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Abstract Book

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TOPICS

General theme : “Evaluation of mental health services: everyone’s business”

At a time when mental health needs are high but care not always up to the challenge, building on users’ and professionals’ experiences is of utmost importance to improve mental health care.

The role of people with a lived experience of mental ill-health across the lifespan is essential, especially in the context of recovery-oriented interventions, as is the role of their families, carers, and professionals. These experiences, integrated into all processes of care and policy, define and shape the clinical, ethical, epistemological, and political aspects of mental health and together determine the quality of mental health care.

The 15th ENMESH Conference presents innovative and state-of-the-art methods and results of current research, and offers opportunities to delve into these and other factors that shape mental health services.

Topics

- Users’ lived experiences
- Child and adolescent mental health
- Health system and interdisciplinary approaches to quality
- New frontiers in research and policy
- *Santé mentale et soins primaires* (French-speaking pre-conference)

Wednesday 3 July - Pre-conference

Mercredi 3 Juillet - Journée francophone

Prévention du suicide chez les adolescents et littératie en santé mentale: du Québec à la France

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Introduction : Le suicide chez les adolescents a connu une décroissance significative ces 20 dernières années au Québec. Cette baisse peut être en partie attribuée au déploiement d'un programme de sensibilisation au repérage de troubles de santé psychique tels que la dépression, programme « Jeunes en tête » dont 1 300 000 adolescents au Québec ont déjà bénéficié (1,2).

En France, près de 400 adolescents se suicident encore chaque année, en dépit du déploiement d'une stratégie nationale de prévention du suicide de plus en plus solide.

Méthode : La littératie en santé mentale est un vecteur clé de la prévention du suicide : les autopsies psychologiques réalisées chez des sujets décédés par suicide mettent en évidence la présence d'un trouble psychique, la dépression en premier lieu, souvent non traitée. Par ailleurs, un essai clinique randomisé européen, Seyle, a également démontré l'intérêt de sensibiliser les adolescents à repérer leurs difficultés psychiques (3). C'est pourquoi il nous a semblé primordial de réaliser une adaptation du programme « Jeunes en tête » afin de le proposer aux collégiens en France, adaptation à la fois culturelle et contextuelle.

Résultats attendus : une amélioration du repérage de symptômes dépressifs par les adolescents et une augmentation du recours au soin psychique.

Discussion : Nous proposons de discuter de l'intérêt d'un dispositif de sensibilisation à la santé psychique chez les adolescents dans le cadre de leur établissement scolaire, en France, selon le modèle québécois adapté.

1. Lesage Alain et al. Solidaires pour la vie. Un programme scolaire canadien de littératie en santé mentale pour prévenir le suicide chez les adolescents. Perspectives Psy. 2020 59(2):127-39

2. Fondation Jeunes en tête. https://fondationjeunesentete.org

3. Wasserman D et al. School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. Lancet. 2015 Apr 18;385(9977):1536-44.

Recherche mixte : "carrières" tabagiques des jeunes dans deux types d'institutions de santé mentale

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Introduction : Parmi les facteurs expliquant l'importante consommation de tabac chez les personnes avec un trouble psychique figure une initiation précoce en institution. On note l'absence de travaux en France sur les processus d'entrée dans le tabagisme de cette population. Cette communication, qui croise sociologie et épidémiologie, porte sur les déterminants sociaux, contextuels et biographiques de la consommation de tabac chez les adolescents et jeunes adultes (AJA) en institutions de santé mentale.

Méthode : Dans un souci de triangulation et de comparaison, une méthode mixte (questionnaires et entretiens avec des AJA) a été utilisée dans 7 centres : 3 cliniques en Ile-de-France (IDF) et 2 cliniques en province, 2 Dispositifs Intégrés Thérapeutiques Educatifs et Pédagogiques (DITEP) en IDF.

Résultats : L'analyse des 6 entretiens avec les AJA identifie quatre phases de la « carrière » tabagique : expérimentation, poursuite, renforcement et installation de la pratique. Dans une analyse dialectique avec le volet quantitatif (143 questionnaires) ces étapes sont reliées avec les facteurs associés : socio-démographiques, environnementaux (groupes de pairs, famille, type d'institution, gradation des soins). Si les contextes de l'expérimentation et de la poursuite apparaissent similaires aux AJA en population générale, les institutions de santé mentale favorisent le renforcement et l'installation de la consommation, en lien avec les effets « totalisants » de l'institution (organisation de vie quotidienne). Des différences entre les deux populations (clinique et DITEP) sont à noter : différence des contextes et les âges d'expérimentation et de l'intensité de la consommation.

Discussion : Du fait des difficultés que rencontrent actuellement les institutions en santé mentale (restructuration, difficultés de recrutement), les effectifs de l'étude restent faibles, les résultats doivent être validés par une étude visant la représentativité. Cette étude pourra comprendre un volet interventionnel centré sur les articulations entre politique institutionnelle et organisation de la vie quotidienne.

Exploration de l'Implémentation de la Plateforme d'Orientation des Premières demandes en psychiatrie de l'enfant et de l'adolescent (POP) à partir des savoirs expérientiels des professionnels : une étude qualitative.

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Financement CH le Vinatier

Rationnel Il existe en pédopsychiatrie un écart significatif entre les besoins et les soins disponibles. Ainsi, il parait crucial de proposer des solutions innovantes (2). Le CH du Vinatier a mis en place en avril 2021 un dispositif (POP) afin de favoriser l'accès aux soins, de diminuer les listes d'attentes et de fluidifier le parcours de soin en PEA. Cette plateforme a conduit à une modification du parcours de soin des patients et également à une modification des pratiques. La plateforme d'orientation POP n'a jamais été sujette à une évaluation de son implémentation.

Objectifs L'objectif principal est d'évaluer l'implémentation du dispositif à partir des savoirs expérientiels (3) des acteurs et partenaires en lien avec POP. Le cadre RE-AIM (4,5) et le modèle de Damschroder (6) permettront d'explorer comment les caractéristiques de l'intervention identifiées dans le modèle de Damschroder influencent la mise en œuvre et le maintien de l'intervention comme décrit avec le cadre RE-AIM.

Méthode Les données qualitatives seront relevées via des entretiens semi-dirigés (7) auprès des professionnels en lien avec POP et retranscrites à l'aide du logiciel WHISPER®. Trois chercheurs vérifieront et réviseront les codes extraits afin de garantir la triangulation des chercheurs (8). L'étude sera conduite selon une analyse thématique de contenu (9) à partir des thèmes des deux cadres. L'approche sera déductive puis inductive (10) et l'analyse des verbatims se réalisera à l'aide du logiciel NVIVO® (version 14).

Discussion L'étude propose une approche innovante pour optimiser la plateforme d'orientation POP implémenté au CH Le Vinatier en interrogeant directement les professionnels. S'inscrivant dans une démarche d'amélioration d'accès aux soins en PEA, enjeu de santé publique majeur, elle explore une dimension peu étudiée en se concentrant sur une population hétérogène de professionnels tous en lien avec POP à différents niveaux.

Portrait du diagnostic du déficit de l'attention avec ou sans hyperactivité (TDAH) au Québec

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Le déficit de l'attention avec ou sans hyperactivité (TDAH) constitue un problème de santé publique touchant un grand nombre d'enfants et de jeunes adultes. Cette présentation vise d'abord à décrire la prévalence au Québec du TDAH diagnostiqué, les déterminants socioéconomiques, les maladies concomitantes, l'utilisation des services et la mortalité chez les personnes à partir de données médico-administratives du système intégré de surveillance des maladies chroniques du Québec.

La population à l'étude est composée de toutes les personnes âgées de 24 ans et moins ayant reçu un diagnostic principal de TDAH entre 1996 et 2016 et qui sont admissibles au régime d'assurance maladie du Québec. Pour être considéré comme ayant un TDAH, l'individu devra avoir eu au moins une visite médicale ou une hospitalisation avec un diagnostic principal de TSA (codes 314 de la CIM-9 ou leurs équivalents CIM-10-CA).

La prévalence et l'incidence indiquent un accroissement constant du diagnostic du TDAH dans le temps. La prévalence à vie s'établit à 11,3 % avec un ratio de deux garçons pour une fille (les données seront mises à jour). La proportion de personnes diagnostiquées avec un TDAH diffère selon l'âge et varie considérablement d'une région à l'autre. La proportion de sujets présentant une maladie concomitante est plus importante parmi les personnes avec un TDAH que dans la population générale. Cette différence est particulièrement significative pour les troubles mentaux de manière générale (64,4 contre 24,0), les troubles anxiodépressifs (30,9 contre 11,1), le retard du développement (28,3 contre 6,6) et les traumatismes (77,6 contre 62,8). Les omnipraticiens et les pédiatres sont les médecins les plus consultés par les personnes avec un TDAH.

Les prévalences observées au Québec se comparent à celles de certaines provinces canadiennes. Les variations interrégionales sont également semblables à celles observées par le Centers for Disease Control and Prevention, (CDC) des États-Unis.

FS-01 | Utilisation des bases de données médico administratives pour la surveillance du TDAH au Québec - Alain LESAGE, Centre de recherche Institut universitaire en santé mentale de Montréal

Prescription de Médicaments pour TDAH et l'impact sur les traumatismes et la mortalité des jeunes

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Le TDAH touche un grand nombre d'enfants et de jeunes adultes. De plus en plus, les personnes avec un TDAH reçoivent une médication. L'objectif de cette présentation est de décrire la prévalence au Québec de la prescription de médicaments pour TDAH et d'examiner l'impact de celle-ci sur les traumatismes, la mortalité et les blessures.

Les estimations ont été obtenues à partir d'un suivi longitudinal, allant du 1er avril 2000 au 31 mars 2020, pour toutes les personnes de 24 ans et moins admissible au régime public d'assurance médicaments (RPAM) du Québec.

Les résultats indiquent un accroissement constant de la prévalence annuelle de prescription pour TDAH dans le temps, allant de 1,9 % en 2000 à 7,7 % en 2020. Les médicaments sont, non seulement, prescrits pour les personnes avec un diagnostic de TDAH, mais aussi pour celles qui n'ont pas de diagnostic inscrit dans le bordereau de paiement de la visite. On observe un écart important selon les régions socio sanitaire (allant de 3,2 % à 14,4 %). La prévalence de prescription est plus faible chez les personnes provenant de milieux très favorisés économiquement. Ce sont en majorité des omnipraticiens, suivis des pédiatres qui effectuent la première prescription. Les psychostimulants restent de loin les classes de médicaments les plus prescrits. Des différences existent entre les personnes atteintes de TDAH traitées et non traitées en ce qui concerne la comorbidité psychiatrique et l'utilisation des services. L'exposition aux médicaments contre le TDAH est associée à un risque de mortalité et d'événements liés à un traumatisme plus faible chez les jeunes personnes atteintes de TDAH par rapport à celles non traitées.

L'information issue de cette étude permet de dresser un portrait de la prescription de médicaments pour TDAH au Québec et fournit de nombreuses pistes pour de futurs projets.

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Impact de la pandémie de coronavirus sur la prévalence du TDAH et l'utilisation des services

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Plusieurs études ont montré que la pandémie de COVID-19 et les mesures de sécurité mises en place ont affecté la santé, le bien-être psychologique et l'utilisation des services de santé des personnes avec TDAH. Cependant, les effets de la pandémie sur les Québécois atteints de TDAH demeurent peu connus. Cette étude vise à comparer l'incidence et la prévalence du TDAH pendant la période pandémique (avril 2020 - mars 2022) avec celles de la période prépandémique (avril 2017 - mars 2020) chez les Québécois âgés de 24 ans et moins. Cette comparaison est faite selon le sexe, l'âge, les régions et l'utilisation des services de santé.

La période d'observation s'étend du 1er avril 2017 au 31 mars 2022. La prévalence annuelle et l'incidence ont été sélectionnées pour évaluer l'impact de la pandémie chez les individus de 24 ans et moins diagnostiqués avec le TDAH ou ayant reçu une prescription de médicaments pour le TDAH.

Nos résultats révèlent une augmentation de la prévalence (passant de 3,5 % à 4,4%) et de l'incidence (passant de 1 % à 1,5 %) dans la période pandémique par rapport à celle prépandemique. Cette hausse est particulièrement marquée entre le quatrième trimestre 2020 et le premier trimestre 2022. On observe une augmentation de prescriptions de médicaments pour le TDAH par les omnipraticiens durant la période pandémique comparativement à la période pré pandémique tandis qu'on note une légère baisse chez les pédiatres et les psychiatres au cours de la même période. Aussi, les personnes avec un TDAH ont connu une réduction des hospitalisations, des recours aux services d'urgence et des services spécialisés pendant la période pandémique.

