions.

Fadia Gamieldien

Recovery from Severe Mental Illness: A South African perspective

Introduction

Mental illness contributes significantly to the global burden of disease and has serious consequences for individuals, their families and communities. In South Africa, the deinstitutionalisation process has created a treatment gap across the levels of health care and there is limited service user participation in defining mental health care services. The development of recovery focused interventions offers an opportunity to address these shortcomings. However, the individualised view of recovery requires further consideration in relation to the social complexities impacting service users' recovery journeys in South Africa. Acknowledging the multiple individual realities and experiences of social contexts, this qualitative study aims to understand what recovery is for men with severe mental illness, their caregivers and stakeholders. This presentation reports on how a collective and gendered interpretation of recovery informed the conceptualisation of this study. Initial

insights into supporting recovery in local communities will be shared.

Methods

Applying an instrumental case study design, data collection methods included photo-voice methodology, timeline graphs, community maps and in-depth interviews with men with severe mental illness, their caregivers and stakeholders. A thematic data analysis generated initial insights which are being further developed and verified as data generation continues.

Results

The utility of applying an intersectional interpretation of the elements needed to support recovery in communities will be described. Recovery from severe mental illness is multidimensional and unique. For mental health service users, their participation within their communities of choice are impacted by contextual and socioeconomic factors.

Discussion

A discussion on how a recovery focused lens in the reengineering of its mental health services in South Africa may entail re-orienting services towards a collective, co-constructed, culturally appropriate understanding of barriers and facilitators of recovery and mental wellbeing in context.

Frank Keating

The meaning of recovery for African and Caribbean men: An intersectionalities approach

Background

This presentation will consider the meaning of recovery for African and Caribbean men with experience of mental health issues. It sought to illuminate the perspectives of service users, family, carers and practitioners on recovery in relation to 'race' and culture; to describe the characteristics of activities that promote wellbeing for African and Caribbean men; and to explore to what extent socially-oriented oriented approaches to recovery address the lived experience of these men.

Methods

A qualitative design captured the dynamics of recovery processes and outcomes for African and Caribbean men across two study sites. Participant were recruited via community based organisations that provided mental health services to African and Caribbean communities. Fifty-nine in-depth semi-structured interviews were conducted with African and Caribbean men with mental health experience (n=30), supporters/family carers (n=15), and service providers (n=14). Data were analysed using Interpretative Phenomenological Analysis (IPA). At two co-creation events, service users co-analysed the data.

Findings

Recovery for African and Caribbean men is a complex, dynamic concept. A number of interconnected and often overlapping aspects collectively represent and contribute to recovery. These include recovery as a healing journey, leading a 'normal' life, autonomy and control, aspirations for the future, identity, and being free from health services. The discovery or recovery of agency was identified by the participants as possibly the most significant dimension of recovery. A further key finding was that social recovery is significantly facilitated by creating safe spaces in which men can develop authentic relationships of interdependence based on mutual trust and shared life experiences.

Conclusion

Whilst previous research similarly highlights issues of autonomy, social inclusion, personalisation, and identity as fundamental to recovery for all service users, this paper argues that recovery for African and Caribbean men is underpinned by their lived-experience at the intersections of ethnicity and gender and social inequality.

Jyotsna Jain

A qualitative study: Parents of persons with schizophrenia: Planning with them

Background

India's mental health policy 2014 acknowledges the absence of home care and support mechanisms for orphaned persons with mental illness. It recommends urgent action towards this issue. Parents are ill prepared in planning for the future and state provisions provide little

help. Mental health professionals(MHP) must be well equipped in functioning as nodal contacts in identifying and addressing these issue.

Aim

1) To qualitatively study “What after parents’ concerns” and to develop semi-structured interview (SSI) schedule.

Methodology

Observational cross- sectional study in the following phases:

1) Phase 1- Literature Review (including textbooks, database search and literature from service providers)

2) Phase 2- Qualitative interviews experienced (more than 20 years) mental health care and rehabilitation providers (psychiatrists, Psychiatric social workers, lawyer, seasoned experts) with N=10.

3) Phase 3-Development of interview schedule.

4) Phase 4-Assessment of parents using SSI schedule.

Purposive Sampling

Inclusion criteria

1. Parents of persons with ICD 10 diagnosis of schizophrenia.
2. CGI severity of illness ≤3.
3. Duration of illness >10 years.

Analysis

Thematic analysis of transcribed interviews.

Results and Conclusions

Research mentions this issue tangentially under homelessness and assisted community living. Experts reported frequently encountering such concerns in the guise of marriage concerns and placement concerns. Client-centred approach and discussion on legal protection and continuation of care were encountered rarely. SSI schedule with 6 heads- narrative experiences, help seeking, help from MHP, Peer discussions, Planning process, services expectations. “What after parent” concerns impact rehabilitation and recovery journeys. Most parents may need assistance in such planning. These concerns need to be addressed by care professionals when encountered. Collaborative client centred approach and empowerment with information regarding available mechanisms should be emphasized.

Parallel Session 4
Wednesday 4th September
3.30pm – 5pm

Parallel Session 4.1
Theme: NEON Study Symposium
Room: LT2

Joy Llewellyn-Beardsley
The characteristics of mental health recovery narratives

Introduction
Mental health recovery narratives have played a central role in survivor/user-led movements, and in development of the recovery paradigm within mental health policy and practice. They have enabled a sense of empowerment, hope and self-determination for individuals, and are used in therapeutic and peer support, staff training, online interventions and anti-stigma campaigns. However, a recent systematic review found potentially harmful as well as helpful impacts on recipients. A clearer understanding of the characteristics of recovery narratives could support their future use to provide maximum benefits while minimising harms. The aim of the study was to develop a conceptual framework characterising mental health recovery narratives, and to assess the relevance and comprehensiveness of the framework with narratives of under-researched groups.

Methods
A systematic review and narrative synthesis was conducted of 45 studies analysing the characteristics of 629 recovery narratives, producing a conceptual framework. 77 interviews were conducted with four under-researched groups. A typology was developed from the framework and used as a basis for deductive and inductive narrative analysis.

Results
Narrative synthesis organised characteristics into nine overarching dimensions (Genre; Positioning; Emotional Tone; Relationship with Recovery; Trajectory; Use of Turning Points; Narrative Sequence; Protagonists; Use of Metaphors), each comprising two to six types. Interview analysis found the majority of dimensions were identifiable in most recovery narratives. Further types were identified. Two case studies of non-fitting recovery narratives were presented as case studies demonstrating limits of the framework.

Discussion
The conceptual framework provides a defensible theoretical base for practitioner and research use. The typology can be used to support informed selection of the narratives most likely to be beneficial for individuals; and to identify heterogeneity of narrative and narrator types within collections. Supporting non-language based approaches to narrative construction, such as through art, is an important aspect of narrative-based practice.

Stefan Rennick-Egglestone
A change model for the impact of mental health recovery narratives

Introduction
Mental health recovery narratives are first-person lived experience accounts of recovery from mental health problems. They can be received as part of informal or intentional peer support, or by engaging with narratives presented in books or on websites. Receiving a narrative can make an impact on a recipient. The objective of this paper is to develop a change model describing how, and in what form impact occurs.

Methods
A change model was developed through two research activities (1) a systematic review and narrative synthesis of empirical evidence on the impact of mental health recovery narratives on recipients [8137 records assessed, 5 included] (2) iterative thematic analysis of interviews with 77 participants.

Results

Impact is initiated when the recipient develops a connection to a narrator or narrative, either by comparing themselves to the narrator or their narrative and finding a match, or by feeling empathy for the narrator. Impact is mediated by the recipient recognising shared experiences, noticing narrator achievements or difficulties, learning how recovery happens or experiencing an emotional release. Helpful outcomes include connection, validation, hope, empowerment, appreciation, reference shift and stigma reduction. Harmful outcomes include inadequacy, disconnection, pessimism and burden. Receiving a recovery narrative can empower people to make positive behavioural change, or can potentiate diagnostically-specific harmful behaviours, such as emulating disordered eating described by the narrator. Recovery narratives perceived as authentic may make a greater impact, and a narrative may make less impact for a recipient experiencing a crisis.

Discussion

Interventions that incorporate recovery narratives, such as anti-stigma campaigns and bibliotherapy can use the change model to maximise benefit and monitor harms. Interventions should incorporate a diverse range of narratives and narrators to maximise opportunities for connection and learning. Service providers using recovery narratives should preserve authenticity to maximise impact, for example by avoiding excessive editing.

Fiona Ng

How do recovery narratives generate hope and connectedness?

Introduction

Sharing recovery narratives is a core feature of interventions such as peer support and anti-stigma campaigns. Despite their wide use, little is understood about the mechanisms of action and the impact of receiving narratives may have. Existing studies have identified connectedness and hopefulness as core mechanisms of change, however these are not well understood. A preliminary change model to describe the role of connectedness and hopefulness, based on synthesising existing literature identified three main components (1) the mechanisms which underpin connectedness, (2) the impact of connectedness on hope, and (3) the influences of hopefulness. This presentation will present data to further understand the components within the change model.

Methods

An experimental study with 40 participants who engage with statutory mental health services within one Trust in the East Midlands was conducted. Participants were sequentially shown recovery narratives and asked to rate and describe their level of connection with the narrative and narrator, and their sense of hopefulness immediately after engaging in a narrative. Separate qualitative thematic analyses were then conducted on the data, to gain further knowledge on the mechanisms which underpin each component of the change model.

Results

The study confirmed that mechanisms underpinning the generation of connection included: recognising shared experiences, noticing narrator achievements and difficulties, learning how recovery happens and experiencing emotional releases. Hope was generated through the structure of the narrative, where narratives consisting of growth, progress and positivity were regarded as more hopeful. The impact of connection on hope will be discussed in the presentation.

Discussion

The identification of change mechanisms of recovery narratives has important implications for their use in mental health services and broadly. The mechanisms can provide an indication of what promotes and hinders connectedness and hope, therefore, potentially providing an evidence-based approach to selecting narratives which may assist individuals with mental health concerns.

Caroline Yeo

“Whose VOICES are they anyway?” The Curation of Mental Health, Madness and Recovery Story Collections

Introduction

A curator is in charge of the process of putting together a collection of stories or pieces of artwork. The curator makes decisions about for example what stories or objects are selected to go into a collection, if and how they are edited and how the collection is presented. The curation of mental health, madness and recovery story collections involves a wide variety of considerations and strategies. A recent systematic review concluded that there is little research on this subject. The aims of the study were to: develop a typology of curatorial considerations and strategies; and to establish the ecological validity of the typology when used in practice.

Methods

A typology was developed through a systematic review of documents providing insights into curation and the inductive thematic analysis of 30 interviews with curators. The typology was used as a tool to structure curation of a mental health exhibition at the Nottingham Institute of Mental Health and City Arts (a Nottingham-based organisation which regularly curates mental-health related exhibitions).

Results

The thematic analysis developed the VOICES (Values & Motivation, Organisation, Inclusion & Exclusion, Control & Collaboration, Equity & Legal, Safety & Wellbeing) typology of curatorial considerations and strategies. Reflections on the experiences of using the VOICES typology in the collaborative curation process of an art exhibition were made by a people with lived experience of mental health difficulties, art curators and researchers.

Discussion

The VOICES typology served as an effective tool for negotiating the complex issues in the process of curating mental health, madness and recovery story collections. Reflections on the use of this typology provide insight into possible applications of this as a tool to be used in future curatorial practise. The study has highlighted the benefits of 'co-curation' with people with relevant lived experience.

Adaresh Bhogal

Practical considerations for mental health recovery narrators

Introduction

There are many opportunities for narrators to share their narratives of recovery. Narratives can be published through websites, books or pamphlets, or shared "live" in research conferences. Sharing may be beneficial for the narrator, but can carry risks such as exposure to stigma or misuse of the narrative by others. The aim of this paper is to provide guidance to narrators considering sharing their story, to aid informed decision-making, and to shape ideas and support planning.

Methods

This talk synthesises the knowledge of the NEON study Lived Experience Advisory Panel. Issues relating to recovery narratives have been discussed at panels since 2017. Three members have published their own recovery narratives.