Cette étude contribue à une meilleure compréhension des effets de la pandémie en lien avec l'accès aux soins de santé et de l'utilisation de médicaments pour le TDAH.

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Initiatives communautaires et implication des partenaires de soins pour atténuer la stigmatisation

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Monsieur Boisrond témoignera des besoins non-comblés au niveau des services sociaux, scolaires et de santé. Il parlera de l'évolution au Québec de la stigmatisation des parents dont les enfants ont des troubles de comportements dus au TDAH et qui acceptent un médicament contre le TDAH. Enfin, il partagera la force de l'entraide et de la reconnaissance de l'expertise des parents partenaires de soins, de recherche, de surveillance et de représentation citoyenne.

Monsieur Frédéric Boisrond est un parent avec expérience vécue avec le TDA\H, et directeur général du Regroupement des Associations PANDA du Québec (Accueil - Regroupement des Associations PANDA du Québec (associationpanda.qc.ca). Cet organisme aide à mettre sur pied des services de première qualité pour favoriser la réussite scolaire et sociale des personnes atteintes de TDA/H et pour répondre aux besoins spécifiques de leurs proches. Ce réseau national d'organismes à but non lucratif est dédié uniquement à l'entraide des personnes ayant le TDA\H et leurs proches. Il a fait partie en 2017 du comité de suivi de l'agence québécoise d'évaluation des technologies de la santé (INESSS) qui se penchait sur les trajectoires optimales de services psychosociaux et médicaux dans le TDAH. Il a été invité pour rencontrer à l'Assemblée nationale du Québec, une délégation de parlementaires belges, pour parler de l'expérience québécoise du TDAH, au moment où une commission parlementaire québécoise se penchait sur la prescription peut être excessive de la médication contre le TDAH. L'INSPQ via son Système Intégré de Surveillance des maladies chroniques basé sur le jumelage des données administratives de santé couvrant 98% de la population québécoise, a produit un portrait de la prévalence, de l'utilisation des services et des issues de santé et dernièrement sur l'usage du médicament.

Manifestations symptomatologiques de la dépression: analyse par réseau selon la position sociale

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Afin d'améliorer la prise en charge de la dépression, il est crucial de comprendre quelles manifestations symptomatiques incitent les individus à consulter et lesquelles soutiennent le diagnostic. Cette démarche revêt une importance particulière chez les moins favorisés, car leur accès aux soins peut être tardif et à des stades avancés. Cette étude explore les liens entre les manifestations symptomatologiques et l'auto-reconnaissance d'un épisode dépressif d'une part, et le diagnostic clinique d'autre part, selon trois indicateurs de position sociale.

Les données à l'inclusion de CONSTANCE ont été utilisées. Les volontaires ont été regroupés selon le niveau de diplôme, les difficultés financières et la profession, en stratifiant par sexe. En utilisant une approche de réseau psychométrique, 24 réseaux ont été estimés. Les nœuds correspondaient aux 20 items de l'échelle CES-D, avec un nœud externe pour 'Limitations dues à la dépression' (proxy d'auto-reconnaissance) et 'Dépression clinique traitée'. Les réseaux des groupes défavorisés ont été comparés à ceux des groupes favorisés pour chaque indicateur.

Les résultats, basés sur 201 952 volontaires inclus entre 2012-2019, ont révélé quatre symptômes cruciaux connectés à la 'Dépression clinique' et aux 'Limitations', indépendamment de l'indicateur et de la position sociale. Les groupes défavorisés présentaient des réseaux plus denses, indiquant un risque accru d'avoir un réseau "actif". Certaines structures des réseaux variaient en fonction de la position sociale, suggérant des spécificités dans les mécanismes d'activation des symptômes. Les connexions entre chaque nœud externe et les symptômes 'Déprimé' et 'Manqué d'entrain' étaient non-invariantes dans les réseaux basés sur le niveau de diplôme et les difficultés financières.

Cette étude met en lumière quatre manifestations symptomatiques jouant un rôle clé dans l'expérience de la dépression, indépendamment de la position sociale. D'autres insights concernant des symptômes spécifiques pourraient être utilisés pour améliorer la prise en charge de la dépression, notamment des groupes défavorisés.

Perceptions et expériences des soins des femmes migrantes victimes de violences sexuelles.

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Introduction : La féminisation des migrations suscite de nouveaux enjeux liés au genre. En raison de leur histoire marquée par des violences sexuelles (VS), les femmes demandeuses d'asile (DA) se trouvent vulnérables dans leur nouvel environnement 4.8% ont subi un viol au cours des douze derniers mois de vie en France. L'accès aux soins primaires est donc crucial pour leur santé physique et mentale.

Méthode : Une étude est actuellement conduite en interrogeant des femmes (DA) ou déboutées de la demande d'asile (DDA), ayant subi des VS en France ou avant leur arrivée. Ces femmes sont prises en soins au sein d'une maison de santé participative à Marseille, grâce à un protocole de soins pluriprofessionnel. L'approche privilégiée pour cette analyse est une méthodologie phénoménologique interprétative, visant à explorer de manière approfondie les expériences subjectives liées à la prise en charge médicale.

Résultats : Les premiers résultats, basés sur l'analyse des huit premiers entretiens (environ 15 entretiens sont prévus d'ici mars 2024) mettent en lumière la maison de santé comme un environnement familier offrant une prise en charge pluriprofessionnelle. Le suivi régulier par le médecin généraliste établit une relation de confiance permettant l'émergence d'un espace de parole favorisant la verbalisation des VS et la prise en soin des syndromes post-traumatiques. En revanche, l'absence de suivi et de familiarité avec les spécialistes érige pour certaines femmes une barrière psychologique à l'accès aux soins gynécologiques et psychologiques et complexifie alors l'expression des violences vécues. L'accompagnement personnalisé se relève être un levier d'empowerment en matière de santé chez les femmes.

Discussion : Les entretiens préliminaires mettent en évidence l'importance d'un suivi continu en soins primaires, offrant une accessibilité aux femmes DA/DDA. Il est cependant nécessaire que les professionnels demeurent attentifs aux enjeux de précarité et aux conséquences psychosomatiques des VS liées à la migration.

Stratégies de recours aux soins des femmes demandeuses d'asile victimes de violences sexuelles

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Introduction

Les femmes demandeuses d'asile sont particulièrement exposées aux violences sexuelles (VS). L'étude française INCIDAVI a révélé une incidence de 26 % de violences sexuelles après l'arrivée dans le pays d'accueil parmi les femmes demandeuses d'asile. Selon cette étude, moins d'une victime sur dix a consulté un professionnel de la santé lorsqu'elle a subi des VS.

Objectif

Cette étude avait pour objectif d'explorer les stratégies de recherche de soins dans le pays d'accueil au sein de cette population.

Méthode

Cette phase qualitative de l'étude INCIDAVI a été basée sur une approche de théorie ancrée. Des entretiens semi-structurés ont été réalisés entre le 1er février 2022 et le 29 juillet 2022. Les entretiens ont permis d'explorer l'histoire des femmes en matière de VS, les conditions dans lesquelles les femmes parlent de VS et les conséquences perçues des soins. Nous avons réalisé une analyse inductive à l'aide du logiciel NVivo® 14.

Résultats

Vingt entretiens ont été réalisés (saturation des données au 18ème entretien). Les parcours de vie des demandeuses d'asile ont été traversés par le VS, ce qui influencait leur rapport aux soins et stratégies de mise en sécurité, et pouvait les réexposer au VS. Parler des VS était un choix rare et stratégique axé au départ sur la recherche de protection. Lorsque des soins appropriés étaient prodigués, ils étaient perçus comme bénéfiques et conduisaient à modifier les représentations des soins avec intégration d'une perspective de reconstruction.

Conclusion

Une attitude proactive de la part des soignants dans la détection des VS peut conduire à des expériences positives de soins, qui à leur tour influencent les perceptions initiales des femmes sur la VS, leur permettant d'envisager un rétablissement de leur santé.

Évaluation de l'impact d'un programme de soutien par les pairs pour la santé mentale des hommes.

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Introduction : Certaines sous-populations masculines sont à risque de problèmes de santé mentale, par exemple les pères d'âge moyen divorcés ou séparés, qui présentent des taux élevés de suicidalité et de toxicomanie. Ce risque a été attribué à plusieurs facteurs, notamment la séparation d'avec les enfants, une diminution du soutien social et un sentiment d'échec et de honte. Il existe un manque de services officiels pour les pères divorcés ou séparés au Québec. L'un des seuls services est un programme de soutien par les pairs : Pères Séparés (Montréal). Ce programme est officiellement accrédité par le ministère de la Santé du Québec pour fournir un soutien comprenant un coaching individuel et des groupes de soutien hebdomadaires aux pères divorcés ou séparés.

Méthodes : Afin de mieux comprendre l'expérience vécue des utilisateurs de ce programme, nous avons entrepris de mener un projet pilote en utilisant une méthode innovante connue sous le nom de vidéo participative. Il s'agissait de créer un groupe de travail composé d'utilisateurs qui ont d'abord été formés aux techniques de base de la vidéo. Les membres du groupe de travail se sont ensuite interrogés mutuellement sur leurs expériences devant la caméra, puis ont distillé ensemble les thèmes principaux de ces entretiens pour les inclure dans la vidéo.

Résultats : La vidéo qui en résulte contient trois thèmes (i) les luttes uniques des pères séparés ; (ii) l'importance du programme pour briser l'isolement ; et (iii) le rôle inestimable du soutien par les pairs dans le rétablissement. La vidéo a été montrée à des gestionnaires et à des cliniciens à des fins éducatives.

Discussion : Les résultats impliquent que de tels programmes de base sont bien placés pour aider les pères vulnérables dans leur rétablissement, pourtant des recherches quantitatives sont nécessaires pour évaluer formellement l'impact sur la santé mentale.

La mise en œuvre d'interventions axées sur le rétablissement: Une revue systématique d'études mixtes

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Contexte: Le rétablissement est un paradigme mondial dans la prestation de services de santé mentale. À ce jour, aucun examen connu des données probantes n'a été publié sur la façon dont le rétablissement a été mis en œuvre dans les services et sur les facteurs qui influencent la mise en œuvre de services axés sur le rétablissement. Pour combler cette lacune, nous avons procédé à une étude systématique.

Méthodes: Des bibliothécaires ont effectué des recherches dans sept bases de données. Toutes les études ont fait l'objet d'une sélection indépendante en deux étapes par deux auteurs de la revue à l'aide du logiciel Distiller SR. Nous avons utilisé le Consolidated Framework for Implementation Research pour l'extraction des données, Best-Fit Framework pour la synthèse, Mixed-Methods Appraisal Tool pour l'évaluation de la qualité des études.

Résultats: 70 études qualitatives, quantitatives et de méthodes mixtes ont été incluses. Les études ont été menées en Europe, en Amérique du Nord, en Asie et en Australie. Le rétablissement a été mis en œuvre par le biais des e-innovations, d'innovations axées sur la famille, du soutien par les pairs, de collèges de rétablissement, de la navigation des services et de la formation du personnel. Les problèmes communs de mise en œuvre comprennent: le degré de flexibilité de l'innovation; l'établissement de relations; l'inclusion de personnes ayant une expérience vécue; les défis posés par le modèle biomédical; l'engagement organisationnel en faveur de la transformation du rétablissement; la rotation du personnel; le manque de ressources pour soutenir les objectifs personnels de rétablissement; la variabilité des connaissances sur le rétablissement.

Conclusions: Cet examen des données probantes apporte une valeur ajoutée aux décideurs, aux organisations et aux praticiens qui prévoient de mettre en œuvre des interventions de rétablissement en santé mentale dans les services.

Variation des dépenses de santé mentale des jeunes adultes : le rôle de l'offre de soins locale

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Les problèmes de santé mentale et addictifs sont très prévalents chez les jeunes adultes (18-25 ans) par rapport à la population générale, ce qui induit des dépenses publiques et privées importantes. Cependant, la nature et l'accessibilité des dispositifs de soins pour les jeunes varient entre les départements français. Cette étude vise à analyser les liens entre les dépenses de santé mentale des jeunes adultes et la configuration de l'offre de soins au niveau local.