Results

Narrators differ in many ways. An excessive focus on guidance might disrupt the natural telling of a story, and cause anxiety. As such, guidance should be seen as optional in most cases. Narrators interested in learning from the experiences of others might choose to reflect on (1) why they want to share their narrative (2) which elements of their recovery they might want to include or exclude (3) where and how to share it, (4) who their audience might be (5) when to share it, and (6) who might be needed to support them. Specific issues to consider include whether to be identifiable or anonymous in the narrative, and the reality that a narrator's life story will continue to develop whilst the narrative remains fixed. '

Discussion

Sharing a recovery narrative can be transformative for the narrator, and specific guidance might support a narrator in deriving meaning from this activity. There is a lack of guidance for people who might be considering sharing their story, particularly there is a lack of guidance from people who have shared their story themselves.

Ada Hui

Institutional injustice: learning through the recovery narratives of marginalised communities

Introduction

Institutional injustice considers the ways in which policies and practices, through serving the needs of majority populations, inadvertently disadvantage, underserve or exclude minority groups, such black and minority ethnic communities and people with complex health and social needs. The mental health recovery narratives of individuals from marginalised communities can offer nuanced perspectives on the complex ways in which institutional injustice can impact at an individual level in everyday life. Whilst not all of these experiences are unique to marginalised populations, the narratives offer complex stories through which to examine the ways in which institutional injustices occur.

Methods

77 narrative interviews were conducted with groups who are known to be marginalised or under-served by current mental health services. The interviews were analysed iteratively and inductively, focusing specifically on ideas and themes relating to institutional injustice, as a means of highlighting barriers to and enablers of recovery.

Results

Findings from this study highlight various approaches to understanding mental distress from individual, socio-cultural and institutional perspectives. Each of these influence how the individual views themselves and their experiences, how the individual and their experiences are perceived by others, as well as the processes through which individuals navigate their journeys of recovery, where systems do not readily understand their individual experiences or serve their specific needs. Institutional injustices in relation to mental health systems and organised social networks will be characterised and contextualised.

Discussion

Through examining the recovery narratives of people from marginalised communities and understanding the challenges faced and successes/survival achieved, lessons can be learned about a) how dominant discourses may need to be challenged; b) how services and organisations may better enable and support recovery for individuals from marginalised groups. The role of each of these in bringing about institutional justice through organisational change will be discussed.

James Roe

How can recorded recovery narratives find a place in mental health practice?

Introduction

Due to the 'physician's bias/clinician's illusion' some mental health workers may hold overly pessimistic expectations about the prospect of recovery. Evidence suggests that recovery narratives can increase hope and provide a turning point in many people's recovery journey. Direct social contact with recorded recovery narratives by staff themselves may also reduce such pessimistic beliefs. The aim of this study was to understand how and where recorded recovery narratives could find a place in mental health settings, both as a resource for service users during routine clinical practice and as part of an educational resource during professional training.

Methods

Focus groups with mental health workers (both within and outside the UK National Health Service) were conducted to address these aims. Four categories of focus groups were conducted: (1) previous use and use of stories in principle, (2) use of stories in routine practice, (3) use of stories during initial professional training and, (4) use of stories within individual teams. Normalisation Process Theory was used to inform the topic guide, coding and analysis procedures.

Results

Barriers and enablers to the use of recorded recovery narratives in mental health settings will be reported. Specifically the opportunities, practical constraints and support required for their usage in everyday settings will be characterised. The role of recovery narratives as an educational resource for staff will be described, including contributions to ongoing

professional training and the potential impact on staff attitudes and behaviour.

Discussion

Greater personal and professional contact may reduce stigmatising beliefs and overly pessimistic expectations. Having access to hope promoting narratives may lead to more hopeful and positive risk-taking behaviour amongst mental health staff.

Parallel Session 4.2
Theme: Democracy, Relationships and Recovery Symposium
Room: LT5

Geoff Dennis
Slough – an enabling town

Introduction

Slough is the most deprived borough in the Thames Valley, and it has a particularly diverse population. The ASSiST programme and EMBRACE group exist within a broader public health strategy based on developing preventative approaches with a growing team of peer mentors through 'Hope Recovery College', with principles of asset-based community development.

Methods

Themed discussion of Slough as a case study for 'relational practice' at various levels: clinically, staff teams, organisations and sectors. Underlying theoretical models include complexity, field theory, whole systems and gestalt.

Results

Recognition of value shown in official reports, awards received, commissioning processes, public events, online presence, and social media feedback. The nature of the cross-cutting policy (health, social services and public health) takes the work outside institutional walls and into the wider community.

Discussion

Requires complex cross-sector working and carefully managed process of overcoming the organisational and cultural obstacles that exist in large public sector organisations as well as competitive private providers. However, it can be seen as a small example of the economic, social and sustainability benefits of preventative and 'joined up' working across health, care and housing agencies. Scope exists for extending it into educational and criminal justice sectors in the future.

Natasha Berthollier
Alternatives to admission – a new form of Therapeutic Community

Introduction

The ‘ASSiST’ service in Slough is an assertive engagement and stabilisation team which provides psychotherapeutic alternatives to repeated hospital admissions. The local pathway includes a weekly 2.5 hour ‘EMBRACE’ group, which is the hub of a modified therapeutic community, with various cross-sector activities coordinated across the whole town.

Methods

Standard evaluation using various commonly used questionnaires, and systematically collected open text feedback from service users, peer mentors, staff, professional visitors, family, friends and carers. Qualitative and quantitative analysis and reporting of the programme outcomes.

Results

Reduced use of psychiatric beds and other mental health services, improvement shown on standardised symptom and wellbeing questionnaires, with more meaningful occupation and activity. Qualitative evidence of overwhelmingly positive experience reported by all groups.

Discussion

Using a relational model that is not based in any specific professional discipline, or upon any single model of therapy, is seen as 'a different way of doing mental health' to most mainstream approaches. It has found widespread favour amongst all groups who were asked.

Vanessa Jones
Co-creation for recovery in the psychiatric hospital

Introduction
The EMBRACE group provides a space not only for support and advice for current members, but also for sophisticated opportunities for asset-based hospital and community developments across the local mental health system. The graduates of the EMBRACE group, who have often had long and traumatic histories of psychiatric care, can train to become peer mentors. The EMBRACE group provides them with opportunities to co-create new elements of the 'whole town TC' by designing and running new elements of service, for which they are now paid. This presentation presents a qualitative analysis of one element of this process.

Methods
This study is a small-scale preliminary project to gather some basic information on how a new ward-based service-user-led group works, and recording progress towards its aims. Interviews were conducted with the two graduates (ex-services users) who run the group and the service manager who instigated this development. In addition, a discussion was held with two members of the EMBRACE group who had joined the programme after their experience of the ward group.

Results
This information was systematically themed and indicated what was being achieved both in terms of the in-patients, the peer mentors and the ward staff. The strengthening of the links from in-patient settings to community services indicates better chance of engagement and recovery.

Discussion
These developments are now embedded into the wider system, including the work of the psychiatric wards, and provide seeding for further novel initiatives for co-creation and asset-based development. Sufficient energy and 'critical mass' has now been established with these dynamic interventions to facilitate system-level culture change. In this way, peer mentors now have a pathway to move beyond the limitations of an 'expert by experience' role. Ways of expanding this co-creation of inpatient services with services users will be discussed. In addition the results of this small study are informing a future larger scale observational ethnographic study.

Gary Winship
Chaos and recovery

Introduction
Democracy is often seen as the key method for the way in which Therapeutic Communities (TC) operate as a living-learning experience for empowering clients. Colleagues in Ghent have articulated this approach in term of Orthopedagogy, a philosophy has some parallels with the way in which recovery colleges take an educational approach. But sometimes best laid democratic plans can go awry, and the TC can be plunged in periods of disruption and chaos.

Methods
Qualitative descriptive reflection using 2 illustrative case anecdotes: i) Bion and the TC that ran riot; ii) Winship and the TC that ran out of food.

Results
In both case the period of disruption was a catalysts for progressively changing practices where there was a correction learning experience for staff and clients.

Discussion
Alongside the role of democracy, as well as bureaucracy and authority, we need to consider the important role that anarchy plays in bringing about progress change. It is argued here that anarchy is the necessary 4th strain in organisational process. A helix schema for mapping the four elements that shape the organisational process is considered here in regard to the design of the optimal milieu for recovery.

Kleopatra Psarrakis

Therapeutic Communities as a social movement

Introduction

Therapeutic communities claim that the organization of mental health services can act as a therapeutic agent enhancing patients' return to society. They aimed at remodeling the services through the purposeful use of relationships, and by promoting 'self-governance'.

Methods

This presentation is based on a PhD study that explores: the opportunities and constraints the movement confronted over time; the available resources; the collective identity of members.

Results

The link between therapeutic communities and recovery is well established since the years of open-door and social psychiatry, and it extends to non-clinical settings. The movement has peaks and lows connected to socio-political conditions. The present culture does not favour ideals such as those promoted by the movement. Opportunities for survival comes from unresolved problems of deinstitutionalization: there is shortage of services in the community for people experiencing mental health issues accompanied with substance abuse or homelessness. Therapeutic communities have expertise in how residential structures can achieve maximum rehabilitation, for example partially sustained farms that host such populations.

Discussion

New mental health movements reject past solutions, but this weakens reforms. The ideal of places that are therapeutic is old. This is an indication that real and lasting reforms in psychiatric services have not yet been accomplished. Every time optimism for 'the solution' to psychiatric problems fades under the weight of reality, too many people remain 'ill', then neglect and harsh treatments often return.

Rex Haigh

Modified Therapeutic Communities for the future

Introduction

Full-time residential democratic therapeutic communities no longer exist in the NHS, and over the past three decades, new models have been emerging. The Slough model, described in other contributions to this symposium, is one such variant. Other different developments, both nationally and internationally, also use the underlying principles of 'relationship-based practice' and 'democratic mental health'.

Methods

Various policy documents and other information from the government, Royal College of Psychiatrists, British Psychological Society, service user groups and other organisations are analysed to show the unmet need for 'complex treatments', and how modified democratic therapeutic community approaches are helpful.

Results

People with complex disorders - such as 'dual diagnosis', 'complex post-traumatic stress disorder' and 'personality disorder' are not much helped by simple one-model therapies. A more recovery-focussed approach is needed, which addresses social factors and builds enduring relationships in therapeutic environments.

Discussion

Several recent developments are showing promise, and three specific ones are used as illustrations: Enabling Environments, EEs, (in various settings); Psychologically Informed Planned Environments, PIPEs, (in prisons); and Psychologically Informed Environments, PIEs, (in homelessness services).

Parallel Session 4.3
Theme: Mental health crisis care
Room: LT4

Nicky Fitchett

My Wellbeing Plan, a co-produced collaborative approach to care and crisis planning.

Introduction
This project aims to make care planning and crisis planning in Dorset more collaborative, accessible and recovery orientated. We will share our experiences of the co-development and pilot of the My Wellbeing Plan, which includes co-produced care and crisis plans.
Methodology
This workshop will examine the process of co-developing the My Wellbeing Plan. It will explore the key themes that arose from this process and explain how each section was developed. There will be a brief summary of the initial feedback from the pilot.
Background
The Wellbeing and Recovery Partnership (WaRP), a partnership between Dorset HealthCare and Dorset Mental Health Forum (a local peer led charity) led the co-production of the My Wellbeing Plan. There were drivers locally from professionals, people accessing services and family members to make care planning more collaborative and meaningful. People did not always identify that they had a care plan and when they did, did not always feeling their views were reflected. Supporters did not feel included in the process. Clinicians told us they wanted the meaningful inclusion of people, for plans to be simple, flexible, and not overly bureaucratic. These themes are also present in the literature around care planning (Coffey et al., 2017; Simpson, 2016; Gilbert et al., 2013). The co-production process sought to balance these ambitions and ensure all parties' views were incorporated.
Findings
The early indications of the My Wellbeing Plan pilot are positive. For example, clinicians spoke of "real engagement with people and families" and "a real focus on their needs and the priorities of people". One unexpected finding was that My Wellbeing Plan increased conversations between the person and their family not just the collaboration with the professional.
Discussion
We will share the challenges of co-producing the My Wellbeing Plan and the initial findings based on the pilot.

Jonas Fisker & Andreas Hoff
Return to work after sick leave with depression, anxiety or stress

Introduction
Sick leave due to common mental disorders like stress, anxiety or depression has huge consequences for individuals and societies. Returning to work after sick leave with one of these conditions typically is a difficult process both requiring treatment, vocational rehabilitation, personal effort and social support. Previous studies show that high expectations of own return to work and high return to work self-efficacy are important factors in the process of successful return to work.
Methods
The IBBIS project tests if an intervention consisting of a) integrated mental health care and vocational rehabilitation leads to a faster return to work compared to a b) non-integrated mental health care intervention and c) treatment as usual. This is done in two three-armed RCT's for people with 1) depression and anxiety, 2) stress related disorders. Primary outcome is time to return to work rates at 12 months follow-up. Secondary outcomes are RTW rates at 6 months follow-up and as well as symptom levels on several relevant domains. We also investigate, if high return to work self-efficacy at baseline influence the rates of return to work, at 6 months and 12 months follow-up.
Results
Currently, significant differences between the 3 groups has been shown on measures of anxiety, depression, stress and client satisfaction. Due to investigator blinding during analyses completion, group allocation is unknown until ~August 2019. Associations between return to work-self-efficacy measured at baseline and follow-up will be presented, as well as the above-mentioned outcomes, and blinding will be broken.
Discussion
The results will provide knowledge about relevant factors that typically influence the length of a sick leave period, providing a better foundation for the design of new return to work

interventions.

Claire Rotheram

The Life Rooms: Does a non-clinical response to mental distress work?

Aim

To explore both the impact of the Life Rooms on use of secondary mental health care services, and the experiences of the Life Rooms for those under secondary mental health care.

Method(s)

Three Life Rooms users worked alongside staff at every stage of the project.

Quantitative

1. A cohort of Mersey Care service users were identified that had accessed the Life Rooms. A matching activity was undertaken to identify similar service users of Mersey Care that had not accessed the Life Rooms.
2. The clinical activity of both cohorts (187 in each cohort) was obtained over three time periods:
    - 1st April 2016 - 31st March 2017
    - 1st April 2017 - 30th September 2017
    - 1st October 2017 - 31st March 2018
3. Financial costs were attached to the activity information.

Qualitative

18 of the cohort participated in semi-structured focus groups to explore their experiences of the Life Rooms.

Key Findings

After the intervention period, the Life Rooms cohort cost, on average, £19.80 less per clinical contact. The following themes were significant to focus group participants:

- People and environment
- Non-judgemental and a safe space
- Self-development and self-awareness
- Social inclusion
- Development of personal goals

Conclusions

Within the identified cohort, Mersey Care service users evidence a reduction in clinical cost when compared with Mersey Care service users who did not use the Life Rooms. It is clear from exploring the main themes from the qualitative data that, for these participants, the Life Rooms was a significant factor in their recovery journey. **This research was funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC)**

Jacob Beale

The Retreat; the role of lived experience in a drop in mental health crisis service

Introduction

There is a growing national interest in commissioning ‘crisis café’ models of delivery. The Retreat is an out of hours, mental health drop-in service run completely in partnership between an NHS trust and a peer led charity. This presentation explores the role of lived experience in the delivery of this service, and how lived experience at every level of the service create positive experiences for people utilizing the Retreat.

Methods

Anonymised data of people visiting the Retreat including ages, times attending, reasons for attending and outcomes for those attending, as well as qualitative feedback the experiences of staff and people who visit.

Results

The Retreat offers an option for people in emotional distress and self-defined crisis that is different to emergency services such as Police, Ambulance or emergency departments of general hospital. The service was commissioned to provide quick access to mental health support whilst in a crisis and provides an alternative to detention under section 136 of the

mental health act, admission to general hospital, or accessing acute secondary mental health support.

Discussion

A peer workforce, supported in partnership with an NHS Trust can provide a robust, cost-effective, recovery focused alternative to current services, even in services that are open door, unpredictable, and support people in acute crisis. The effectiveness of the service is heavily reliant on processes that support wellbeing of staff, the role that lived experience plays at every level, and collaboration with people who visit the service.

Corrine Hendy

Qualitative Study of Open Dialogue working with people and their support network in crisis in Nottinghamshire Healthcare Foundation Trust

Introduction

This paper presents the experiences of clients and members of their social network who have received Open Dialogue and discuss the core themes of this study.

Method

Interviews were audio recorded with clients and family members. Interviews were transcribed and analysed by the authors independently using a thematic analysis.

Discussion

The four themes identified in this study are: Mutuality, Quality of Relationships, Openness and Inclusivity and Personal and Network Change. Mutuality requires individuals to relate to both themselves and those around them as whole persons. The main proponent of this sense of mutuality seems to have been the use of self disclose within the group meetings, enabling all those present to view each other as equal partners and embrace polyphony. Participants felt Shared Decision Making was an important component of network meetings and commented on how network meetings allowed them to retain a sense of autonomy; becoming an active agent in their own recovery (Mead, S 2014). The findings in this study suggests that having a peer worker in network meetings can increase levels of self disclosure between those present and reduce isolation of the person a the centre of concern. Introducing peer workers in Open Dialogue teams is a new concept originally introduced by the New York Parachute Project using the Intentional Peer Support model (Mead, S 2014).

Conclusion

We conclude the implications for using Open Dialogue in mental health services is encouraging as a framework for recovery that integrates a person's care and social network. As a grass roots initiative in the UK this model appeals to people who use services, family members and professionals as a holistic way of responding to a person in crisis.

Katie Brown

Safety and Support Plans: the challenge of meaningful care plan co-production in a secure setting.

Introduction

Over the last 20 years, there has been a growing recognition that service user involvement supports improvements in care quality. This presentation describes a process for the co-production of recovery focused care plans for people with complex and varying mental health needs in a low secure inpatient setting. Due to the nature of secure settings, individuals within these environments may experience invalidation due to lack of involvement in their care.

Method

The "Safety and Support Plan" format seeks to increase psychological understanding of distress and behaviour for both the service user and the team supporting them. It supports service users to take an active role in their care and treatment planning by creating personalised risk assessments and self-directed coping strategies. The "live" document is frequently reviewed alongside service users through an adaptation of the Positive Monitoring process, supporting active feedback .The aim of this process is to empower service users to direct their preferences regarding their care and support.

Results

Previous research within the current setting has found that service users frequently feedback positive experiences related to the co-production of Safety and Support Plans, reporting that they improve the experience of care, and that the process provides a space to talk and "open up". However current results highlight a cohort of individuals within the setting who do not feel empowered or even understood by their team through these processes.

Discussion

This presentation reflects as to why this disparity of experience may occur. Qualitative data are offered to support discussion as to why the presence of co-produced care plans alone does not guarantee that people will experience their care as co-produced. Suggestions regarding the methodology of quality monitoring of behaviour support plans, given that these are now a requirement within all inpatient secure services commissioned by the NHS.

Parallel Session 4.4
Theme: Narratives research
Room: LT1

Sam Robertson

Using lived experience to develop a personal narrative workshop programme in order to aid mental health recovery

Introduction

In current UK recovery-orientated provision, service users are asked to 'tell their stories' within clinical settings as a tool for diagnosis, formulation and treatment plans. There is little current evidence that narrative or narrative development is being used systematically within an NHS therapeutic setting. Based on the premise that mental health recovery is an unique and individual journey (Anthony, 1993), this PhD study explored the process of developing a personal narrative and its possible contribution to mental health recovery.

Method

A three-phased approach was used. The Conceptual Recovery Framework (Leamy et al., 2011, Bird et al., 2014) and The Personal Recovery Framework Model (Slade, 2009) were drawn upon to critically analyse the emergent themes (Braun and Clarke, 2006) which informed subsequent phases:

Phase 1: Developed and analysed my recovery autoethnography, 'From the edge of the abyss to the foot of the rainbow' (Robertson et al., 2017).

Phase 2: Participatory Action Research (PAR). Co-researchers who had developed their personal narratives discussed their narrative development process

Phase 3: Through three cycles of PAR, an eight-session, peer-led Personal Narrative Workshop Programme (to support service users to develop their narrative) was co-produced. This was fully documented – Programme Framework, Scheme of Work and Session Plans.

Key Findings and Discussion Points

The integrated emergent themes were incorporated into the workshop programme design and content:

• A realisation of the difficulty of narrative development (reliving trauma).
• The value of the group setting (supports collaboration and validation).
• The role of 'the voice of others' in our narratives (implications for relational ethics).
• Therapy or therapeutic?
• Who decides who participates?
• Who owns and delivers the programme?

Given 'my insider perspective', methodological issues were highlighted:

• The complexities of using a PAR approach (the ethics of working with 'vulnerable researchers', anonymity and regaining/losing voice and how much do we expect of our co-researchers?)
• The multiplicity of roles and tensions of those roles

A key element of the Personal Narrative Workshop Programme was ensuring a balanced approach between educational content and the time and space to 'do' within a supportive environment. The workshop programme will be piloted post-doctoral.

Anneliese de Wet

"For different clients it will be different": Interviews with service users, service providers and carers regarding the meaning of mental health recovery in the South African context.

Introduction

Mental health recovery has been conceptualised and defined by many scholars in many different settings. However, the understanding of what mental health recovery means in the South African context is still sparse. The main study, that the data for this presentation forms part of, is focussed on developing an instrument to measure individual mental health recovery of service users for the South African context. What will be reported on in this presentation is an initial analysis of how participants conceptualised mental health recovery.

Methods

For that part of the main study that this presentation is based on, interviews were conducted over the course of approximately 3 months in 2018 with 38 participants, consisting of service users, service providers and carers of service users, across three tertiary public psychiatric hospitals in the Western Cape. Through the interviews, the aim was to explore what mental health recovery means and what the facilitators and barriers to recovery in the context of the participants were.

Results

Themes regarding the meaning of mental health recovery, that have emerged from the interviews so far, are (1) Unique, incremental and holistic nature of the recovery process, (2) improvement of health, (3) re-integration and re-connection, (4) achievement, (5) adherence to medication, (6) symptoms, (7) hope and meaning, (8) psycho-education, (9) skills acquisition, (10) acceptance and, (11) support.

Discussion

Although it is crucial to always bear in mind that the process of recovery is unique for each person, it is possible to identify some themes that are common to many individuals' understanding of recovery and that are necessary to distinguish dimensions of recovery, to develop an appropriate measure of individual recovery for service users in the South African context.

Heike Bartel

Poetry and Recovery? Poems on Male Eating Disorders

Eating disorders (EDs) are perceived as a female-only problem despite growing numbers of EDs in men and boys. The AHRC project 'Hungry for Word', PI Bartel, investigates the role personal narratives can play in articulating, communicating and understanding male EDs from the perspective of sufferers, carers, family et al. Narratives, including those voiced through poetry with its particular focus on language and form, can play an important role in recovery helping to find a language for this particular illness and male mental healthiness general.

We have gathered poems voicing lived experience of Male EDs and I will introduce them via close readings framed by theoretical discourse of illness- and recovery-narratives, poetry therapy and comments from authors and readers. I will present findings on the role of poetry in the process of recovery but, as part of this, also discuss the potential of lyric to not only voice 'green shoots' of recovery but also the 'dark alleys' of personal lived experience.

Simone Arbour

Recovery and Adolescents: Leveraging Lived Experience as a Driver of Adolescent Mental Health Research

Introduction

Half of all lifetime cases of mental health conditions start before age fourteen and three-quarters emerge before age 24. An increased understanding of the experience of mental illness (MI) and recovery for young people is essential in minimizing the potential impact on an adolescent's developmental trajectory. The current presentation represents the first of two phases of research designed to create a developmentally appropriate conceptualization of recovery for adolescents with MI.