Nous avons créé une cohorte de 542477 jeunes qui ont consommé des soins psychiatriques pour la première fois en 2015 et sont suivis jusqu'en 2019 via le Système National des Données de Santé (SNDS).

Nous étudions conjointement leur dépense de santé mentale, leurs résultats de soins au niveau individuel puis l'organisation de l'offre de soins et médico-sociale dans le département où ils résident via un modèle multiniveau. Les dépenses étudiées regroupent les soins hospitaliers (séjours dans tout type d'établissement avec un diagnostic principal psychiatrique) et les soins de ville (médicaments psychotropes, consultations). Les résultats de soins sont estimés par des évènements indésirables (suicide ou tentatives, actes de désespoir, hospitalisations de longue durée, prescriptions inadéquates, polymédication, réhospitalisations …).

Afin d'identifier les déterminants des dépenses, nous récoltons des indicateurs d'offre de soins médicaux et médico-sociaux en contrôlant de paramètres comme les besoins de soin et la défavorisation sociale.

La dépense annuelle moyenne de santé mentale par jeune est de 277 euros. Elle varie entre 100 euros dans le territoire de Belfort à 10 000 euros dans le Loiret. Notre typologie de l'offre montre également une variation territoriale importante dans l'organisation des soins de santé mentale. Par exemple, les départements du Sud ont plus de psychiatres que les autres départements.

La modélisation multiniveau permettra d'établir des territoires ayant une organisation des soins plus performante toutes choses égales par ailleurs.

Thursday 4 July

Agency- in- practice: Young people peer-led evaluation

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Introduction

Agency is the capacity of an individual to act independently and make their own choices. The Agency project explored how young people feel helped or harmed by mental healthcare interactions. To do this the project team collaborated with young people, their families, clinicians and academics across philosophy, ethics, psychology and neuroscience to investigate agency, identity and justice in youth mental health. This collaborative team analysed verbal and non-verbal communication in mental healthcare encounters involving young people to examine how young people's sense of agency is encouraged or hindered in these encounters. Agency-in-Practice is a follow up study which will develop a new methodology for involving young people as co-analysts of mental health encounters.

Method

A young people peer research evaluation explored what worked well in the first Agency project interviewing eight stakeholders (young people, academics, clinicians). There were three young people peer researchers working in the study who led the work from design, through to data collection, analysis and write up. The qualitative materials, including the information sheets, consent form and interview guide developed by the young people's peer research team in partnership wit the young people's advisory group.

Framework analysis was used to explore in interview data. Key stages the young people peer researchers took to do this were: data familiarisation, framework identification, indexing, charting and summarising and Mapping plus interpretation.

Results and discussion

We will share the key themes, including key roles that facilitated youth involvement in the Agency project, what went well for each stakeholder (young people, academic team members) and areas that were identified for improvement. We will reflect on how to encourage best practice youth involvement more generally in mental health services research and the benefits for individuals involved including skill-building and direct advocacy supporting local service improvements.

Involving youth mental health experiences in big data research: the impact of Covid-19 on UK youth

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Introduction

Covid-19 impacted young people's mental health across the globe in new ways through school closures within lockdowns measures, and the surfacing of known stressors such as health anxiety, financial uncertainty in households, and domestic violence. The full extent of the impact will not be known for some time, but using routinely collected data to map the use of mental health diagnoses and treatment is important for long term planning. We joined a study (called CHOOSE) examining the impact of Covid-19 by exploring data on youth mental health diagnosis, prescriptions and referrals from the Clinical Practice Research Datalink (CPRD) led by researchers at Universities of Manchester, Keele and Exeter.

Method

Youth involvement in this study was led by the McPin Foundation. A youth advisory group was formed with 8 members. A parent/carer advisory group was also formed with 5 members. These groups met 6 times over the project with ad hoc work and written tasks in between meetings. The group provided a voice of lived experience throughout the project. The youth advisory board advised on the synthesis of research findings, dissemination and put forward key recommendations to clinicians and other health social care services. The CHOOSE study was picked up by the UK media and featured on the radio and in newspapers providing an impact case study to dissect.

Results and discussion

In this presentation we will explore first hand lived experiences of working as a youth advisor on CHOOSE. We will reflect upon the role as described in adverts and in practice, skills used in the role, support and training required and opportunities for further development. We will also focus on the synthesis process in an epidemiology study and the role of youth voice in 'big data' studies and dissemination including recommendations for other studies

Involving youth lived experience of self-harm:testing a new intervention in UK emergency departments

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When adolescents present to emergency departments with self-harm, it's a critical opportunity to intervene to provide meaningful support. Young people presenting to emergency departments in crisis face many difficulties, such as stigma, feeling unheard or "tick boxed" and being sent away with general advice and untailored support. We joined the Supporting Adolescents with Self-Harm (SASH) study, trialling a new intervention specifically designed for young people seeking support for self-harm/suicidality from emergency departments. The intervention involves a combination of a Therapeutic Assessment, safety plan and solution-focused follow up care, placing the young persons voice at the centre. The project is led by researchers at City, University of London and Queen Mary, University of London.

Method

Youth involvement in this study is being led by the McPin Foundation. A youth advisory group was formed with 8 young people (aged 16-26), all with lived experience of self-harm/suicidality. The advisory group meet 4 times a year. The group are the voice of lived experience for the project and have had crucial input throughout, such as training medical practitioners, trialling the measures, informing recruitment, and feeding back on the structure of the care that young people in crisis receive. Their involvement has and continues to shape the project ensuring that the SASH intervention best supports adolescents who present to emergency departments with self-harm/suicidality.

Results and discussion

We will explore first hand lived experiences of working as a youth advisor on SASH. We will reflect upon the advisory role as described in adverts and in practice, skills used in the role, support required and opportunities for training and development. We will also focus on the support and adjustments needed for working with young people when having discussions about self-harm/suicide and how best to ensure young people feel safe without inhibiting these important conversations.

The Blueprint Project - The Co-Researcher Role

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Introduction

The Blueprint study aimed to develop a model of high-quality service design for children and young people experiencing common mental health problems. The study consisted of three stages: evidence synthesis phase, primary research phase & model building phase. Six co-researchers were recruited to work on the primary research phase alongside the research team. The co-researchers employed were young people with lived experience of mental health issues. They received bespoke training at the start of their role which covered research ethics, interview skills and qualitative research methods.

Method

The co-researchers co-interviewed children and young people service users, parents and carers and service providers from nine mental health services across England and Wales alongside the lead researcher. They were able to ask as little or as many questions as they liked, generally building this up over time to help train them to feel competent and confident interviewers. The co-researchers assisted the research team in the framework analysis of the interviews. The study papers were reviewed and co-authored by the co-researchers. For the co-researcher reflection paper, each of the co-researchers wrote their own reflective piece of their co-researcher journey. One co-researcher worked with the lead researcher using thematic analysis to analyse all the reflective pieces. The emerging themes where then discussed and agreed on amongst the team, before co-written up into the paper.

Results & Discussion

In this presentation we will explore first hand lived experiences of involving young people as co-researchers in the Blueprint project and what resources are needed to do this successfully. We will share the co-researcher reflections, which include what made the co-researcher journey successful on the Blueprint project, as well as some challenges that were also faced.

Hospitalisations for self-harm between 2012-2022 in the French health system: alert on young women

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Two recent publications point to an increase in somatic hospitalisations with self-inflicted injuries among adolescents and young women from the end of 2020 compared with 2019, an important indicator that includes suicide attempts. This study presents and discusses trends in patients admitted to hospital with a diagnosis of self-harm, by age and sex.

Using national health databases from 2012 to 2022, time series of unique patients with a diagnosis code of self-inflicted injury (ICD-10 code: X60-X84) were collected and presented by sex and age group. Changes in the characteristics were studied in young women and adolescent girls on the basis of available information.

Two-thirds of patients hospitalised for self-inflicted injuries are women. The number of annual patients fell by 10% between 2012 and 2022 (-8% for men,-15% for women). Over the same period, they increased by 47% in psychiatry (+24% in men and +62% in women). These average trends differ according toage group and gender: increases in the number of female patients aged between 10 and 24 have been observed since 2015, with an acceleration in 2022 (+40% in somatic care and +107% in psychiatry compared with the 2012-2019 average). Conversely, the number of patients aged between 35 and 55 will fall sharply over the period. Between 2012 and 2021, suicide rates have been stable among men of age groups comprised between 0 and 74 years old between and decreasing among older men. Concerning women, these rates have been slightly increasing amon less than 25 years old age group and stable or decreasing among older.

Complementary analyses for patients aged between 10 and 24 show a peak in frequency centred on 15 years. The increase in their hospital admissions concerned the two main diagnostic codes: intoxication and use of a sharp object, excluding the possibility it is only related to scarification. All regions are concerned, with no significant variation in intensive care visits (10% of hospital admissions).

The time series of hospital admissions for self-harm injuries reveals contrasting and lasting trends by age group, which need to be monitored and investigated further.

A stakeholder study of Comprehensive School-Based Dialectical Behaviour Therapy for self-harm

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Introduction

Self-harm is a growing concern among children and young people, and schools play an important role in supporting children and young people who engage in this behaviour. However, currently there is no established evidence-base of targeted approaches for adolescent self-harm that can be implemented in schools. Dialectical Behaviour Therapy for Adolescents (DBT-A) is an evidence-based treatment approach that has been shown to be effective in reducing adolescent self-harm in clinical settings. DBT-A has since been adapted for use in schools for ages 11+. This study reports on a pilot that used the adapted comprehensive school-based DBT (CSB-DBT) intervention with self-harming secondary age students (ages 11-16). The aim of this study was to explore the initial views of stakeholders on potential feasibility and acceptability.

Methods

Semi-structured interviews were carried out with students, school staff and CSB-DBT therapists at one school in the South of England. Interviews took place in person at the school. Analysis was conducted using an adapted form of thematic analysis.

Results

7 students, 14 school staff and 3 CSB-DBT therapists participated in interviews. We found that providing CSB-DBT in a secondary school setting is feasible and acceptable. Students found the structured and group-based aspect of the therapy useful and reported using the skills taught in CSB-DBT to manage emotionally charged situations. Having therapists readily available on the school campus helped students embed the skills they were learning in their lives and provided reassurance to staff that students were receiving the support they needed.

Discussion

These findings suggest that school based CSB-DBT may be a promising approach for supporting young people who engage in self-harm. However, before the efficacy of CSB-DBT can be established, further research is needed that robustly compares outcomes before and after treatment in students that have been randomly allocated to treatment or no treatment.

Feasibility of ecological momentary assessment to assess suicidality among inpatient adolescents

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Introduction. Ecological momentary assessment (EMA) is a new method of data collection that allows frequent assessments of suicide ideation in participants' everyday life through smartphones. Few recent US studies suggest that EMA designs are feasible and acceptable among high-risk suicidal adolescents following acute psychiatric care. However, conducting EMA surveys during inpatient psychiatric care may pose different challenges for researchers. To date, little is known about the feasibility of EMA studies to assess suicide ideation among adolescents in inpatient psychiatric care.

Methods. Adolescents (12-21 years old) were recruited during inpatient psychiatric care in Germany. After a baseline assessment, adolescents participated in 7 days of EMA surveys (7 x per day at randomized times between 7:00 am and 09:00 pm), administered via a smartphone application. The EMA survey contained 16 questions about momentary suicide ideation and potential psychological correlates (i.e. perceived burdensomeness, thwarted belongingness, feelings of defeat and entrapment). Following the 7 days of EMA surveys, we asked participants about their overall experience of participation with standardized items and by conducting a brief qualitative interview.

Results. Preliminary results suggest a high compliance (i.e. percentage of answered surveys above 70%) among participating adolescents. Participants generally reported a high satisfaction with their study participation and indicated that they would participate in a similar study again. If adolescents reported any burdens, they mainly referred to technical problems of the smartphone.

Discussion. The results of this study suggest that EMA studies to assess suicide ideation among adolescents in inpatient psychiatric care are feasible and accepted by participants. Compared to studies with adolescents after discharge from psychiatric care, study designs may be adjusted to consider the different context of data collection and the demands of the clinical team.

Development of a safety planning smartphone app to reduce suicide risk among adolescents (EMIRA)

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Introduction. Suicide is among the leading causes of death among adolescents. Interventions to reduce suicidal thoughts and behaviours (STBs) are integral for successful suicide prevention among adolescents. However, such interventions are scarce. EMIRA aims to close this important gap by developing a personalized crisis support smartphone app to reduce STBs among adolescents (aged 12-21 years) at risk for suicide.