Method
In order to identify a qualitative methodology that would be appropriate for adolescents, the first phase of the research was to recruit a lived experience co-investigator and interview a small cohort of young people with MI to help co-produce the data collection for the second phase –to explore the recovery framework for adolescents. Five adolescent service users (four female; age range from 13-18) were individually interviewed and asked questions designed to inform language, compensation, recruitment strategies, and the data collection methodology for the subsequent phase of research.
Results
Adolescents shared a variety of arts- and narrative-based methods to assist in the second phase of research. They also indicated that a customized data collection methodology for the second phase of research was preferred. In addition, results revealed adolescents tended not to use the word recovery and instead use words such as "coping" or "moving forward". Participants also suggested recruitment and compensation strategies.
Discussion
It is suggested that results from this first phase of research in addition to the inclusion of a lived experience co-investigator can be used to enhance the quality and relevance of adolescent mental health research – especially as it relates to recovery. The implications of this approach will be discussed.

Dimitar Karadzhov
Recovering at the Extremes of Disadvantage: A Transatlantic, Qualitative Investigation of the Experience of Mental Health Recovery in the Context of Homelessness

Introduction
The now influential personal recovery framework has been critiqued for its inadequate focus on the role of social inequalities and complex disadvantage. This study sought to understand: (a) how individuals experiencing co-occurring homelessness and serious mental illness (SMI) conceptualise personal recovery; (b) what facilitates and what hinders those individuals' personal recovery; and (c) how those individuals navigate and negotiate socio-structural conditions to enable better well-being and recovery.
Methods.
A transatlantic qualitative participatory study was conducted in five homeless services provider locations in Glasgow (Scotland) and New York City (U.S.) with 18 chronically homeless adults with a diagnosed SMI. In-depth, lifestory interviewing was combined with a novel mobile diary data collection method and photo-elicitation.
Results.
The participants experienced recovery as achieving insight into the core source of their struggle, as belief in the possibility for a better life, as daily labour ('trials and tribulations') and as an unfamiliar and intimidating alternative reality ('the other side of life that I never experienced'). Many participants defined recovery in negative, implicit and ambiguous terms- a unique property of recovery in multiple disadvantage. Five core recovery enabling/impeding processes were identified relating to the processes of pursuing one's need for being connected to others, achieving insight and self-management, achieving stability and constancy, mobilising a strong and positive sense of self, and nurturing meaning and a purpose in life. The dynamic influence of chronic disadvantage, the lack of a safe and stable family environment, structural (system-level) arrangements, and the (de)humanising professional support was revealed.
Discussion
Researchers and policy-makers should no longer 'sanitise' the concept of recovery by neglecting the socio-structural context of individuals' lives. The implications for an enhanced understanding of recovery at the extremes of multiple disadvantage for the delivery of person-centred care and for the designing of socially inclusive public health policy interventions are discussed.

Louise Canacott

How do women with a diagnosis of Borderline Personality Disorder, detained in secure and locked services perceive recovery? A grounded theory.

Introduction

The principles of connectedness, hope, identity, meaning in life and empowerment (CHIME) are seen to underpin personal recovery. Studies to date have researched experiences of recovery across mental health services, including forensic services and services for individuals diagnosed with personality disorder. However, the needs of women diagnosed with Borderline Personality Disorder and detained in secure services has not been explored.

Methods

Seven women with diagnoses of Borderline Personality Disorder participated in this study. Participants were recruited from medium- and low-secure services and a locked rehabilitation service. Semi-structured interviews were completed, transcribed verbatim and analysed according to constructivist grounded theory methodology.

Results

A staged model of recovery was developed, describing how these women adjusted psychologically throughout recovery. The process of recovery was influenced by factors which acted as both barriers to, and facilitators of recovery; including relationships, participant coping skills, readiness for recovery and the management of risk in the secure environment. Relationships, particularly those with staff, were the key facilitative factor for recovery but also a common source of setbacks. Constructs of coping and self-management were reflected as key recovery objectives.

Discussion

The emergent grounded theory model moves from the idea of motivation to change as in intra-personal endeavour and identifies the central role of relational factors in progressing participants through recovery, which could be used to harness motivation in the forensic service. Results share similarities with findings from other studies of recovery in secure environments. However, findings from this study, perhaps associated with the complex relational trauma experienced by service-users, locate the relational security as a precursor to recovery. Safe relationships. this enabled service-users to move towards recovery and self-discovery. Further, the model identified distinct stages of recovery each with particular barriers to be overcome by the service-user. Through identifying these barriers, thus, revealing opportunities which staff have to intervene and support recovery for service-users in times when they are encountering particular challenges.

Parallel Session 5
Thursday 5th September
10.30am – 12pm

Parallel Session 5.1
Theme: Education
Room: LT7

Abigail Harris
An evaluation of the extent to which Leicestershire Recovery College is accessible to and promotes good recovery outcomes for the local community

Introduction
Recovery Colleges (RCs) complement traditional 'treatments' using an educational approach whereby 'students' attend courses on a range of subjects related to mental wellbeing. Previous evaluations of RCs have found strong evidence to suggest that services contribute to positive recovery outcomes for students. This study evaluated the extent to which Leicestershire Recovery College (LRC): 1) promotes good outcomes for its students and 2) is accessible to all those living in the community that LRC serves.

Method
A mixed methods approach was used. Recovery outcomes were assessed by evaluation forms specifically designed to assess quality of recovery-supporting care. These comprised 14 statements rated on a 5-point Likert scale plus opportunities for students to provide comments. These were completed anonymously at the end of every course from 2013-2017, equating to 2,259 forms. Accessibility was measured through a comparison of demographic data of LRC students enrolled (age [n= 1399], gender [n=1538] and ethnicity [n=1590]) and local demographics. Data were analysed using descriptive statistics, thematic analysis and a series of chi-squares.

Results
Evaluation forms indicated students enjoyed the courses, find them useful, feel that teaching methods are effective, feel involved, safe and supported throughout their learning and would recommend the course to others. Qualitative analysis revealed themes of "moving forward", "thinking differently", "relationship with self", "taking control of wellbeing" and "relationship with others". Accessibility analyses indicated that males, youngest and oldest age categories, those from White-British and Asian/Asian-British backgrounds were under-represented.

Discussion
This service-evaluation suggested that LRC promotes positive recovery outcomes. LRC's embodiment of the principles of recovery was particularly apparent in students' narratives about empowerment, hope, encouragement and opportunities for growth. Efforts should be made to address barriers contributing to the lower rates of student attendance among older and younger age brackets and from Asian/Asian-British backgrounds.

Karen Machin
Learning together: "The course that lives up to its title"

Introduction and method
This paper reports and analyses an online MSc on mental health recovery and social inclusion, which has been offered to a mixed group of international learners for over five years. We reflect on the steps taken to ensure barriers to learning are identified, and opportunities are created. Values underpinning the course include collaboration, co-production, co-learning and shared power, and it is driven by principles which reflect those of Recovery Colleges. However, unlike courses offered by Recovery Colleges, the Masters course is accredited at Level 7 for post-graduate study, and sits within an academic institution.

Results

Students and tutors are from a range of backgrounds, academically, professionally and internationally, with 53% of students having lived experience, many more than originally anticipated. Students reflect positively on their joint learning experiences, including opportunities for co-production amongst mixed teams of learners. Studying enables students to keep motivated and supports their wellbeing, with materials that are enriching both personally and professionally. Their self-confidence increases and is also noticed by employers who report changes in their practice. Tutors pay attention to the support required for distance learning, with a readiness to provide pastoral support and flexibility about deadlines for all students. There appears to be no link between failure rate and routes into the course. Similarly, students leave for 'personal reasons' not usually connected to mental ill health.

Discussion

The key to ensuring equal power for all students seems to lie in adhering to a recovery and social inclusion philosophy which focuses on strengths, alongside a system of flexibility in acceptance conditions without compromising on the academic level of the incoming students. Tutors and students are expected to role model the values of recovery and potentially stigmatising behaviours are used as an opportunity for reflection, to create an inclusive community of learning.

Toby Brandon

Teaching Mad Studies: a possible route to knowledge democracy

Introduction

For the past three years at Northumbria University we have been delivering one of the first UK Mad Studies programmes. Mad Studies is a relatively new academic discipline which has emerged from a number diverse, critical fields. The class cohort is a blend of those who have experienced mental health distress (many from the local recovery college) and students studying for a BA (Hons) degree in Integrated Health and Social Care. This second year module invites a co-productive understanding of madness with a particular focus on the critical utility of recovery and the relative impact of intersectionality.

Methods

With ethical approval class conversations concerning mental health recovery, intersectionality and the nature of madness were digitally recorded. In addition students at the beginning and end of the programme were asked to comment on their learning expectations and experience. A qualitative thematic analysis was undertaken and the themes are presented here.

Results

The captured co-constructed understanding of recovery is presented here along with wider learning from this Mad Studies programme. The contested importance of recovery in current mental health provision was explored along with critical challenges to diagnosis, treatment and the potential for stigma and discrimination.

Discussion

The co-productive configuration of the programme where authentic conversations took place between experts by experience, students and academics provided a disruption to traditional pedagogic teaching. Mad Studies appears not to be an agreed syllabus or fixed curriculum but a co-produced process of reclaiming suppressed history, disrupting power imbalances and creating a new knowledge democracy around both critical mental health theory and practice. These points among others will be explored through the voices of experts by experience in the paper.

Joanna Fox

A first person narrative: The potential of Acceptance and Commitment Therapy to improve wellbeing at work

Introduction

Many people with mental health issues are workless; and of the minority who do work, many are in elementary occupations. Despite this, good quality work is often promoted as beneficial for mental wellbeing, and is key to recovery. Brief psychological therapy services,

provided through IAPTS (Increasing Access to Psychological Therapy Service), can be effective in supporting people with mental distress to function better in the workplace and manage their disabling symptoms. Experiences of receiving Acceptance and Commitment Therapy (ACT), to improve work place wellbeing, are explored through a first person narrative.

Methods

This first person narrative reflects on my difficulties caused by mental ill-health symptoms that impact on wellbeing at work. This methodological framework emphasises the primacy of experiential knowledge and enables practitioners and researchers to develop a better understanding of how services can support a person to manage their recovery. The narrative explores the importance of a working identity as central to my recovery, whilst acknowledging the impact of mental distress on wellbeing; it considers how services can be effective in supporting occupational wellbeing.

Results

ACT, a Cognitive Behaviour Therapy, delivered through IAPTS, was found to be effective in enabling me to learn how to manage distressing symptoms at work alongside the central role of the therapist in delivering this intervention. The benefits of receiving ACT are considered in enabling me to develop optimal functioning at work, allowing me to move beyond just managing my mental health symptoms to working effectively with them and experiencing wellbeing at work.

Discussion

The potential of ACT, as brief psychological support, is considered and the benefits of its wider implementation across mental health services are identified; specifically at times when an expert-by-experience moves from living with the diagnosis, to living beyond this experience, and achieving increased wellbeing and recovery at work.

Parallel Session 5.2
Theme: Structured Interventions
Room: LT5

Margaret Hendriks

The Use of a Structured Program to Support, Empower and Promote Recovery in Persons with Mental Health Issues

Background & Hypothesis

The Institute of Mental Health introduced a structured program in 2010 which enlisted psychiatric case managers (CM) and clinical trackers (CT) to help provide continuous aftercare for Persons with Schizophrenia and Delusional Disorders. The objective is to build a therapeutic relationship with these persons, provide continuity of care thus empowering them to Refocus on Recovery. Literature searches state that persons with mental health issues, especially those with severe psychotic illnesses, namely Schizophrenia and Delusional Disorders encounter difficulties with continued treatment and follow-ups. Lack of insight into their illness, poor family support is just some of the contributing factors. Therefore this paper will explore the benefits a structured program which assist patients to remain well in the community.

Methods

Using a case management framework, either a CM or CT is assigned to person's needs for care and support in the community. Close contact by telephone, meeting them on their appointment dates with doctors, continuous psychoeducation and counselling sessions, linking them with community partners and resources enable them to Refocus on their Recovery. Retrospective data of patients managed from 2009(baseline) to 2017 was mined and results analysed using Microsoft excel.