Methods. EMIRA consists of four sub-projects. 1) We conducted qualitative interviews with adolescents who previously experienced STBs and health care providers to identify intervention needs. 2) We currently investigate the short-term variability of STBs and their cognitive correlates among adolescents using Ecological Momentary Assessment (app-based self-report). Drawing on the results from the first two sub-projects, we will develop a personalized crisis support smartphone app (mobile safety planning). 3 + 4) We will conduct two consecutive studies to test the feasibility and efficacy of the smartphone app in reducing STBs among adolescents at risk for suicide. We follow the ideas of community-based participatory research (CBPR) and include a CBPR-panel in the research process (i.e. stakeholders, such as young adults who previously experienced STBs and health care providers, contribute to the development and refinement of study designs).

Results. Adolescents and health care providers (sub-project 1) suggested that the crisis support smartphone app should provide a digital safety plan and offer opportunities for distraction. As adolescents and health care providers suggested various and partly contrasting features, it became evident that options need to be customizable so the content can be adjusted to individual needs. App development and data collection in sub-project 2 are currently underway and results will be summarized as part of the suggested presentation.

Discussion. EMIRA may have great potential to close a crucial gap in adolescent mental health services and significantly improve suicide prevention among this group.

Antipsychotic discontinuation discussed through the lens of epistemic injustice

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Introduction: After decades of research to improve adherence to antipsychotic treatment for people with schizophrenia, papers and debates questioning the risk benefit ratio are now emerging. This debate remains inherently complex and emotionally charged. While all stakeholders acknowledge that there are well documented risks and benefits, these are valued differently. Challenging the legitimacy of antipsychotic long-term treatment is not only an academic issue, but a real-life dilemma of health care professionals working with people with psychosis, making ethical thinking about these issues a necessity. Methods: In this conceptual article we suggest that the term epistemic injustice can add useful perspectives to the academic debate as well as the ethical considerations in the clinical encounter. Epistemic injustice, a term coined by the feminist philosopher Fricker, refers to a wrong done to someone as a knower or transmitter of knowledge. Epistemic means relating to knowledge. Injustice occurs when someone is unfairly judged to represent uncredible knowledge, due to unjustified prejudices. Results: Epistemic injustice can be useful term to understand why user voices are ignored, resulting in 1) the lack research on why and how people stop antipsychotic medication, resulting in absence of clinical guidelines at an organizational level, and 2) the skewed power in clinical encounters with professional “knowing what is best”. The injustice condition is met as there is a biased priority of research supporting adherence and medication maintenance, ignoring that most people will have at least one attempt to discontinue, and therefore need to know how this can be done as safe as possible. Discussion: We argue that both epistemic humility is necessary and listening to voices with lived experience may be valuable to improve the understanding of the field.

Use and Discontinuation of Antipsychotic Medication Results from the OPUS Trial 20 years follow-up

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Background and hypothesis: Exposure to antipsychotics has proven to be beneficial on the short-term. However, studies are lacking regarding the effectiveness of long-term use. The aim of this study was to investigate changes in use of antipsychotics through a period of 20-years after a first-episode schizophrenia.

Study design: This study is part of the Danish OPUS trial (1998-2000), including 496 participants with first-episode schizophrenia and followed through interviews over 20-years. Main outcomes were number of medicated days, redeemed prescriptions of clozapine, psychiatric hospitalizations, and employments.

Study results: At the 20-year follow-up 143 participated with 36% (n=51) in remission-of-psychotic-symptoms-off-medication. Also, the lowest number of medicated days (mean (SD), 339 (538) days) with 5% of observed days spent in treatment with antipsychotics was found in this group. Using the Danish registers with data on redeemed antipsychotics on all trial participants (n=416), those in treatment with antipsychotics (n=120) at the 20-year follow-up had spent significantly more days in treatment (5405 (1857) vs. 1434 (1819) mean days, P=.00) and more had ever redeemed a prescription of clozapine (25% vs. 7.8%, P=.00) than those who had discontinued antipsychotics (n=296). Further, the discontinue group had significantly higher employment the past year prior to the 20-year follow-up (28.4% vs. 12.5%, P=.00).

Conclusions: A substantial part were in remission-of-psychotic-symptoms-off-medication with high persistence over 20 years. Further, those in treatment with antipsychotics differed significantly with more days spent in treatment, higher ever redeemed prescriptions of clozapine and fewer in employment than those who had discontinued antipsychotics at year 20.

Perceptions of Antipsychotic Treatment Encounters among Individuals Affected by Schizophrenia

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Introduction: Managing schizophrenia spectrum disorders often entails a lifelong commitment to antipsychotic medication. However, the prevalence of treatment-related side effects poses a significant threat to the physical well-being and functionality of users, leading to hesitancy in initiating antipsychotic treatment or a desire to taper or discontinue the medication. Despite this, mental health professionals frequently perceive individuals with mental illness as incapable of making rational decisions regarding their medical treatment.

Methods: the study aims to explore instances of epistemic injustice within these encounters. Semi-structured interviews were conducted with 11 individuals affected by schizophrenia spectrum disorders. The data will be analyzed using abductive analysis, and the results will be interpreted in the context of epistemic injustice within mental healthcare treatment.

Results: The presentation will showcase the study's findings and encourage a discussion on these results in relation to shared decision-making.

Discussion: This presentation discusses an ongoing study that seeks to investigate the experiences of encounters related to antipsychotic treatment in mental health care, as perceived by individuals affected by schizophrenia.

Creating Neighbourhood teams to integrate and improve community mental health services

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Introduction: Often primary and specialist care providers work disjointedly, providing sub-optimal support to people with mental health difficulties. In England, these people often fall through gaps in care. England`s Community Mental Health Framework (CMHF) policy (2019) creates an impetus to address these challenges by integrating systems including primary and specialist care alongside voluntary/community providers.

Method: Researchers in residence were embedded in four care systems, interviewing NHS and Voluntary sector staff, observing meetings and reviewing case notes to create and test realist programme theories of change. Also, we hosted national and regional knowledge exchange networks to learn more about implementation. We used the analyses to develop a set of theories about how to effectively integrate services locally for people with mental health difficulties.

Results: Organisations worked together to create neighbourhood teams that included primary care, specialist services and the voluntary sector. The sizes of these teams and the populations covered varied by location (30,000-150,000). People with mental health difficulties asking for help in these systems were generally offered something but how decisions were made and the interventions available varied (most but not all included social and psychological support, a few included medication advice). Few teams actively approached people with the most severe problems. Barriers to good integration included power imbalances between organisations, different approaches to flexible delivery, inadequate supervision and differences in working practices/cultures. Agreeing flexible arrangements for joint working, relationship building amongst practitioners and liaison roles in primary care were important enablers for change.

Conclusion: Integrating across and within primary care, specialist care and the voluntary sector is possible in neighbourhood teams. Addressing the different approaches and cultures between organisations is essential to create efficient team working. Further reserach is needed to understand how service users experience these changes

Clinical Dilemmas in whole system community mental health change: Risk and Diagnosis

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Introduction: The Community Mental Health Framework in England (NHSE) promotes both needs led and person centred mental health care across large communities which encourages different organisations to work together as a whole system. Whilst this approach is welcomed by many, it has reignited some old clinical dilemmas .

Our aim was to understand the nature and impact of different approaches to assessment, risk management, and diagnosis as a means of understanding mental health and illness.

Methods: ?Realist informed evaluations were conducted across four integrated care systems in England. Researchers-in-Residence, observed real time delivery of care in community mental health services with multiple new teams and interviewed practitioners and managers (n=60+).

Results: We found that the changing and varied cultures of decision making around risk and diagnosis had a considerable impact upon the delivery of community mental health services. Some teams were comfortable creating a shared understanding with minimal attention on risk or diagnosis, doing brief work focussed on the concerns of individuals and supporting engagement with social support. Others required fuller clinician led assessments with diagnosis and would reject referrals due to concerns about 'holding risk'. This could lead to delays and disappointment for service users, conflict across teams, and inefficiencies in the system. Facilitating change designed to challenge existing cultural beliefs about clinical care appeared to require strong, consistent collaborative leadership across the integrated system of primary care voluntary sector and mental health teams. Examples of how this was done included promotion of ideals by changing language and modelling different approaches to risk.

Conclusion: How risk and understanding of mental illness operate within and across teams can have wide ranging impacts. The presence of effective collaborative leadership is crucial to promote robust cultural change in mental health service delivery across all levels of a system of delivery.

How do we achieve a `balanced system`in community mental health services? A realist evaluation

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Introduction: For years people have been rejected from mental health services as not ill enough for specialist services or too risky, complex for psychological services. The Community Mental Health Framework(CMHF) in England aims to fill this `gap` in services. Our evaluation of CMHF services witnessed teams being overwhelmed by demand therefore we started to ask `what would make a balanced system and how could this be achieved`?

Method: Realist informed evaluations were conducted across 4 integrated care systems in England. Researchers in residence observed real time delivery in community mental health services across multiple teams interviewing practitioners and managers (n=60+). Analysis, interpretation and dialogue with services and wider stakeholders generated a whole system model including indicators of system balance and imbalance.

Results:Analysis across 4 systems indicate problems with over complex pathways, fear of holding risk and uncertainty of how to support those with less severe problems to self care. We found examples of flexible, efficient processes alongside engagement with social/community assets. Our whole system model includes a set of causal links which need to be understood by system leaders to make decisions. We propose placing the service user journey or support at the centre whilst considering the impact of system change on staff to be essential. These can be aggregated to a set of measurable outcomes including whether those most in need are seen; waiting times and flow data; staff wellbeing and retention.

Conclusion: A systems approach to community mental health service delivery where community assets sit alongside traditional interventions, are important for generating positive outcomes and addressing inequalities. New measures of system functioning are needed alongside data on experience to support decision makers.

The mental health (MH) dashboard: A tool for improving the EU countries' capacity to analyse MH data

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INTRODUCTION. Given the need of sound monitoring and evaluation programs for mental healthcare (MHC), appropriate data collection and use of indicators are essential to measure and improve quality of MHC. Thus, we aimed to design and implement a dashboard for MH indicators for a standardized monitoring and evaluation of MHC pathways provided by the health services (HS) of JA ImpleMENTAL countries.

METHODS. A detailed survey was sent to JA countries to understand the availability of health electronic records in various national Mental Health Information Systems (MHIS). Parallelly, research in literature for MH indicators was made. A list of MH indicators was proposed.

RESULTS. 13 European countries have answered to MHIS-Questionnaire (MHIS-Q), giving an overview on MHIS (information flows, coding systems, type of interventions, etc). Collection on electronic records of MH data is highly fragmented.

A list of MH indicators was set up and discussed in a consensus workshop (June 2023). Answers to MHIS-Q were used to understand how data available in countries' MHIS fit proposed indicators. A minimum set of MH indicators monitoring care delivery (prevalence/incidence, MH service availability) and evaluating MHC quality (Accessibility, Appropriateness, Continuity, Mortality) was agreed.

For a standardized data collection, a manual for building indicators (defining indicators, their calculation, between-countries-harmonization, variables list, processing details) was developed; data extraction assisted. The research platform for MH indicators (based on R open-sourced code) is in testing phase and being implemented (first demo available). By June 2024, final version of dashboard will be installed. Stratification of MH indicators by mental disorders, age, sex, education, will be implemented.

CONCLUSIONS. This dashboard, using as input the common minimum database, guarantees a standardized and automatized calculation of MH indicators in JA countries, following shared and rigorous rules for data collection and processing. A platform providing timely, relevant, comparable MH data.

Lessons learned from an internal evaluation of pilot implementation on community-based mental health

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Introduction. Community-based mental health care (CBMHC) is associated with continuity of care, greater users' satisfaction, increased adherence, better protection of human rights, and prevention of stigma. To facilitate the adoption of CBMHC across Europe, the EU-funded Joint Action (JA) ImpleMENTAL (2021-2024) supports 11 participating countries in transforming their mental health (MH) care systems through pilot implementation of selected elements of the Belgian model of MH services reform.

Methods. To draw lessons from the pilot implementation process, the pilot actions are submitted to an internal evaluation. A questionnaire has been developed for the countries, which is complemented by individual interviews and focus group discussions to investigate in more detail specific topics raised in the questionnaire. The analysis focuses on learnings from the implementation, specifically in regard to user participation, intersectoral collaboration for network building, and interconnections of the MH system as a whole. It also addresses the usefulness of the approach and tools applied for planning and conducting the pilots.