Results

Reduction in readmission rates FY09: 43.1% (baseline), FY10: 41.0% and to date FY 16: 38.3%. First TCU after discharge rates FY 10: 87.7% and to date FY17: 94.2%

Discussion & Conclusion

The program has brought benefits to:

- Persons with mental health issues: receive continuous support and valued care and are able to remain well in the community enjoying better quality of life and refocussing on their recovery.
- Staff: find a fulfilling role of supporting persons with mental health issues well in the community
- Hospital: financial reduction in cost of default and readmission rates
- Community: better reintegration of these persons within the community and enabling them to gain dignity and value to society.

Laurie Hare Duke
Development and feasibility evaluation of a social connectedness intervention

Introduction
Social connectedness supports recovery for many people. There are few existing mental health service interventions which specifically aim to increase social connectedness. This study aimed to:
(1) Develop a social connectedness intervention.
(2) Assess the feasibility of the intervention for adults accessing services for depression.

Methods
(1) Intervention development. An existing social connectedness programme was adapted for a clinical context using the results from 3 sub-studies: (i) Stakeholder interviews, (ii) Pilot study of unadapted intervention and (iii) Expert consultation via online survey.
(2) Feasibility study. Sample: Adults (18-65); primary or secondary diagnosis of depression; score above loneliness cut-off. Study design: pre/post measures and process evaluation interviews with intervention completers and drop-outs.

Results
(1) Intervention development. Stakeholder interviews (n=22), pilot study (n=4) and expert consultation (n=12) identified 17 possible adaptations to meet the needs of adults with depression. These included both structural and content changes. Ten of these adaptations were made.
(2) Feasibility study. 29 participants were recruited. Retention and follow-up rates will be reported, along with pre-post differences in social connectedness (primary outcome), loneliness, anxiety and depression. Process evaluation findings will characterise participant experiences of the intervention, including acceptability and casemix issues.

Discussion
A social connectedness intervention for adults with depression was developed and piloted. Dropout rates were comparable to group psychotherapy interventions. The intervention was acceptable to service users, and preliminary data suggests it may be a useful adjunct to other depression interventions. The process evaluation highlighted areas for future research, including the length of the intervention and the choice of primary outcome. Future research will refine the change model, and make specific recommendations about the participants who are most likely to benefit from the intervention.

Lorenzo Pelizza
Implementation of Individual Placement and Support in an Italian Department of Mental Health.

Introduction
Individual Placement and Support (IPS) is an evidence-based psychosocial intervention for helping people with mental illness to obtain and maintain competitive jobs in open labor market. In the last decade, some European mental health leaders were interested on its implementation. Aim of the study was to assess the IPS effect in Italian patients with moderate-to-severe mental illness, examining the main competitive employment outcomes and the drop-out rates during a 42-month follow-up period. To date, no rigorous evaluation of IPS has been conducted in Italy.

Methods
Participants (n = 95) were clients receiving psychiatric treatment in one of the community

mental health centers of the Reggio Emilia Department of Mental Health. In addition to drop-out rates, we calculated job acquisition (employment in the labor market for at least 1 day during the follow-up), job duration (total number of days worked), job tenure (weeks worked on the longest-held competitive job), and total hours per week worked.

Results

A crude competitive employment rate of 41.1% and a crude drop-out rate of 30.5% were found over the follow-up period. Using a Kaplan-Meyer survival analysis, the cumulative employment rate increased up to 44% at 12 months and 61% both at 24 and 42 months.

Discussion

This study documents the feasibility of an implementation strategy for introducing the IPS model in the public mental health care system in Italy, also in order to precipitate system changes towards the development of a recovery-oriented system.

Pau Dotor

The Alerts System at the PSI-PCA program: key tool for the continuity in assisting complex-need patients

Introduction

The Case Management and Outreach Program for individuals with mental health conditions is an intensive program, suitable for chronic/complex patients, which assures their participation following the patient-focused support model. Mental Health Disorder rates in the justice system are higher than those of the general population. When released from prison, people with Severe Mental Disorders show substantial marginality, high rates of re-hospitalization and re-offending. They also present high difficulties to engage with the health and social services and other community services. The Department of Health working together with the Department of Justice in Catalonia have developed several actions in order to support people with Mental Health Disorders in their release process by introducing this support model.

Objectives

The activity in the case management and outreach program in forensic mental health over the year 2018 is described and the profile of the supported patients is identified.

Methods

Descriptive, observational and longitudinal study in retrospective. We revised the database over 2018 across the Barcelona province were both minimum security justice facilities are based.

Results

Over the first year since the program took over we have supported 78 individuals, 63 of which are men. 85% age between 26 and 55 years old. All of them present social vulnerability.

Discussion

The obtained results suggest that the program is attending some needs that have been disregarded in the past. This study shows how the referred patients present some criteria of complex health and social needs. These factors justify an intense individual support for their transition to the community, in order to promote a successful reintegration.

Parallel Session 5.3
Dialogical Session
Room: LT4

A space to share your ideas, thoughts and reflections on the conference with others.

Parallel Session 5.4
Theme: Arts and Mental health
Room: LT1

Audun Pederson

Art and culture as recovery tools

During the last 20 years art and cultural activities have been offered as an important part of

the mental health services in Bergen, Norway. The starting point was in 2000, when the local user's movement in mental health made the city council finance a new centre for art and cultural activities. The centre is organized like a Fountain House, but with art and culture as the main content.

One year later the municipal culture administration established a new program for art, culture and mental health. This program offers many activities where professional artists, authors, musicians and others are engaged – building a bridge to the ordinary culture life in the city. Especial the literature project called "Power plant" has been a tremendous success, with several hundred persons engaged in writing-courses and writing texts for the Power plant journal. Several painters and potters have opened their ateliers for persons from the mental health services, to work with them for 3 hours per week, and to give guidance and help.

In 2006 we started a workshop for different kind of artistic work and a gallery where we could exhibit and sell the products. There are around 15 persons working there, and most of them are either professionals or skilful amateurs. In Bergen we have 8 activity centres for mental health service users, and during the last 15 years they more and more offer cultural activities, such as courses and workshops in painting, writing, ceramics and so on. The feedback from our service users is that these services many times are more important for their recovery process than pharmacology and problem focused conversations with psychologists. To find a way to express themselves and to connect with people with similar interests seems important.

Kristin Berre Ørjasæter

Experiencing small positive moments through participation in performing arts

Introduction

Having a meaningful everyday life is important in recovery. Despite a growing interest exploring first-person experiences related to participation in meaningful activities, less attention has been paid on the importance of mundane non-therapeutic arts activities within mental hospitals. This study has an emphasis on participation in performing arts rather than focusing on the major goals and rehabilitation outcomes in a mental hospital.

Methods

Framed within a qualitative methodology, this study explores what participation in performing arts bring to the lives of persons with long-term mental problems. Data was gather through in-depth interviews with 11 people with long-term mental health problems who were or had been participants in a music and theatre workshop located in a Norwegian mental hospital. Data was analysed by hermeneutic-phenomenological analysis.

Results

Findings indicate that participation in performing arts have the potential to bring small positive moments of meaning, flow and peak experiences for people with long-term mental health problems. Despite, these moments appeared in glimpses, the participants experienced that they added great value in life. These small positive moments gained hope for a better future as participants were able to transform these moments to "meaning making" far beyond arts.

Discussion

There is a need to raise professionals` awareness of the profound role of small positive moments of meaning, flow and peak experiences for people with long-term mental health problems and elaborate the power of such moments. Therefore, it is important to explore different ways professionals can facilitate small positive moments.

Kristin Berre Ørjasæter

Performing arts as a free-zone that supports recovery processes

Introduction

There is a growing interest using arts in mental health. Traditionally, when arts activities are located within a mental hospital, they are run by arts therapists and conducted as music- or drama therapy. However, there is limited evidence on how participants experience arts programs in mental hospitals that are not considered therapy.

Methods
This study applies a qualitative hermeneutic-phenomenological framework to explore experiences of participation in performing arts among people with long-term mental health problems. Data was gathered through informal observation and in-depth interviews with 11 people who were, or had been participants in a music and theatre workshop located within a Norwegian mental hospital.
Results
Participants experienced the music and theatre workshop as a free zone. This free zone appeared to be a physical, as well as a psychological space. In line with Winnicott's concept of potential space, participants described this free zone as an intermediate area where they could explore areas between fantasy and reality. Based on the empirical analysis of participant`s stories, this free zone facilitated a multitude of transformations and thus supported recovery processes among the participants.
Discussion
Some cornerstones appeared to create the music and theatre workshop into a free zone. High degree of accessibility and flexibility, gave participants an opportunity to determine the frequency and duration of their participation according to their own needs. Through a person-centred approach, they experienced being recognized as fully fledged individuals and human beings with equal rights. Because diversity was embraced, the participants also developed a sense of belonging and ownership. Despite the hospital management and health professionals saw the value of performing arts in mental hospital, the music and theatre workshop was at continual risk that the arts program mainly was considered as a tool to lessen symptoms, increase functionality and improve quality of life.

Nastaran Doroud
Living Well; Supporting recovery through an innovative photo-voice program

Introduction
The emergence of the recovery paradigm led to development of programs to encourage hope, meaning, choice and partnership. This presentation introduces an innovative recovery-oriented program called Living Well. Based on the Freire's critical consciousness theory, occupational therapy models and photovoice method, Living Well is being developed as part of a participatory research project.
Methods
The participatory research project gathered data through a photovoice course in collaboration with a peer-worker and twenty-one participants with lived experience of mental illnesses at Mind Australia's Recovery College and Recovery Communities. The photovoice course involved individual interviews and weekly sessions of group discussions between which participants took photographs about their recovery and everyday activities. The data was analysed using constant comparative methods.
Results
Recovery as a journey of living emerged as the central theme from the data. It involves four interrelated processes, including: 1) living a life on hold; 2) choosing to recover; 3) learning and developing strategies; and 4) maintaining a good quality life. The findings from the study suggests that recovery is a unique and ongoing journey that is embedded in the context of everyday lives.
Discussions
Based on the findings from the research, the Living Well program uses photography tasks, individual and group activities to enable consumers reflect on their recovery journey in the context of their everyday lives. Through cycles of action and reflection, the program works collaboratively with the consumers to identify strategies for living well. It involves identifying strategies to manage difficult times, to rebuild a sense of hope and motivation, to learn about capabilities and about the impacts of mental illnesses, and to find ways to connect with others and participate in the community. This presentation suggests that Living Well has potentials for recovery-oriented mental health care and merits further development and evaluation.

Parallel Session 5.5
Theme: Compulsion
Room: LT6

Sarah Markham

Challenging Epistemic Injustice at State Level in the Context of the Independent Review of the MHA 2018

Introduction

The independent review of the Mental Health Act 2018 gave patients the opportunity to share their personal experiences and views of detention under the act. These accounts of what it is like to be detained helped to raise awareness of the need to significantly improve the quality of mental health services and the ways in which individual patients are treated.

Methods

The final report of the Independent Review says "We must improve choice and decision making, both prior to and within a setting of compulsion." By acknowledging and centering the knowledge and concerns of patients, rather than ignoring them, the review focused on formulating pragmatic recommendations which may best support the wishes, preferences, and well-being of those that the Mental Health Act is supposed to serve.

Results

One of the findings of the initial data gathering part of the review was the struggle that patients detained under the Mental Health Act have in terms of self-determination and asserting their choice within mental health settings. The review revealed that both patients and carers may often find themselves at the painful end of damaging epistemic relations with clinicians and other mental health staff. The review uses the phrase "epistemic injustice" to describe the feelings that patients described of having "their capacity as a person with knowledge wrongfully denied." Patients described how their experiential knowledge of which treatments work best for them can be disregarded without explanation or justification by clinicians, and far too often patients who disagree with their treating team may be labelled by default as "lacking insight." If a patient or a carer raises a concern, they can often find themselves facing a blank wall of denial from the service provider and practitioners concerned.

Discussion

Patients have knowledge & agency which is essential to their recovery. One way of challenging structural epistemic injustice is to examine the assumptions underlying legislation at the state level, together with the implications for clinical practice and service provision. The existence of flawed assumptions within legislation may legitimise, normalise and propagate these assumptions throughout the system and beyond. This is what may have happened over the last decade since the 2007 amendment of the Mental Health Act, which led to an increase in disproportionately risk averse decision making within mental health services. There needs to be a shift away from defensive practice & blanket restrictions towards better clinical treatment which best serves the individual patient. It is important to remember that patients, even when oppressed by the disabling effects of a mental health condition have knowledge and agency which is essential to their recovery. Disregarding or suppressing this means of personal recovery with practices or rules which seek to eliminate all possibility of risk, may erode patients' sense of self and potential to achieve meaningful outcomes for themselves. This may constitute a challenge on associated public authorities, including National Health Service (NHS) organisations, to fulfil their obligation to respect the human rights in the European Convention on Human Rights.

Candelaria Mahlke

A co-produced mental health worker training for acute wards to reduce violence and involuntary treatment

Introduction

Involuntary treatment and coercive measures have a negative impact and are often perceived as a traumatic event of the person receiving it, with the violation of human rights at

risk.

Methods

A systematic review on interventions to reduce such incidents was concluded and results discussed in expert-panels with people who have experienced involuntary treatment, peer support worker from acute wards and mental health staff. A workshop was developed to facilitate a recovery oriented and person-centred delivery of this interventions. An additional module on the experience and long-term effects for service users was developed, containing video material of persons telling their experiences. A Delphi procedure on the workshop modules was concluded.

Results

Results on the Delphi procedure are reported

Discussion

Co-production is crucial in the development and delivery of mental health care in settings where human rights are at risk.

Andrew Hider

"I don't want to come off my CTO" : The impact of Psychological Factors in the operation of Section 17a of the Mental Health Act

Introduction

Community Treatment Orders delivered under Section 17a of the Mental Health act have been in existence since 2008. While originally designed as a means of ensuring adherence to medication in the community, they are increasingly used following discharge for people who attract the diagnosis of Borderline Personality Disorder.

Method

This paper argues that the relational processes underpinning the use of and experience of Community treatment orders has received insufficient focus, in turn resulting in the possibility that for some people with complex attachment needs, their use may be countertherapeutic and may paradoxically increase risk.

Results

Arguments are presented, derived from psychological theory, to provide a clinical account of how the containment function of CTOs may present long term barriers to functional and psychological recovery in some people. Anonymised case examples are used to illustrate how these processes may manifest in clinical practice.

Discussion

Finally, suggestions are made with regard to potential changes in the use of S17a in clinical practice that may minimise this iatrogenic potential while also ensuring that where risk issues are present, statutory process could still allow for safe support of this client group.

Vicky Stergiopoulus

Implementing a trauma-informed intervention for female survivors of gender-based violence: Lessons learned in a large urban centre.

Background

Gender-based violence is associated with an elevated risk of physical and psychological harm for girls and women (Deshpande & Nour, 2013; Heise, Ellsberg, & Gottmoeller, 2002). This study examines service user and provider experiences of a trauma informed, peer facilitated group psychosocial intervention (Peer Education and Connection through Empowerment [PEACE]) targeting female-identified youth affected by gender-based violence.

Methods

Participants were recruited among service users and providers of the intervention, delivered in Toronto, Canada. We conducted 18 semi-structured interviews between May and October 2017, engaging 11 service users and 7 additional stakeholders (including social service providers, peers and program administrators). We elicited participant perspectives on the acceptability of the intervention and key enablers of successful implementation and engagement of the target population. Qualitative transcripts were analyzed using thematic analysis.

Results

Service users, including survivors of sexual exploitation, forced marriage and honor crimes, described satisfaction with and acceptability of the intervention. A number of factors were perceived as contributing to the intervention's successful implementation, including a focus on service user needs, program quality, flexibility and accessibility, and strong inter-and intra-agency networks. Introducing peers as mentors led to unanticipated challenges with respect to peer mentor education and training to prevent boundary crossings and peer mentor turnover. The need for clear guidelines on the management of trauma disclosures and a systems-wide approach to service provider and administrator training in the effective integration of peer support services also emerged as important areas for future development.

Discussion

A group-based, trauma-informed and peer supported psychosocial intervention was acceptable to service users and providers and successfully engaged female-identified survivors of gender-based violence. Findings add to the scant knowledge base on interventions to support this population and identify important areas for future research.

POSTER PRESENTATIONS

Poster 1
Dr Patrick Sims
Recovery through Power Threat Meaning

The Trauma Informed Care Recovery College course at Arnold Lodge is based on the principles of the 'Power Threat Meaning Framework' (PTM; Johnstone & Boyle, 2018). The framework offers a perspective to understand emotional distress and individual experience considering patterns in emotional distress within four interrelated aspects (i) the operation of power, (ii) the kinds of threats that the negative operation of the power may pose to the individual, (iii) the central role of meaning in shaping experiences and expression and (iv) the learned and evolved threat responses to ensure adaptation. The framework is being planned within the Recovery College to enable service users to understand the value of telling their story and to create a narrative about their lives and difficulties. This empowering course allows for service users to understand their pattern of behaviours to provide a sense of validation and acceptance of their experiences. The framework's application within the Recovery College is on-going.

Poster 2
Li-yu Song
The patterns of rehabilitation service use and personal recovery among persons with psychiatric disability

Rehabilitation services are supposed to facilitate recovery. However, there is no concrete evidence in Taiwan. This study examined the patterns of rehabilitation service use and the association between pattern of use and personal recovery. Thirty-two community psychiatric rehabilitation centers in Taiwan agreed to participate in this study. A sample of 592 participants filled out the questionnaires. Eight kinds of rehabilitation service were included: Independent living and self-care training, interpersonal and social skills training, daily life arrangement and community life rehabilitation, physical activities, symptom management training, occupational therapy, sheltered workshops, and vocational training. Recovery was measured by Stage of Recovery Scale. Cluster analysis was utilized to classify the patterns of service use among the participants. ANOVA was used to examine the association between pattern of use and recovery. The results revealed five patterns of use: (1) Overall middle level with emphasis on work, (2) independent living plus occupational rehabilitation, (3) independent living plus vocational rehabilitation, (4) overall low-level of use, and (5) overall high-level of use. The differences among the five groups of participants on each kind of rehabilitation service were significant (Eta2=19.2%). The recovery status of overall high users was significantly better than overall middle-level users and overall low users. The recovery status of low-level users was significantly worse than the other four groups. The findings imply that greater rehabilitation service use is conducive to recovery. Comprehensive use of various types of service or the combination of independent living and other types seem to facilitate recovery.

Poster 3
Gianfranco Zuaboni
The Recovery Seminar – A recovery-based group concept on a psychiatric acute ward

Introduction

The establishment of recovery-oriented approaches in acute psychiatric settings poses a challenge. This is often tackled by the implementation of appropriate group offers. The "Recovery Seminar" is such a group format and was developed on the basis of practical experience and literature-based findings. The Sanatorium Kilchberg is a psychiatric hospital with a public service mandate for an area with 170'000 inhabitants. The Hospital has a total of 188 beds on nine wards. The psychiatric acute ward, called "B2", has a focus on the

treatment of affective diseases. Despite this treatment focus, patients with other mental illnesses are also admitted. The average length of stay is three weeks. The treatment is based on therapeutic talks with physicians, nurses, peer staff and psychologists as well as therapeutic groups, pharmacological, art and physical therapies.

Methods

We developed a new group concept in co-production and literature supported. We used “CHIME”- framework and the “Coproduction”- approach as the foundation of the concept. Like a Recovery College, the "Recovery Seminar" doesn’t pursuit a therapeutic but an educational approach. Primarily we want to offer participants a framework in which they can reflect their own values and beliefs about their recovery and learn new approaches. The seminar will be facilitated by a peer worker and another professional (nurse or psychologist) together. It is offered twice a week and one CHIME topic per week is addressed. For example, in the “C-week” the “Connectedness” is being addressed. Personal relevance and experiences are discussed. Even if the moderators give the input, the focus is on mutual learning.

Results

The participants regularly assess the “Recovery Seminar” very positively. It is often mentioned that one has the opportunity to openly discuss relevant topics in a hopeful atmosphere.

Discussion

The “Recovery Seminar” seems to be a good approach to work with patients in acute psychiatric wards on relevant and recovery-oriented topics.

Poster 4

Michaela Høj

Working with relationships and engagement of social networks in public sector services

Introduction

Research describes the importance of social relationships in the process of recovering from mental health difficulties, especially for young adults. However, provision of supportive relationships in public sector services is not uncomplicated. This study therefore provides insights into the challenges and perspectives of working with supportive relationships in public sector services.

Methods

Through a critical perspective, this study investigates 12 narrative interviews with young adults with mental health difficulties connected to the mental health and the employment centre, respectively. Focus is on investigating 1) the relationship between the young adult and the professional, 2) peer-to-peer relationships, and 3) the provision of support for the young adults through inviting their social network to “network meetings”.

Results

Findings suggest that in all three domains, the possibilities of providing supportive relationships are profoundly affected by institutional values and structures. Furthermore, findings suggest how issues related to stigmatization becomes pivotal in establishment of peer-to-peer relationships, and that stigmatization is also an important factor influencing the professionals’ possibilities of establishing positive relationships with the young adults.

Discussion

The study directs awareness on the profound influence of the context, and how the contextual framework interacts with the possibilities of providing supportive relationships in public sector services.

Poster 5
Chalotte Heinsvig Poulsen
Yin Yoga Recovery - a recovery-oriented intervention to patients with anxiety disorders

Introduction
Anxiety disorders lead to considerable losses in health and functioning and have implications for long-term health e.g. increased risk of cardiovascular disease – highlighting the need for effective health promoting interventions with the aim of improving the patient's recovery and ability to cope with symptoms. Yin yoga is based on the physiology of Traditional Chinese Medicine and is a meditative form of yoga that lets the body experience a deep relaxation in a way that has been suggested to have sustained impact on heart rate variability and symptoms of anxiety.

Methods
In this pilot-study we, in collaboration with a psychotherapeutic clinic in the Capital region of Copenhagen aim to:
1. Develop a 12-week Yin yoga intervention targeting patients in treatment for phobic anxiety disorders, obsessive-compulsive disorder, posttraumatic stress disorders, panic disorders and generalized anxiety disorders.
2. Test the feasibility of the intervention in clinical practice and perform the necessary adjustments before the planning of a randomized trial.
3. Test if an objective heart rate variability method that via Garmin activity trackers (watches) utilizes RR-interval data from 24 hours measurements to determine the participants time spent in sympathetic reactions (physiological stress), parasympathetic state (physiological recovery) and physical activity (oxygen consumption) can be used as a reliably proxy measure for changes in anxiety symptoms.

Results
Planning phase: Results in a draft manual of the Yin yoga intervention.
Feasibility study: Results in evaluations of accept, clinical demand, adjustments and implementation of the intervention.
Test of the design and method: Results in evaluations of the primary outcome (Heart rate variability vs Hamilton Anxiety Rating Scale) and the impact of heart rate variability data awareness.

Discussion
This pilot-study will form the basis for discussions regarding planning a randomized trial and of the recovery potential of a Yin yoga intervention targeting patients with anxiety disorders.

Poster 6
Siv Therese Bogevik Bjoerkedal
Meaningful Activities and Recovery (MA&R) – developing a novel intervention and partnership.

Background
Engagement in meaningful activities is fundamental to health and well-being. Interventions that enable participation in daily activities that are personal and social meaningful to the individual can be a significant contribution to psychiatric rehabilitation and support the recovery process through providing routine and structure, connectedness, purpose, identity and empowerment. While psychosocial services have made significant advances when it comes to supporting education and employment, there is a lack of interventions that tap into broader aspects of everyday life.

Method
MA&R was developed with inspiration from "Life-style redesign ®", a program for elderly people, which provide the participants opportunities to explore relationships between meaningful activities and well-being and to make changes in daily life. MA&R was pilot-tested in community mental health centers and found acceptable and feasible. However,

changes in the participants` daily life was hard to identify. A qualitative study mapping transfer processes from rehabilitation services to daily life was conducted. Results from the study were integrated in an iterative process with experienced occupational therapists and peer-workers developing the program into its current format, where peer-support and individualized support are key ingredients.