Results. The analysis of the (preliminary) results shows barriers and facilitators for the implementation of CBMHC in Europe and provides insights into the question of whether the approach and tools used have been perceived as helpful for the implementation process. Depending on their systems and context, the implementing countries face different challenges and need to find adequate solutions. Even though the countries differ in their initial set-up of MH services, some common barriers and facilitators can be identified.

Conclusion/Discussion. The investigation enables us to draw conclusions on the short-term achievements of the pilots and experiences of the implementation approach that will feed into further discussion and follow-up activities related to the sustainability of the pilots. This includes their potential upscaling and further recommendations for the transferability of the activities.

Mental health systems in Europe: an analysis from the JA ImpleMENTAL SANA and Country Profile data

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Introduction. The adoption of community-based mental health care was endorsed by the EU as a key component to improve quality of care. However, to what extent the move away from an institutional model is progressing in the European countries remains unclear.

Methods. The EU-funded Joint Action (JA) ImpleMENTAL (2021-2024) supports participating countries in transforming their mental health care systems through implementation of selected elements of best practices consistent with the mental health services reform. Within this project, a Situation Analysis and Needs Assessment (SANA) has been conducted for the 14 countries to fine-tune preliminary considerations for pilot implementations. The SANA was conducted in two parts, the first one analysing the situation at national level and making gaps in mental health community care visible on a country level, the second one targeting the level of the pilot implementations. The SANA questionnaire was based on questions from the WHO MH Atlas 2020 questionnaire, complemented by general population indicators from Eurostat, IHME, and EHIS, and original questions to which the countries answered using national databases or expert interviews. The questionnaire contained closed and open questions and the opportunity to provide comments on each of the closed questions.

Results. The collected data give an overview of the main features of the mental health system, available services and community-based care in the respective countries and pilot areas. The main results of the SANA were compiled into country-specific profiles followed by a SWOT analysis of strengths, weaknesses, opportunities and threats by each country.

Conclusion. The results highlight that the transition towards community-based mental health care is progressing at an uneven pace, showing commonalities and differences across the countries and presenting data gaps that should be appealed to in the future. The need for a joint effort in data collection and quality improvement will also be addressed.

Evaluating the Joint Action ImpleMENTAL pilot implementation using the Theory of Change framework

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Introduction: Mental health problems represent significant public health challenges. In response, one of the two best practices selected to be piloted for implementation in the current EU Joint Action (JA ImpleMENTAL) on mental health (2021-2024) is the Mental Health Reform in Belgium (BMHR). Out of 14 participating Member States (MS), 11 are pilot-implementing aspects of the BMHR. The pilots require an evaluation framework that is beneficial in telling the story of pilot implementation, despite contextual differences across MS, and can set the scene for upscaling after the Joint Action. Therefore, the Theory of Change (ToC) methodology was chosen. This presentation will focus on the application of this approach to evaluation across MS. Method: Individual country-level ToC models have been developed in co-creation with the implementers from each of the 11 MS, via several workshops. Clusters were developed to categorise different elements of the best practices (e.g., “Building, maintaining and sustaining inter-sectoral collaboration/network”). Currently, a logic framework, containing indicators that aim to evaluate pilot implementation, is being co-created with MS and subsequently used for data collection. Results: Using the ToC as an evaluation framework was new to the majority of MS, but its usability was evaluated positively (4,27/5). During the presentation, cluster selection and preliminary findings from reported output realisation will be presented, together with identified limitations of the evaluation approach. Discussion: Ultimately, the ToC framework will act as a tool for implementers to measure their pilot implementation and relay results to decision-makers. The model can determine where adjustments to implementation strategies, or outputs need to be made to better achieve outcomes and (eventually) the desired impact on a regional/country level. This unique opportunity to synthesise and compare ToC models across many countries is useful for both policy and for directing future health services research.

Knowledge complementarity in Recovery College: a qualitative study in Québec and Lombardy

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Introduction

The English Recovery College model has spread widely in recent years (Perkins et al., 2017; Hayes et al., 2023). The distinctive feature of the RC model is its emphasis on the complementarity of experiential, clinical and theoretical knowledge. Within each of training courses, the various types of knowledge are embodied by trainers and learners with diverse profiles (people living with mental illness, family members, practitioners, healthcare professionals, managers, citizens). Training of trainers has a crucial role in fostering the knowledge complementarity by modeling roles and co-production approach of trainers. A recent qualitative study in Québec points that continuous training and tools are required to effectively support knowledge complementary work. The purpose of the present study is to explore issues and challenges faced by trainers, by comparing the experiences of two Recovery Colleges, one in the Canadian province of Québec, and one in the Italian city of Brescia, in the Lombardy region.

Methods

Two focus groups were conducted, one in Québec and one in Brescia. Participants were recruited among different Recovery college stakeholders (i.e. trainers, supervisors, learners, etc.). Focus groups' transcripts were analyzed using thematic analysis.

Results

The results of the Québec qualitative pilot study identify «normal» areas of tension in knowledge complementary work. The results confirm the importance of training trainers jointly, regardless of their previous background, and equipping them to constantly fulfill their role as facilitators of integrated knowledge. It is expected that the results point to the identification of common issues and strategies to support trainers' work even more effectively.

Discussion

Training of trainers is a crucial process to ensure complementarity of knowledge, which is a core element of the Recovery College model. This process involves challenges that must be addressed and managed using specific tools that promote collaboration and reflective practice.

SP-13 | How to combine experiential, clinical, and theoretical knowledge? Benefits, challenges and tools - Anick SAUVAGEAU, Université du Québec à Trois-Rivières / CRIUSMM

Working with knowledge complementarity: support and self-reflection tools for competency development

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Introduction: The importance of experiential knowledge in the delivery of mental health services is well established. The complementarity of knowledge (experiential, clinical and theoretical) brings an important richness to mental health intervention, whether through the involvement of patient-partners, peer-helpers, peer-resource trainers, and so on (Repper et al., 2013; Shalaby et al., 2020). However, the consideration of experiential knowledge on the same level as clinical and theoretical knowledge challenges the predominant professional culture in healthcare. The aim of this presentation is to outline the components of a training program designed to support the competency development of trainers working in knowledge complementarity.

Method: The components of the Health and Recovery Learning Center's train-the-trainer program (Recovery College model, Perkins et al., 2017) and the self-reflection tools developed is described, highlighting the values and principles that defined them. The challenges encountered (between discomforts and tensions) in knowledge complementarity work is addressed and considered beyond the Recovery College context.

Results: The train-the-trainer program and the development of tools are based on five domains of competency: (1)knowing oneself and mobilizing one's knowledge, (2)communicating and listening, (3)working together, complementing, and adapting, (4)facilitating in a diversity of learners, (5)mobilizing integrated knowledge and supporting change. Here are the training themes that enable reflective practice in knowledge complementarity work: (reflecting on) my posture in a context of co-learning and personal self-determination; possible tensions in knowledge complementarity work; the judicious and balanced use of experiential knowledge, clinical knowledge, and theoretical knowledge; the importance of plurality of expertise; values and issues related to equality and power sharing.

Conclusion: The knowledge complementarity work requires ongoing support focused on reflective practice and competency development. To achieve this culture transformation, we need practical tools based on self-reflection. The tools developed can serve as models for other contexts.

SP-13 | How to combine experiential, clinical, and theoretical knowledge? Benefits, challenges and tools - Anick SAUVAGEAU, Université du Québec à Trois-Rivières / CRIUSMM

The co-production process of a Recovery College course in knowledge diversity: collective benefits!

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Introduction: The knowledge complementarity work (experiential, clinical and theoretical) is a key ingredient of the Recovery College (RC) model (Repper and Perkins, 2017). In a Quebec RC, a team of trainers, accompanied by a resource person, co-produced a training course on eating attitudes and behaviors. With a committee of experts in knowledge complementarity, the team put in place an innovative process of co-production and co-validation. The aim of this presentation is to illustrate the co-production and co-validation process established specifically for this training course, as well as the benefits gained.

Methods: The teams of trainers deployed a two-stage process: co-production and co-validation. 1) Co-production stage: A collaborative work process, alternating between periods of collective work (trainers and resource person) and periods of independent work (trainers only), enabled the course to be co-produced. 2) Co-validation stage: To ensure validation of the course, a committee of experts in knowledge complementarity (including the training team) met for three periods of collective work. Various work-sharing, power-sharing, speaking-up, work preparation and structuring practices were implemented to bring out the full potential of all knowledge.

Results: Trainers report that they have learned and feel that co-production and co-validation process supports their recovery journey. They felt recognized and validated in their expertise. Members of the expert committee report having learned from each other. While some people were unsure of their individual contribution, the sharing of experiential knowledge gave them a sense of collective contribution.

Conclusion: Knowledge complementarity is an important element of co-production and co-partnership practices for the development of healthcare initiatives (Boivin et al., 2022; Loignon et al., 2022). This co-production and co-validation process deployed in RC maximizes the contribution of all those involved, regardless of their expertise, and ensures the integration of knowledge. These processes can be useful in other contexts than RC.

Lived experience dilemmas and challenges

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Introduction: Recovery seems to have become a bandwagon that almost everyone in the mental health field wants to jump on. However, those who ride in the wagon seem to rarely examine it for building defects that may threaten its integrity and eventually its future. Methods: In this proposed talk we challenge the current inclusion of lived experience and suggest that a paradoxical paternalism lies in the lack of critical appraisal of lived experience. This is important, because paternalism is a way to keep the power on the professional hands and continue the suppression of user voices. Results: We suggest therefore, that to achieve true power equality, we need to develop abilities to discuss all types of perspectives critically and respectfully, while paying attention to the sensitive situation of sharing personal experiences. Discussion: We will discuss challenges related to dilemmas about what meets the criteria of lived experience, its use and misuse and disclosure.

The LEARN project: Lived Experience And Research iN mental health

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Introduction: Lived Experience (LE) led research is the most extended form of participatory research. However, LE researchers remain uncommon, and their role is often undefined and insecure.

The overall aim of this project is to develop a standardized set of methods for LE research on how to apply lived experiences throughout the research process, and guidelines to ensure a safe, inclusive, and flexible work environment.

Methods: The project originates from the Danish research program Recovery & Inclusion at Copenhagen Research Centre for Mental Health (CORE), which has employed LE researchers since 2015. The project methods encompass a scoping review on methods for involving LE researchers, interviews with stakeholders (including LE researchers, colleagues, and leaders) to investigate experiences with including LE researchers in a research team, and finally, the production of a logic model of change mechanisms and effects.

Results: The project will result in several products: (1) A general job description for LE researchers, (2) A standardized set of methods for LE researchers, (3) Guidelines for research leaders, with recommendations on how to create a safe and inclusive work environment, (4) Guidelines for LE researchers with recommendations on how to navigate in the role, and (5) A logic model.

Discussion: The products will be a significant contribution to the literature and practice of LE researchers. It will create less uncertainty about their role, strengthen their professional competences, and increase the quality of mental health research. The provision of guidelines will prompt commitment and adjustments from leaders in working practices into more inclusive and flexible practices.

Future research includes a feasibility study of the methods and guidelines. The products have the potential to be implemented throughout CORE and in other research institutions. By contributing with new and essential knowledge, the project will contribute to a viable and thriving LE workforce.

How lived experience shifted my epistemic perspective as a psychiatrist

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Introduction: Throughout my training in psychiatry, I underwent a profound shift in my scientific perspective, transitioning from a constrained, biomedical framework to a more expansive and pluralistic approach that acknowledges the diverse legitimate ways of comprehending and addressing mental suffering.

Methods: Drawing from my personal experiences, I encountered various methodologies for conceptualizing mental health issues, spanning from humanistic frameworks to diagnostic approaches and medication. Notably, I found the latter to be less beneficial. Working within a medical environment that espoused a narrow understanding instigated a sense of cognitive dissonance, leading to a scientific crisis in my own professional development. Driven by this dissonance, I immersed myself in the realm of the philosophy of psychiatry.

Results: Philosophical assumptions form the bedrock of any scientific discipline, constituting the agreed-upon "rules" within the scientific community. These assumptions encompass beliefs about the nature of the world (ontology), our capacity to understand it (epistemology), and the proper practice of science (norms). The pivotal moment for me was not merely uncovering these assumptions but recognizing that other scientific fields had opted for alternative assumptions, thus fostering diverse approaches to conceptualizing mental health and distress.