Results

MA&R is an eight months manualized rehabilitation intervention, that aim to enable participation in meaningful activities. It consists of eleven group sessions, eleven one- on one sessions and individualized support. MA&R is facilitated by an occupational therapist and a peer-worker in an equal collaboration.

Conclusion

MA&R is currently tested in a randomized trial, to assess its clinical effectiveness.

Poster 7
Abdikani Askar
Mental health and human rights

Introduction

Mental health is one of most neglected clinical centre in Somalia. world health organization estimated with one in three people affected Mental disorder and many patient have to face all sense of human right volition ,as people are not aware of mental health disorder ,they typically chain them and beat them ,the fact that there are a limited number mental health professionals Somalia. Our team set up mental health care centre in Qardho in our Punt land in North East Somalia. The care was basic on mental health as a human care

Method

Qardho Mental health service was established as a medical centre patients were treated as medical patient. This was the first service in punt land to medicalize mental health services Inpatient and outpatient where patient are not chained take seat with their family members and get treated after care full assessment . Follow up also done in regular Qardho mental health care service are free of charge. this is support by Somali Mental Health Foundation

Results

Over 15,000 patients received free mental health care in Qardho and from our team out reach service in the rest of Punt land State of Somalia. This reduced stigma and discriminations related to human right violation better access to treatment is our attitude neglect of mental health patient

Discussion

Mental health approach as a human right subject open doors for discrimination mental health care in Somalia . it helps in establishing mental health services oriented as a critical service This making sure psychiatry being regarded as medical Practice in the county .Human right aspect of mental health service need to be done at a large scale.

Poster 8
Monika Syc
Cogito Academy of Leaders – movement of experts through experience

Introduction

Despite progress in so many areas of life: education, communication, medicine, and growing social awareness, the stigma placed on the mentally ill is still present and afflictive. Our presentation depicts a movement of experts through experience – the Cogito Academy of Leaders – gathering people who have undergone a psychotic crisis themselves and are acting for the mentally ill in Poland.

Methods

CAL was established three years ago, and gathers the most active and engaged individuals, representing beneficiaries' organisations in Poland. Its aims and activities include integration of the communities acting for the mentally ill, counteracting stigma, representing the ill in public life, empowering them and giving a chance for inclusion in the society. CAL members

also empower themselves – we learn how to work in a group, to value and utilise interpersonal differences, to build personal competence and self-esteem, how to identify and put to use our own strengths, as well as to harness the expertise and potential resulting from the experience of mental illness.

Results

CAL may boast of many achievements in the field of education on mental illnesses, media-reports, publications and research. CAL contributed to the constitution of a new profession – Assistant in Recovery – in Poland, which gives a chance for experts through experience to work and help others with their own example – an example of leading a good life in spite of the illness. This way, the CAL members intend to inspire other psychiatric patients and deliver the message of hope.

Discussion

The example of ALC shows that it's possible to lead a good life despite the experience of a mental illness; moreover – it is possible to help others and conduct unified, coordinated efforts and activities on a national level. New roles are emerging for the persons after mental crises (educator, researcher, Assistant in Recovery).

Poster 9

Rie Mandrup Pulsen

Trust between patients, health care providers and social insurance officers in inter-sectoral collaboration

Introduction

Trust is warranted in many 'patient-professional-relations'; particularly in mental health care. Integrated care has been warranted for people with mental illness. The interdisciplinary provision of support in integrated care creates a new type of relation: 'patient-professional-professional-relations'. The role of trust in this type of relation is scarcely investigated. We have studied the diverging perceptions of and practices regarding trust in encounters between patients on sick leave because of depression, anxiety and stress, mental health care professionals from the health care sector and social insurance officers from the social sector in an inter-sectoral intervention.

Methods

This multi-method study was based on four types of qualitative data collected for a process evaluation. The attitudes and behavior regarding trust were described through observation of 12 intersectoral roundtable meetings, 24 semi-structured interviews with mental health care professionals and social insurance officers, 17 semi-structured interviews with patients, and six interviews with supervisors.

Results

Preliminary finding show that trust was a warranted aspect of the 'patient-professional-professional-relation' according to patients and most health care professionals but to a lesser degree by social insurance officers in the integrated intervention. The flow of communication between professionals and the uncertainty related to mental illness created a need for trust in the 'patient-professional-professional-relation'. The social insurance officers' power over the patients' economic situation was both described as the main reason for the need for 'patient-professional-professional' trust and also an important barrier towards creating that trust.

Discussion

The need for trust-based relations has previously been argued to be important when patients' conditions and their need for support is subject to a high degree of uncertainty. We argue that trust was particularly needed in intersectoral collaboration between the social sector and the health care sector were diagnoses and prognosis were changeable, and information was thought to flow easily between sectors.

Poster 10
Mark Rice
Strategic Directions in Minimizing the Use of Seclusion and Restraints in Tertiary Mental Healthcare

Introduction

The use of seclusion and restraint (SR) within hospital-based mental health settings has been an historical practice that has come under intense scrutiny in recent years. The World Health Organization has identified that the use of SR has the potential to create lasting physical and psychological trauma for both service users and health practitioners, and represents an issue of human rights. Research literature has also demonstrated that during episodes of SR, there is an increased risk of physical injury to both the service user and provider. As a result, safety within mental health units has been an area of focus and legislative changes in Canada will further hold organizations accountable for safety outcomes and ensuring that both service users and providers work together in environment that enhances health and welfare, respect, autonomy and dignity.

Methods and Results

The purpose of the proposed presentation is to outline the strategic approach undertaken by a tertiary mental health hospital to reduce and minimize the incidents and duration of SR in order to align with recovery-oriented principles that guide mental health care system transformation, while enhancing safety and human rights. A number of innovative practices will be presented as well as an examination of SR data collected over time, to gauge their impact.

Discussion

This ongoing monitoring and continuous improvement regarding the use of SR demonstrates an important shift in organizational prioritization of recovery-oriented practice, safety and an examination of the use of coercive practice as a violation of human rights. Implementation and impact of the initiatives will be discussed, as well as directions for future research and areas of improvement.

Poster 11
Eve Lagarde
Collaboration between elected officials, users and professionals for the use of art in the political actions of cities to de-stigmatize people with mental health problems

Introduction

Persons with mental ill health face an important social stigma. In France, addressing stigma is part of a city politics, which is coordinated by local mental health councils, composed of local elects, users of mental health services, and mental health professionals, and coordinated by the French WHO Collaborative Centre. The Intermunicipal Association for Health, Mental Health and Citizenship is a council created in 2010 supporting a contemporary art fund named Frontière$. Created in 1996, it is the natural result of a cultural policy implemented since 1977 by Roelandt MD, allowing artists to work in the psychiatric hospital. Combining works from professional artists, amateurs, people with mental health problems or not, and presenting them without distinction, it is used as a political tool for destigmatization. French urban policy is aimed at urban cohesion and solidarity towards the most disadvantaged neighbourhoods. It aims to restore republican equality and improve the living conditions of the inhabitants.

Method

The Intermunicipal Association for Health, Mental Health and Citizenship, with the Contemporary Art Fund Frontière$, responded to calls for projects in the mental health sector with two cities, Lille-Hellemmes and Mons-en-Baroeul. For each of these projects an artist was solicited, and worked on an artistic project with the inhabitants, including persons with mental ill health.

Results

We met 50 persons, which have initiated three projects over three years

Discussion

These projects have made it possible for persons on both sides of mental health stigma to meet, and co-construct projects together. Threw increasing and most importantly enhancing participants artistic capacities they allow a lifting of communication barriers. The incorporation of professional artists show better results than discriminatory artistic interventions targeted toward persons labeled “mentally ill”. The cultural tool is an empowering instrument to convey ideas, through its questioning it challenges health practices and the place of users in the community.

Poster 12

Christine Larsen

The Recovery College in the Mental Health Services, The Capital Region of Copenhagen

Introduction

The first recovery-college in the Mental Health Services, in the Capital Region of Denmark was established in 2015 by four teachers, one nurse and three with lived experiences of mental health disorder. In 2019 we are six teachers and 15 sessional teachers.

Methods

The recovery college in The Capital Region of Denmark forms a central part of the establishment and further development of recovery-oriented services and support recovery processes of people using the services. In the Recovery College, expertise of lived experiences, and expertise of mental health professionals is brought together in creating curriculum and delivering courses. All courses are based on educational principles and have a recovery-oriented curriculum. A recovery college can facilitate development of recovery-oriented services and

Results

In 2018 six teachers and 15 sessional teachers have delivered 25 different courses to 615 students, many have participated in several courses. 65% were patients, 20% were mental health professionals and 15% were relatives. 91% were very satisfied or extremely satisfied with the content of the course. 92% were very satisfied or extremely satisfied with the teacher’s presentation of the course. Courses are held on ten different locations, enabling more people to attend courses. An important part of spreading knowledge of the school and recovery, the teachers have held 63 talks in many different settings. A partnership with four local municipalities has been established in 2018, delivering five courses to 60 students. 90 % of all 2019 spring courses are full.

Discussion

The process of coproduction has been new for all teachers working with the recovery college. The two different backgrounds of the teachers, and three backgrounds of the students is deemed as very effective in engaging the participants. In the recovery college, different kinds of relationships between students and teachers are offered, reflecting a change of power. Research into the effect of the College on the students, and on the recovery-orientation of the services is planned in the future.

Poster 13

Mário César Rezende Andrade

Needs assessment in an outpatient sample of people with schizophrenia in Brazil.

Introduction

Needs assessment among patients with schizophrenia have been one of the most used measures in planning and monitoring of mental health services. However, no study has described the needs profile and its associated factors outpatients with schizophrenia in Brazil, even following the recent expansion of community services. This study aimed to investigate the needs profile of a representative sample of outpatients with schizophrenia disorders in Brazil and their association with service use, adjusted for individual variables.

Methods
This cross-sectional study included a probabilistic sample of 401 patients who were attended at the five Psychosocial Care Centres of the city of Santos, Brazil. Needs were assessed using the Camberwell Assessment of Need. Hierarchical multiple regression analyses were performed to investigate the factors associated with numbers of total and unmet needs.
Results
The average total number needs was 5.85 (±3.09) and the number of unmet needs was 2.91 (±2.55). The most commonly reported needs were psychotic symptoms (67.0%), information needs (55.0%), psychological distress (41.8%), money (41.5%), food (36.6%), activities (35.0%), physical health (34.8%), looking after the home (33.8%) and transportation (33.5%). The numbers of total and unmet needs were shown to be associated only with sociodemographic and clinical indicators of severity, showing no association with the use of services.
Discussion
The mean number of needs was consistent with the results of international studies. Both clinical and basic needs were among the most present. Despite the lack of association with service use, the number of total and unmet needs seemed to work as an index of illness severity.

Poster 14
Mário César Rezende Andrade
Assessing users satisfaction with Residential Therapeutic Services

Introduction
Despite the increased prominence of residential therapeutic services in promoting the psychosocial rehabilitation of people with mental disorders, evaluative studies with such services are still scarce. This study aimed to assess service satisfaction and its associated factors in a sample of people with severe mental disorders living in residential therapeutic services.
Methods
This is a cross-sectional study with a sample of 60 people with severe mental disorders, from 15 residential services in the city of Juiz de Fora, Brazil. Service satisfaction was assessed using the Brazilian version of the Satisfaction Scale (SATIS-BR), originally developed by the World Health Organization to evaluate users satisfaction with mental health services. Satisfaction predictors were investigated through multiple linear regression, using a confidence level of 95%.
Results
The results showed an average global satisfaction of 4.5 (on a scale from 1 to 5), indicating that participants were between satisfied and very satisfied with services. Factors associated with higher satisfaction with service were: participation in rehabilitation activities taking place in the local community mental health service, not receiving visits from primary health care professionals, enjoying the residence location, enjoying the way other residents relate to him/her, agreement with the residence rules and thinking that residents have a good relationship.
Discussion
Results pointed to a good quality of services. However, some aspects need to improve, such as the capacity of staff members to listen and understand residents needs and the interaction of residents with the community.

Poster 15
Sarah Carter
Does recovery in mental health need healthcare professions? – A Critical Realist Synthesis

The concept of recovery is stated within much health and social care policy, legislation and guidelines across the UK, and it is an approach that is widely implemented by occupational

therapists in mental health services. However, the recovery paradigm poses complex and multifaceted challenges to mental health professionals and there is growing concern of the ability to overcome the inherent barriers present in today's health and social care structure and culture (Jacob et al., 2015; Slade et al., 2014).

This literature review explores these barriers in relation to the professional concept and power theories using a critical realist approach (Edgley et al., 2016). The findings reveal there is an issue of power that undermines recovery implementation by occupational therapists within mental health services.

The review concludes that the recovery paradigm needs to shift its focus off service provision and onto influencing societal change by using the power already available to it in the form of community. This calls for action from occupational therapists to unite with services users and other professionals to come together in community to fight for their right to occupational recovery at a societal level rather than focusing on service level implementation.

Poster 16
Roshan Galvaan
Reflections on South African students' need for a recovery orientation to supported education

Introduction

Since 2015, psychosocial disability has been foregrounded in student protests around the critical need for social transformation of South African (SA) higher education institutions. This was brought into sharp relief in late 2018 when the Dean of the Faculty of Health Sciences (FHS) at the University of Cape Town (UCT) took his life. In response, improvements, which adopts a bio-psychosocial orientation, have been made to the mainstream mental health services at the university. The FHS Mental Health Workgroup (MHWG) was mandated to recommend how the FHS could promote mental wellbeing within the faculty and open dialogue sessions and an online survey for students and staff was designed and facilitated in partnership with student leaders and volunteers. UCT FHS MHWG members with an interest in supported education also engaged with various stakeholders at the university to explore transitioning from a biopsychosocial to a recovery orientation of support to students with psychosocial disabilities. This presentation reports on insights into a recovery orientation to support education for students with psychosocial disabilities at UCT.

Methods

Alongside a thematic analysis of the engagements with stakeholders, the authors participated in an action-reflection process focused on the development of a recovery orientation to supported education. A document analysis of notes and memos produced during organising and implementing the engagements with stakeholders was conducted. This elucidated issues to be taken forward.

Results

While changes in institutional culture are critical, we also identified that a co-produced supported education service will require:

• Re-orientation of existing university policies
• Introduction of a recovery orientation to addressing needs
• Relating learning to recovery
• Consideration of broader socio-political issues which impact on the mental wellbeing and recovery of students

Discussion

We discuss how a student-informed supported educational programme in a South African context would could address the recovery needs of students with psychosocial disabilities.

Poster 17
Nadja Kehler Curth
The effects of a Danish model for collaborative care

Introduction
Extensive research suggests that collaborative care (CC) for people with anxiety disorders and depression is associated with significant improvements in patient outcomes compared with treatment as usual (TAU). As there is limited knowledge about the effects of such models outside the US a Danish model for CC (the Collabri model) was developed and tested in primary care clinics in the Capital Region of Denmark between 2014-2017.

Methods
The model was tested through cluster-randomized trials comparing the effects of CC with TAU in patients with generalized anxiety disorder, panic disorder, social anxiety disorder and depression. The CC intervention included a multi-professional approach to patient care (a care manager with a medium-long health education, experience from mental health care and training in CBT, a psychiatrist and the patient's general practitioner), enhanced communication between professionals, treatment based on a person-centered approach, shared decision making and a structured treatment plan with scheduled follow-up. Treatment modalities were accessible according to a stepped care model. All professionals were trained in the model principles and care managers additionally attended a more extensive training program focusing on psychoeducation and CBT. The primary outcomes were self-reported symptoms of depression and anxiety. Secondary and exploratory self-reported outcomes were among others health-related quality of life, general well-being, self-efficacy and experience of support from health care provider(s) in personal recovery.

Results
A total of 731 participants were recruited in the trials. Preliminary results from 6 month's follow-up show larger improvements in symptoms of anxiety and depression in the CC group compared to the TAU group and significant improvements in all self-reported outcomes in the collaborative care group.

Discussion
The results will contribute with important information about the effects of collaborative mental health care that can inform decision makers about implementation of integrated care initiatives in Denmark.

Poster 18
Andrew Hider
Capturing Restraint to Improve Patient Safety: A Novel Data System to Improve Oversight of Physical Intervention in Mental Health Settings.

Introduction
Mental health care at all levels (i.e. community and inpatient) requires accurate behavioural data for clinical, operational and governance purposes (Webber et al, 2011). The implementation of the Mental Health Units (use of Force) Bill 2018 will further entrench this requirement. However, the variability in the data across UK mental health organisations indicates that measurement may not be consistent (Mind, 2013).

Method
A software platform for data capture on behavioural and patient safety related incidents has been designed, built and deployed over a three year period. It allows for multi-level oversight of the behavioural and patient safety status of a multi-site mental health organisation. Data capture is achieved through the use of a form coded in MS SharePoint. Incident form data are used to populate a SharePoint list allowing full data interrogation, with multivariate data stored in MS Excel. Central to the development was the development of a bespoke digital body map tool that integrates with an existing MS Exchange server to record the identities of all staff involved in incidents and the specific physical location of their involvement.

Results
Data can be interrogated on a live basis in a granular manner, allowing for the same

descriptive metrics to be outputted in graphical form at multiple levels - patient, sub-unit (e.g. ward), operational unit (e.g. hospital), and corporate unit (multiple sites). Data is used to automatically populate clinical reports, staff and patient facing quality dashboards, and to support governance risk monitoring at local and corporate levels. The platform contains email notification functionality to support clinician awareness of restraint related incidents

Discussion

The platform has been built as an innovation in the absence of a bespoke tool. Further planned work includes the supplementation of descriptive outputs with formal analytics and use of established machine learning techniques to enhance utility.

Poster 19

Andrew Hider

Human Factors and Mental Health Care - A Reason Why We Continue to Fail?

Introduction

The use of human factors research plays a significant role in service delivery and process design in physical healthcare but has received little attention in the area of psychological and behavioural healthcare. Clinical integration of human factors research is particularly important since, increasingly, clinicians are responsible for designing interventions delivered by others – often unqualified support staff – and training them to do so.

Method

This paper argues that there are cognitive factors intrinsic to human psychology that are likely to influence staff's ability to engage with and apply the principles of psychological informed and therefore recovery focused care, and that failure to acknowledge these can be instrumental in causing service delivery failure, staff – service user conflict and low service user and staff satisfaction . This in turn can have a significant impact on patient safety and perception of recovery support. It is proposed that the neglect of the human factors literature may explain some of the difficulties in successfully implementing person centred, psychologically informed mental health care at scale, despite the evidence base and multiple policy initiatives. The paper refers to Kahneman's (2011) two stage model of human cognition and provides a connected theoretical account of the human factors issues connected to the delivery of psychologically informed care.

Results and Discussion

Practical suggestions in the areas of service design, ergonomics, team functioning and leadership that may be associated with the minimisation of these risks are offered. Ideas for supporting an increased focus in services on the use of the human factors literature in the design, prescription and communication of psychological interventions are discussed. It is argued that consideration of the intrinsic barriers to psychological thinking becomes more important as the complexity of distress within a mental health service increases. Novel training materials with embedded human factors components are presented.

Poster 20

Andrew Hider

"Connections" – A group intervention for encouraging mentalising in staff-service user conflict resolution.

Introduction

Quality of staff/service user interaction in forensic mental health environments is a key factor in maintaining safety and supporting recovery. The complex distress present in such environments can impact on perceived environmental safety for service users and staff, and render care environments counter-therapeutic or damaging. Staff /service user conflict often occurs due to mentalising failures of both service users and staff: in that if staff are unaware of the interpersonal expectations of service users, then they may make incorrect assumptions about the schematic beliefs underpinning service user reactions to staff behaviour, and mismatch their responses, thus escalating conflict situations. Similarly,

service users may attribute negative mental states to staff based on a misinterpretation of staff behaviour, impacting on the development of relational security.

Method

The current paper presents a treatment manual for an open psychotherapeutic group, based on principles of MBT (Mentalisation Based Treatment) and restorative justice, and designed to improve the reflective capacity of an inpatient forensic mental health ward. It reports on the implementation of this intervention over a 12 month period. The ESSEN climate scale and behavioural measures were used as outcome measures.

Results

Results indicated that, post intervention, significant improvements were observed on the 'therapeutic hold' subscale of the Essen-CES, indicating a specific effect on a measure of relational security. Significant reductions in violent incidents were observed over the intervention period. Supplementary qualitative data indicated that relational themes dominated the explanations given for the perceived helpfulness of the intervention

Discussion

Limitations of the study are discussed. The need for specific further research into the role of therapeutic groups in reducing power differentials in secure mental health care is highlighted.

Poster 21

Andrew Hider

Auditing for Values – The development and outcomes of a clinical audit tool to support compliance of behaviour support plans with mental health and human rights legislation

Introduction

Current NHS contracts in the UK require services to ensure the presence of behaviour support plans (BSPs) for all service users with mental health problems, learning disabilities, autism spectrum conditions and dementias. However, despite the presence of published quality checklist (eg PBS Academy, 2018), the extent to which behavioural programmes contained within BSPs are compatible with mental health and human rights legislation is not routinely audited by existing regulatory frameworks.

Method

This presentation describes the development and presents the content of a 'Values Audit' tool designed to enforce compliance with human rights and mental health legislation in a multi-site organisation providing service to all client groups where BSPs are mandatory.

Results

Anonymised data from the completion of the tool for all BSPs across multiple clinical specialisms are presented. Areas for development are highlighted, including ensuring service user involvement in BSP development and the need to ensure attempts to communicate the rationale and content of interventions contained within BSPs to service users who have communication difficulties

Discussion

BSPs are seen as central to the provision of person centred care and an important component of reducing the use of restrictive practice in mental health and learning disability settings. However, the potential for the implementation of interventions derived from behavioural theory that do not support values based practice and person centred care remains outstanding while the technical and human rights legislative components of BSPs are not routinely audited. Suggestions are made as to why this may be and how such monitoring should become part of routine external regulatory audit and inspection of services providing care and support to people with complex behavioural needs.

Poster 22

Mark Hayford Dwira

The Role of Men in the Prevention of Female Genital Mutilation/Cutting among the

Sudanese Population in Nottingham. A Small-Scale Qualitative Study.

Introduction

It is generally assumed that female genital mutilation/cutting (FGM/C) is considered as a feminist agenda and therefore it is women's responsibility to champion prevention of the practice. This ignores the roles that men can play in the prevention of FGM/C in the communities that practice it in the UK. This research explored how men can use their status as father, husband, community and faith leaders to help prevent FGM/C among Sudanese Immigrants living in Nottingham.

Methods

This small-scale qualitative study involved conducting interviews and focus group discussions with 11 men and submitting the data to thematic analysis. The study was situated within a radical feminist theoretical framework comprising of The Silences Framework and Post-Feminist Theory.

Results/Discussion

The research revealed that men's status (as fathers, husband, community and faith leaders) is deep-rooted and linked to their supremacy and decision-making power that make them influential over their children and families in homes and community. Participants believed that their inclusion as principal educators will give them the platform to talk openly about the effects of FGM/C practice (young and old) especially, with those who are married to women who have undergone FGM/C from the practising communities living in Nottingham. The study revealed that people from practising communities do not report suspected FGM/C cases; therefore, participants believed that their role as whistle-blowers in each family would help to safeguard girls and women who may be either their own wards or others at risk of undergoing FGM/C.

Conclusion

This study suggests that policy-makers and Health care professionals, teachers and social workers in the UK and worldwide who have thus far largely ignored the role of men in tacking FGM/C need to redirect their attention to the inclusion of men. Further research is required to understand how aspects of masculinity, which might be regarded as at one level to embody assumptions of power and gender-authority, be mobilized in a positive sense to explore the roles men can play in the prevention of FGM practices in the UK.