Discussion: The prevailing dominance of the medical model in mental health traces back to a narrow-minded education ingrained in the training of medical doctors. I suggest that alternative models of mental health are equally valid and warrant inclusion in a pluralistic mental health system. Embracing a pluralistic approach, characterized by epistemic humility among healthcare professionals, may better serve the process of recovery. This approach nurtures individuals' journeys to find meaning in their personal experiences and construct narratives that empower and heal.

From service user to peer researcher: challenges of managing disclosure in scientific paradigms

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Introduction

Within the emerging discipline of lived experience research there are some culture clashes and epistemological variations. Working from a lived experience perspective in mental health services research can place a person at the heart of debates and tensions within science. This can be exhilarating and energising but it can also feel isolating and fuel a sense of imposter syndrome. In this presentation we explore the role of disclosure in mental health research drawing upon experiences from 10 years of lived experience in research practice.

Method

A case study will be presented from the PARTNERS2 study – based upon the work of a research team consisting of research assistants and service user researchers. We documented our disclosure decisions in the recruitment process for a randomised controlled trial (RCT) to highlight the varied and different ways individual team members potentially distorted the set processes for RCTs in science by personalising approaches and engaging potential participants in conversations woven with disclosure. PARTNERS2 was a study recruiting people with a diagnosis of schizophrenia, bipolar and other psychosis. Logs were kept by the research team, interviews with team members held and a group workshop.

Results

One team member will provide a personal perspective on their role in this study and how their own journey has evolved from service user advisor in the PARTNERS2 study LEAP to service user researcher carrying our qualitative research,doing systematic review tasks and leading PPI teams in research studies. How a lived experience emphasis on disclosure sits alongside frameworks in mental health research scientific discourse.

Improving empowerment of people with severe mental illness by community mental health care

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Despite the improvement of empowerment is a crucial target of contemporary mental health care it has rarely been investigated as primary outcome in studies on the evaluation of services for people with severe mental disorders.

In this study the effectiveness of an implementation of a community mental health care intervention (GBV) in addition to routine care on the empowerment of people with severe mental disorder will be investigated.

In a randomized controlled trial 927 persons were assigned to the GBV intervention (n = 470) or to care as usual CAU (n = 457). Assessments were made at baseline and four follow-ups over 24 months. Primary outcome was empowerment, measured by the empowerment assessment scale (EPAS). Secondary outcomes were functional impairment, measured by the Health of the Nations outcome scale (HoNOS), quality of life, measured by the World Health Organization Quality of Life short form (WHOQOL-Bref), service satisfaction, assessed by the Client Satisfaction Questionnaire (CSQ-8) and met and unmet service needs, measured by the Camberwell Assessment of Needs (CAN). Data were analyzed at an ITT basis by means of mixed effects regression models.

Results of the mixed effects regression models revealed significant improvements of all study outcomes in both groups. Significant interaction effects indicate stronger improvements in the intervention group GBV compared to CAU for the primary outcome of empowerment (d = 0.27), quality of life (d=0.22); service satisfaction (d=0.46), number of met service needs (d=0.19), proportion of met needs to total needs (d=0.26), proportion of unmet needs to total needs (d=-0.26).

The implementation of the GBV intervention in addition to CAU in the German health care system is associated with a stronger improvement of empowerment, quality of life, service satisfaction and an improved need orientation of mental health care in patients with severe mental illness.

Lessons from implementation of Lithuanian Mental health care reform strategy (2020-2024)

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Introduction: Since 2020 new government in Lithuania has started to implement renewed Mental health (MH) care reform strategy that included various interventions for reduction of suicide mortality. It also aimed to improve other MH indicators, including care quality at all 3 levels of MH care. OECD experts were involved in performing data analysis, providing policy recommendations and creating links with other European countries to Lithuanian MH care sites as experience sharing.

Methods: we evaluated progress of implementation of this strategy using multiple analyses and multidisciplinary policy review.

Results: suicide mortality reduction target was achieved (standardized suicide rate 18.6/100’000 inhab. in 2022, in comparison to 28.7/100'000 inhab. in 2016). However suicide attempts among youth and among elderly were trending to increase. Alcohol related deaths and mortality due to unexplained causes are remaining at high levels. Due to MH care reform plan implementation, 238 in-patient beds (9.5%) were reduced in psychiatric hospitals, with additional financing of outpatient MH services. Since 2023 daycare financing has increased by 100%. WHO QualityRights standards started to be implemented with some improvement in Human rights. Shortage of MH care staff, especially child psychiatrists and adult psychiatrists, were biggest barriers for reform implementation in terms of quality of care.

Discussion: despite good results in suicide mortality, there were new suicide risk groups identified (elderly and youngsters). Strategy has not created early intervention services for children and adolescents yet, so new trends of misuse of unidentified narcotics by children and adolescents (added to vaporize devices that imitate smoking) appeared in 2022-2023.

Conclusions: 1. Lithuanian MH care reform strategy, developed in collaboration with OECD, was partly effective in shifting finances and other resources from inpatient to outpatient care. 2. Recovery approach is not yet implemented in care plans. 3. User's involvement is lacking at all levels of reform.

Evaluation of a recovery-oriented group intervention delivered in out-patient clinics

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In mental health practice there is an increasing demand to deliver person-centered and recovery-oriented interventions. Mental health nurses have hesitated to deliver such interventions in groups in the mental health organization in Region North Denmark. However, in collaboration two service users, a researcher, and a mental health nurse designed and adapted a person-centered and recovery-oriented group intervention consisting of two discovery group sessions from the Tidal Modal and ten sessions with the Guided Self-Determination method. It was decided to evaluate the intervention in outpatient services due to clinical outcomes; personal recovery and self-esteem (decided by the service users) and implementation outcomes; acceptability, adoption, and appropriateness (decided by the researcher).

The study design was a mixed methods study conducted in three outpatient clinics from 2019 – 2020. Four mental health nurses volunteered to facilitate two groups each and consented to participate in the research project as participants. A group consisted of one facilitator and three or four patients.

Twenty-four patients gave consent to participate in the study. Seventeen participants completed the groups. The mean attendance rate for all 12 sessions was 73.33% with a range of 63.15 – 91.30%. Facilitators and patients found the content and structure of the group intervention acceptable and meaningful. Facilitators stated supervision to be a necessary mean to support their confidence in facilitating the intervention. Furthermore, participants improved their sense of self-esteem, and goal and success orientation in numbers and word after participation. Of note, the patients expressed that the peer support among the group participants was valued significantly.

Facilitators and patients found the group intervention useful and acceptable, and patients found the intervention to impact their recovery process in everyday life.

A Multidomain Lifestyle Intervention for Psychiatric Outpatients (CHAPTER): a Pilot RCT

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Introduction: Lifestyle-related health issues are common in people with mental illness, contributing to a decreased life expectancy of 15-20 years compared to the general population and high societal and personal burden. Effects of multidomain lifestyle interventions on the overall recovery of psychiatric patients are understudied. This study aimed to investigate the feasibility, acceptability, and preliminary effectiveness on recovery of a multidomain lifestyle intervention in patients with severe or chronic mental illnesses.

Methods: A transdiagnostic group (n=20) of outpatients was 1:1 randomised to the intervention or control condition. The intervention consisted of 11 three-hour group sessions about physical activity, nutrition, relaxation, sleep, substance use, social support and purpose and meaning. Self-report questionnaires, physical measurements, diary questions, accelerometers and semi-structured interviews were administered at baseline, halfway and post intervention. Feasibility and acceptance outcomes included attrition, retention rates, protocol deviations, and quantitative and qualitative evaluations. Multiple recovery and lifestyle behaviour outcomes were assessed.

Results: Diagnoses of participants (mean treatment duration: 15 years) included severe and/or chronic mood, personality, anxiety, somatic symptom and ADHD. Both the intervention and research protocol appeared feasible and acceptable, with relaxation, purpose and meaning and nutrition as highest appreciated themes. Intervention attendance was low (all sessions: 1/10) and drop-out high (3/10). However, overall experiences with the intervention were positive, also among drop-outs. Intervention simplification and deepening was necessary to suit the needs of this heterogeneous group. Preliminary effects were found on all recovery domains, with biggest effects in societal recovery and smallest effects in clinical recovery. Effects on lifestyle behaviour were not unambiguous.

Discussion-conclusion: Based on our positive preliminary findings, multidomain lifestyle interventions for psychiatric outpatients might be a promising innovative intervention. However, to reduce drop-out and match the heterogeneous outpatient population, a more flexible intervention protocol is recommended. A replication study with a greater sample size is needed.

Supporting Physical Activity through Co-production in people with Severe Mental Illness (SPACES)

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Introduction

People living with severe mental illness (SMI) experience a mortality gap of 20-25 years. One of the main reasons for this is due to preventable physical health conditions such as diabetes and cardiovascular disease. Increasing physical activity can improve physical health in all sectors of the population including people with SMI. Therefore, supporting people with SMI to increase their levels of physical activity could help to reduce the mortality gap people with SMI currently experience. The SPACES study was set up to co-produce a physical activity intervention that meets the needs of people with SMI.

Methods

We held a series of workshops with NHS health professionals, people with lived experience of SMI, carers, and clinicians to collaboratively work to design the SPACES intervention using information gathered from systematic reviews, multi-stakeholder focus groups and a survey of people's physical activity preferences. The co-production process was supported by the SPACES Patient and Public Involvement and Engagement group.

Results

The intervention that we co-produced has two overarching components, one-to-one verbal support and physical activity sessions. In the one-to-one verbal support, participants are supported to explore how they can build physical activity into their daily lives. The physical activity sessions consist of weekly two-hour group-based physical activity sessions delivered over 18 weeks. The physical activity session is divided into three components: a physical activity component (up to 60 minutes), an education component (up to 30 minutes) and social time (up to 30minutes).

Discussion-conclusion

The intervention has been tested in a feasibility study involving 71 participants across NHS sites in the UK. Feedback from participants who received the intervention, and from people who delivered the intervention, indicated that the intervention is acceptable and feasible to deliver. The next step is to test the intervention in a full scale RCT.

Understanding experiences of seeking support for CVD for people with severe mental illness (PEGASUS)

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Introduction

People with a diagnosis of severe mental illness (SMI) such as schizophrenia and bipolar disorder, have poorer physical health, have a significantly increased risk of developing cardiovascular disease (CVD) and type 2 diabetes (T2D) and die on average 15-20 years younger than people without SMI. People from racialised communities have an elevated risk of poor metabolic health. This can be compounded by 'double disadvantage' with higher rates of diagnosis of SMI amongst some racialised groups, making the risk of developing CVD and T2D even greater. Currently there are no interventions which reduce such risks in this population while the mortality gap is increasing.

Methods

Funded for 5 years by an NIHR Programme Grant for Applied Research, the PEGASUS study is currently holding focus groups run by service user / survivor researchers to gather data from people living with SMI and physical health challenges. In the focus groups, we are gathering perspectives on what helps and hinders pursuit of physical health interventions. In addition, we are collaborating with grass-root organisations to reach out to individuals from racialised communities. It is imperative to ensure people with diverse backgrounds are a key voice that informs how and why cultural understandings of health can be integrated. Data will be analysed using inductive and deductive framework analysis informed by the Theoretical Domains Framework.

Results

The results of the focus group study will feed into an experience-based co-design process including community partners to develop a peer-supported group clinic intervention which aims to improve metabolic health. Co-design allows equal but different perspectives to inform the development of an intervention which is designed by and for those who will use it.

Discussion-conclusion

The intervention will be tested in a feasibility study involving 40 participants across NHS sites in the UK. Monitoring of the co-production work will allow evaluation of impact and challenges of a co-productive style of working.

The role of peer support in addressing inequalities of access to mental and physical health care

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Introduction

People from racially marginalised communities can be at elevated risk of poor metabolic health, compounded by higher rates of diagnosis of SMI. Healthy lifestyle interventions are generally not culturally adapted. Research suggests that peer support can engage people with services and connect people to community support for their health and wellbeing, but that people from different cultural communities' experience and benefit from peer support in different ways.

Methods

We report two studies that aimed to explore understandings and experiences of peer support among people from a range of cultural communities.

In a community participatory research project, community researchers interviewed nine women from South Asian communities in London about their experiences and understandings of peer support. In our second study, we interviewed 18 peer workers and people offered peer support in mental health services in London and Birmingham, from Black British, Asian British and mixed ethnic groups. A Lived Experience Advisory Panel (LEAP) played a key role in developing and piloting interview schedules. Interviews were analysed using a discursive, interpretive workshop approach involving community researchers and LEAP members.

Results

Results from both studies explored peer support within communities and across cultural difference, foregrounding a gap that peer support can fill between support offered by family and community, and care provided by mental health services. Peer support enabled people to connect to preventative care for their mental and physical health.

Discussion / Conclusion

Findings indicated the potential for community-driven, culturally appropriate approaches to peer support to address inequalities of access and experience of mental health care.

On Being the Conduit: Lived Experience Involvement in Research across Contexts and Perspectives

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Introduction

At a time when co-production has become a 'buzzword' in research and service user involvement is becoming an expected and integral part of research grant and ethics applications it is, based on my experiences and the literature, important that we work to retain the meaning of co-production, how it differs from lived experience involvement and understand and remain connected to its emancipatory roots.

Methods

My work reflects on co-production and lived-experience involvement from the multiple perspectives I have personally brought across time and contexts. Firstly, as an advisory group member, service user researcher and lived experience co-applicant then as a research assistant where others provided lived experience that I don't personally have and latterly as the programme manager on a co-produced randomised controlled trial. As the programme manager I personally have both lived and methodological experience and my role requires me to hold these with awareness of equity and power dynamics.

Results

My work highlights the contextual differences in co-production environments and how one size does not fit all when it comes to co-produced work. In the process of writing the publications that form my thesis, reading, discussing with colleagues, and developing my thoughts around co-production and definition I have considered and discussed ideas around creating a typology of collaboration or guidelines for peer review. I concluded, however, that collaboration is context dependent.

Discussion-conclusion

My conclusion is that possibly the best way that we can hold ourselves to account as a research community currently is to define our collaboration strategy before our work begins and then reflect on how our own aims have or have not been met in order to create accountability, reflexivity, and a push for mutual learning around co-production within the collaborative research community.

SP-14 | Symposium: Implementation of the collaborative care model for common mental disorders in France - Nadia YOUNES, Université Versailles Saint Quentin, Université Paris Saclay, INSERM

Implementation of the collaborative care model: quantitative results from professionnals' survey

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Background

Common mental disorders (anxiety and mood disorders), primarily treated in primary care, could be improved with a better coordination between general practitioners (GPs) and specialized care. The collaborative care model (CCM) is recognized as a best practice model to integrate evidence-based mental health care in primary care. In France, a pilot of this model (SESAME) has been deployed from September 2021 to November 2023, with an implementation study (MOSAIQUE) conducted on a mixed method design combining quantitative and qualitative data.

Objectives and methods

The objectives for this presentation are to present the implementation of the CCM according to quantitative data from collaborative care professionals' surveys. These surveys were conducted online anonymously every 6 months (March 2022, November 2022, March 2023 and December 2023) with the 3 nurse case managers (4 surveys points), the 12 GPs (4 surveys points), the 3 psychiatrists (4 surveys points) and 15 psychologists (1 survey point in December 2023). Data will be analyzed from January 2024 onwards (descriptive and comparative analyses). They provide information on the professional, the motivations for CCM, opinions on CCM activity and on exchanges with other CCM professionals, difficulties and satisfaction about CCM.

Findings and perspectives

We will present preliminary evidence on the implementation of the CCM in primary care in France. These outcomes will be compared with quantitative data from professionals' survey of US implementation studies on collaborative care. Issues with primary care of common mental health disorders in France will be considered.

Implementation of the collaborative care model in France: first quantitative results from registers

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Background

Common mental disorders (anxiety and mood disorders), primarily treated in primary care, could be improved with a better coordination between general practitioners (GPs) and specialized care. The collaborative care model (CCM) is recognized as a best practice model to integrate evidence-based mental health care in primary care. In France, a pilot of this model (SESAME) has been deployed from September 2021 to November 2023, with an implementation study (MOSAIQUE) conducted using a mixed method design combining quantitative and qualitative data.

Objectives and methods

Our objectives are to present the implementation of the CCM according to quantitative data from registers (available from February 2024 onwards, N= 200 patients were included in the research), in terms of penetrance (number of patients who received CC compared to all primary care patients during the study period), in terms of acceptability (rate of patients who received CC compared to those referred by GPs, of refusals and loss to follow-up), in terms of fidelity (demographic and clinical profile of patients included:initial depressive severity, suicidal severity, and type of CC received:number of consultations, percentage of follow-ups at 12 weeks with at least 4 nurse consultations, number of meetings between the nurse and psychiatrist, number of consultations by the GP during follow-up in collaborative care, percentage of patients referred to specialized care, number of patients seen by psychologists, rate of consultations with a psychiatrist in the absence of symptoms improvement) and results (percentage of patients who benefited from adapted pharmacotherapy over 12 weeks, percentage of patients treated for more than 6 months, rate of respondents and of remitted patients).

Findings and perspectives

These outcomes will be compared with quantitative data of US implementation studies on collaborative care. Issues with primary care of common mental health disorders in France will be considered.

SP-14 | Symposium: Implementation of the collaborative care model for common mental disorders in France - Nadia YOUNES, Université Versailles Saint Quentin, Université Paris Saclay, INSERM

Implementing the collaborative care model : qualitative analysis fromhealthcare professionnals

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Background

Depression and anxiety disorders present a significant challenge in France, often evading detection and treatment within primary care. Addressing this requires improved coordination between general practitioners (GPs) and specialized care. The collaborative care model, involving multidisciplinary teams, adopts a population-based approach with routine screening and case reviews by dedicated case managers and a remote psychiatrist. Evidence-based care includes psychotherapies delivered by case managers or psychologists, supported by standardized questionnaires for patient follow-up. While collaborative care has proven effective in international studies, conducting a specific implementation study in French primary care is now essential to comprehend the model's applicability, challenges, and adaptation within the French healthcare context Introduced in France in September 2021, the SESAME project is a pilot study involving four primary care practices, encompassing primary care teams and individual GPs. Nurse case managers with psychiatric expertise, play a key role within this framework.

Objectives and methods

As part of a multidimensional implementation research initiative, this segment aims to explore the adoption and experiences of the collaborative care model among healthcare professionals (GPs, nurse case managers, and psychiatrists) in the initial phase of its establishment in France. Utilizing a qualitative approach, the study plans in-depth interviews with the entire healthcare professionals' cohort (n=20), investigating various dimensions of their experiences and emphasizing the barriers and facilitators in implementing the collaborative care protocol.

Findings and perspectives

SESAME meets physicians' needs by addressing time constraints and tackling challenges related to mental health expertise and access to psychiatrists. However unclear role distinctions within the team and the heavy reliance on the nurse both pose challenges. A comprehensive understanding and adherence to the referral framework, perceived by some doctors as overly restrictive, are also key components. Additional elements will be developed to further reflect the experience of the professionals involved in the protocol.

The ACER Study

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Background

Mental health rehabilitation services provide specialist treatment to people with particularly severe and complex problems. In England, disinvestment in local NHS provision of these services has resulted in over half of the 4000+ mental health inpatient rehabilitation beds now being provided by the independent sector. Concerns have been raised about independent sector services having longer lengths of stay and higher costs, the quality of care provided, and the fact that they are often further from the patient's home than NHS services. However, there has been no research comparing the two sectors in detail and we therefore do not know whether these criticisms are justified. The ACER study (Assessing the Clinical and cost-Effectiveness of inpatient mental health Rehabilitation services provided by the NHS and independent sector) aims to compare the two sectors in terms of: patient characteristics; service quality; patient, carer and staff experiences; clinical and cost effectiveness.

Methods

ACER comprises the following components: 1) a detailed survey of NHS and independent sector inpatient mental health rehabilitation services across England; 2) a qualitative investigation of patient, family, staff and commissioners' experiences of the two sectors; 3) a cohort study comparing clinical outcomes in the two sectors over 18 months; 4) a comprehensive national comparison of inpatient service use in the two sectors, using instrumental variable analysis of routinely collected healthcare data over 18 months; 5) a health economic evaluation of the relative cost-effectiveness of the two sectors. In Components 3 and 4, our primary outcome is 'successful rehabilitation' over the 18-month follow-up period, defined as a) being discharged from the inpatient rehabilitation unit without readmission and b) inpatient service use over the 18 months.

Discussion

The ACER study will deliver the first empirical comparison of the clinical and cost-effectiveness of NHS and independent sector inpatient mental health rehabilitation services.

Inpatient service use before and after a mental health inpatient rehabilitation admission

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Background

Inpatient mental health rehabilitation services provide specialist treatment to people with complex psychosis. On average, rehabilitation admissions last around one year and usually follow several years of recurrent and often lengthy psychiatric hospital admissions.

Aim

To compare inpatient service use before and after an inpatient rehabilitation admission using electronic patient healthcare records in one NHS Trust in London.

Method

Individuals with an inpatient rehabilitation admission which started between 1st January 2010 and 30th April 2019, which lasted for at least 84 days, and where the individual had at least 365 days of records before and after their rehabilitation admission, were included in the study. Regression modelling was used to compare inpatient days before and after the rehabilitation admission, whilst controlling for the variation in the length of pre- and post-rehabilitation admission periods and potential confounding variables, using incident rate ratios.

Results

A total of 172 individuals met the study eligibility criteria. They had a mean of 4.4 years (SD 2.2) of records available before the rehabilitation admission with a mean of 519 inpatient days (SD 400) during this period, and a mean of 5.2 years (SD 2.4) of records available after the admission with a mean of 411 inpatient days (SD 595) during this period. The adjusted regression model produced an incident rate ratio of 0.520 (95% CI 0.367 to 0.737).

Conclusion

The rate of inpatient service use was halved in the period after an inpatient rehabilitation admission compared to the period before.

An ethnographic study of an inpatient rehabilitation ward for complex psychosis in London

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Inpatient psychiatric rehabilitation services support people with complex psychosis to begin their recoveries towards community living. While a recovery-based approach in these services is associated with better outcomes, we have little in-depth understanding of what this looks like on the ground: what is important to patients and staff, and what are the barriers and facilitators? To investigate these questions, I conducted six months of ethnographic research on a psychiatric rehabilitation ward in London, using participant observation and semi-structured interviews with patients and staff. Data were analysed through situational analysis, a recent elaboration on grounded theory. My analysis elucidates the careful relational engagement of frontline ward staff with patients, which laid the foundations for a person-centred approach on the ward. This comprised several key features, including: extremely close attention to detail regarding what encourages or discourages individual recoveries; active appreciation of the slow day-to-day progress that characterises psychiatric rehabilitation; and engaging with patients with a striking degree of curiosity, acceptance, and respect. However, on the other hand, this careful relational engagement was often deprioritised on the ward, relegated to an afterthought or quasi-optional extra by the structural and discursive arrangements dominating the wider psychiatric institution. For example, the institutional structures of the hospital and clinical orientations of staff naturally elevated risk management and discharge planning over face-to-face time with patients; quantifiable tasks and standardised assessments were prioritised ahead of more natural human interactions; and the underappreciation of junior staff members' relational expertise and a lack of reflective space for staff to process their countertransference contributed to staff demoralisation. The resulting relegation of relational engagement was experienced negatively by staff and patients alike. The findings reinforce recent calls to emphasise the relational practice at the heart of psychiatry in general and psychiatric rehabilitation in particular.

Assessing and supporting social inclusion in mental health supported accommodation: the SUSHI Study.

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Background: People with severe mental illness living in supported accommodation are often socially excluded. Social inclusion is an important aspect of recovery-based practice, and improves quality of life. The Social Inclusion Questionnaire User Experience (SInQUE) is a structured measure of social inclusion validated for use with mental health populations. We sought to develop an online version of the SInQUE for use in mental health supported accommodation services, and examine its acceptability and perceived usefulness to staff and residents as a tool to support care planning.

Methods: We developed an online social inclusion questionnaire through iterative phases of lab-testing and field-testing with staff and residents in mental health supported accommodation services in one London borough. We investigated take up and use of the tool across a 5-month study period in three areas, with and without an accompanying strategy to support implementation. Final focus groups with staff and residents explored the potential utility of the online questionnaire for use in practice, and ways in which staff could support residents to achieve desired social inclusion goals.

Results: Staff and service users we interviewed felt that the online questionnaire was collaborative, comprehensive, user-friendly and relevant to their role. Some staff expressed concerns that particular questions might be intrusive or too personal, but service users did not share this view. Interviewees suggested that the tool could highlight areas of common unmet need, to inform service planning. However, the online social inclusion measure was only used by about 10% of staff with the supporting implementation strategy, and not at all in the comparison areas that had no implementation strategy.

Discussion: Implications will be discussed regarding the potential utility of the online SInQUE social inclusion questionnaire to support assessment and care planning around social inclusion in supported accommodation settings. Future directions for research will be considered.

Recovery Characterisation and Testing (RECOLLECT): Results of a global cross-sectional study

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Background – Recovery colleges aim to support the personal recovery journeys of persons with mental health problems through coproduced adult education. Since their initial development in England in 2009, recovery colleges have been set up in several countries worldwide. Nevertheless, international research on recovery colleges remains scant. The overarching objective of the global RECOLLECT study was to build understanding of organizational and student characteristics, fidelity and costs within the context of recovery colleges globally.

Methods – This study applied a cross-sectional design. All countries in which recovery colleges exist were identified. Recovery college managers completed the survey, including questions regarding organizational and student characteristics, fidelity to the RECOLLECT Fidelity Measure, funding models and unit costs. Regression models were used to explore continental differences in fidelity, using England as reference group.

Results – 221 recovery colleges were identified across 28 countries, of which 174 (79%) participated in the study. Most recovery colleges scored highly on fidelity. Overall scores for fidelity, coproduction and being tailored to the student were lower for recovery colleges in Asia compared to England. Annual budgets varied considerably within and between continents, ranging from €0 to €2.550.000. Based on the included data, reported annual budgets added up to €30 million, providing 19864 courses for 55161 students.

Discussion – Recovery colleges exist in many countries. There is an emerging global consensus on key operating principles, especially equality and commitment to recovery, and on the fact that recovery colleges facilitate the development of recovery-oriented systems of support. Most recovery colleges achieve moderate to high fidelity to the original model, regardless of the economic status of their country. When evaluating coproduction and tailoring support approaches, it is essential to take into account cultural differences.

Recovery College courses and their relationship with college characteristics: A document analysis

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Recovery colleges (RCs) support people experiencing mental health challenges through an adult education approach. Individuals with lived and professional experience of mental health challenges can enrol onto RC courses as students. Course curricula varies across colleges but typically encompasses skills and knowledge acquisition in relation to understanding mental health difficulties and treatment, self-management of difficulties and living healthy lives outside of services. Cluster analysis has identified that RCs can be grouped into three types. strengths-oriented colleges (affiliated with statutory health care services and focuses on amplifying students' strengths), community-oriented (focusing on social connectedness) and forensic (focuses on amplifying strengths across forensic populations). This study aims to develop a typology of courses offered across English RCs and investigate how course content links with RC characteristics.

A document analysis of publicly available documents describing courses from RCs across England was conducted following READ methodology outlined by Daglish (2021). Documents were taken from English RCs focusing on personal recovery, co-production and adult learning approaches. Through expert consultation with RC National leaders, existing RC networks and liaison with host charities and mental health NHS Trusts, 88 RCs were identified across the three clusters.

Documents detailing course descriptions were available from 79 of the 88 RCs. Two hundred and forty-nine documents were screened out due to ineligibility. A total of 2365 courses over 554 documents will be analysed via a hybrid inductive-deductive approach.

Preliminary analysis on 300 courses titles indicates English RCs offering a broad array of courses, spanning art and crafts, being outdoors in nature and self-management of personal wellbeing across both strengths and community-oriented RCs.

Ongoing analysis will investigate whether course provision differs depending on RC type and whether colleges are maximising quality by learning from other similar courses in order to deliver course of high pedagogical content.

Post-pandemic Recovery Colleges: A multi-site qualitative study

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Introduction: During the COVID-19 pandemic, mental health problems increased whilst access to clinical mental health services reduced. Recovery Colleges (RCs) are recovery-focussed adult education initiatives delivered by people with professional and lived mental health expertise. Designed to be collaborative, inclusive, and community focussed, RCs were uniquely positioned to support people experiencing mental health problems during the pandemic. There is limited research exploring the lasting impacts of the pandemic on RC operation and delivery to students. The aim of this study was to ascertain how the COVID-19 pandemic changed the operation of RCs in England.

Methods: A coproduced qualitative interview study of RC managers across the UK. Academics and co-researchers with lived mental health experience collaborated on conducting interviews and analysing data using a collaborative thematic framework analysis.

Results: Thirty-one RC managers participated. Five themes were identified: Complex organisational relationships; Changed ways of working; Navigating the rapid transition to digital delivery; Responding to isolation; and Changes to accessibility. Two key pandemic-related changes to RC operation were highlighted: their use as accessible preventative services that relieve pressure on mental health services; and the development of digitally delivered courses for individuals with mental health needs, including forensic RC students and healthcare staff experiencing burnout.

Conclusions: RCs offer two potential benefits to mental health services post-lockdown: Mental health service use prevention through accessible hybrid face-to-face and digital course delivery; and overcoming digital poverty barriers to mental health service access through digital skills training. These benefits are strengthened by strong relationships with partner organisations and autonomy from statutory healthcare infrastructures.

Balancing acts in a Recovery College when values are brought into practice

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Introduction: Recovery Colleges (RCs) facilitate a peer-supported learning environment that is co-created bottom-up for and by people with mental vulnerabilities. The philosophy of RCs comes with key values such as equality, reciprocity, connectedness, empowerment and free space. We scrutinize how these values are brought into practice. **Methods:** We adopted triangulation by combining participatory observations with twin-interview data and diary data. All aspects of this study (i.e., design, recruitment, data collection and analysis) were co-created with experiential researchers who are RC participants. First, twenty-six RC participants (course students, retreat students, visitors, volunteers, employees and ex-participants) were interviewed by an academic and experiential researchers duo (hence twin-interviews). Second, five participants took part in the follow-up diary study, filling out diaries every other day for maximal two months. Third, the principal researcher conducted participatory observations from 2022 up till and beyond the time of writing, including attending courses, team meetings, volunteering and visiting the social meeting ground. **Results:** Two balancing acts were identified in the practice of an RC that is shaped by its key values. The balancing acts are closely intertwined and together form a dual axis model. One axis represents the constant balancing between stimulating self-direction, empowerment and autonomy (individualization) vs. facilitating a peer supported community (collectivism). The second axis represents a balancing act between providing a place of normalization, stimulating integration of the RC in the community vs. a safe niche facilitating a peer supported community focused on mental vulnerabilities. We also discuss the impact of organizational growth on these balancing acts. **Discussion:** Bringing key values into practice can be challenging in a growing bottom-up co-created organization.

Peer support worker initial training content

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Introduction: Peer support worker (PSW) initial training is integral for the mental health peer support worker (PSW) role. Training needs to incorporate the advances in digital peer support and increase in PSW roles internationally. Currently, there is a lack of evidence on training topics that are important for initial PSW training and on which training topics can be provided on the internet.

Method : A systematized review was conducted to identify a preliminary list of training topics from existing training manuals. The Delphi consultation consisted of three rounds to establish the importance and web-based deliverability of each topic. In round 1, participants were asked to rate the training topics for importance, and the topic list was refined. In rounds 2 and 3, participants were asked to rate each topic for importance and the extent to which they could be delivered over the internet.

Results: The systematized review identified 32 training manuals from 14 countries. These were synthesized to develop a preliminary list of 18 topics. The Delphi consultation involved 110 participants (49 PSWs, 36 managers, and 25 researchers) from 21 countries. After the Delphi consultation (round 1: n=110; round 2: n=89; and round 3: n=82), 20 training topics were identified. There was a strong consensus about the importance of five topics: lived experience as an asset, ethics, PSW well-being, and PSW role focus on recovery and communication. All training topics were identified with a strong consensus as being deliverable through blended web-based, face-to-face training or fully deliverable on the internet with moderation.

Discussion The 20 training topics identified can be recommended for inclusion in the curriculum of initial training programs for PSWs. Further research on web-based delivery of initial training is needed to understand the role of web-based moderation and whether web-based training better prepares recipients for web-based peer support.

SP-06 | The international growth of peer support I: stakeholder perspectives and active ingredients - Galie S MORAN & Yael GOLDFARB, Ben-Gurion University in the Negev

A Process evaluation of the intervention "Paths to EvERyday Life" (PEER)

Cecilie Høgh EGMOSE[1,2,3], Chalotte Heinsvig POULSEN[1], Siv Therese Bogevik BJØRKEDAL[1], Lene Falgaard EPLOV, [1]

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Introduction:

The peer support intervention “Paths to EvERyday life” (PEER) is a co-peer-led manualized intervention delivered in a Danish municipality civil society setting. PEER is a ten-week group course for people with mental health difficulties facilitated by two voluntary peers. The focus of the course is on everyday life, well-being, and personal recovery. PEER was investigated through an RCT and a process evaluation.

Methods:

In a process evaluation framework, the perspectives of the participants, as well as the volunteer peers were studied. Participants receiving PEER were interviewed using realistic interviews at the end of the 10-week group course with a focus on mechanisms of change. The analysis was informed by peer support theory and guided by reflective thematic analysis. The perspective of the volunteer group facilitators was studied through focus groups with a focus on their working conditions.

The implementation of PEER throughout the RCT was measured with a fidelity scale developed for the intervention.

Results:

Four overarching themes were identified, elucidating how, when, and under what circumstances PEER impacted the recovery and well-being of the participants. The preliminary results deal with themes about connectedness, cultivating hope, identity and change process.

The volunteer peers experienced a contradictory dual role between facilitating and sharing equally, the structured manual was safe but challenging for group dynamics. The fidelity measuring showed that implementation had gone well with some differences across municipalities and groups.

Conclusion:

The process evaluation showed that the intervention was mainly implemented according to the values and principles. The qualitative studies indicate that the PEER participants experienced some individual changes that are essential for the recovery of mental illness and that the volunteer peers find the role to sometimes be challenging but find reassurance in the structured manual.

Multicultural experiences of UPSIDES peer support workers across HI/LMI-countries

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Introduction: Peer support is gaining recognition as essential in recovery-oriented care worldwide and alleviating global burden on mental-health (MH). However, there is lack of research about peer support workers' (PSW) experiences across varying income-level and cultures. This study aimed to assess the experiences of PSWs who engaged in UPSIDES intervention – a multi-country research project designed to empower and scale-up peer support in low-middle- and high-income (LMIC/HIC) countries.

Method: Nine focus groups totaling 38 PSWs were conducted 18 months after starting UPSIDES intervention at six study sites: Ulm and Hamburg (Germany), Butabika (Uganda), Dar es Salaam (Tanzania), Be'er Sheva (Israel), and Pune (India). Transcripts were analyzed using qualitative content analysis and MAXQDA software.

Results: Four general domains (2 sub-domains in each) were identified regarding PSWs' experiences: (i) personal recovery, (ii) vocational/organizational aspects, (iii) PSWs' relations with staff and MH systems, (iv) expanding influence to broader circles. Across sites, risks for successful assimilation of peer-support in MH were mentioned, specifically, lack of role-clarity, integration challenges with MH services and limitations in resources. In HIC self-disclosure and peer-vocational development were central issues. In LMIC, PSWs had meaningful interactions with stakeholders in the community (e.g. relatives, police, etc.) enticing social-educative and anti-stigma influence. PSWs in LMIC additionally experienced unique gains to their MH conditions and financial standing.

Discussion and Conclusions: This first multi-country study identifies PSWs' subjective and tangible gains as well as challenges across varying income and cultural contexts. Findings suggest that along with supporting service users, PSW experience personal recovery, occupational and societal benefits, reflected differently across MH systems and HIC/LMIC contexts. In addition PSWs demonstrated their ability to act as change agents, impacting familial and social circles within and outside MH services - thus enhancing a recovery-culture across different income-level and cultural contexts.

Mental health workers' perspectives on a peer support intervention in five countries

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Objective: Around the globe, the introduction of peer support in mental health teams creates opportunities and challenges for both peer and non-peer staff. However, the majority of research on mental health workers experiences with peer support comes from high-income countries, with questionable transferability to diverse mental health services and cultural backgrounds. Thus, this study investigates mental health worker experiences across a range of high-, middle-, and low-income countries.

Methods: Six focus groups with 25 mental health workers (19 female, 6 male) were conducted about 18 months after the implementation of the UPSIDES peer support intervention. Qualitative data was collected in the UPSIDES study sites in Ulm and Hamburg (Germany), Butabika (Uganda), Dar es Salaam (Tanzania), Be'er Sheva (Israel), and Pune (India). Transcripts were analyzed using thematic content analysis.

Results: Mental health workers gained trust in peer support over time and valued peer support workers for sharing their lived experiences with service users. Participants in lower-resource study sites (Uganda, Tanzania) reported additional benefits, including provision of mental health services in the community and reduced workload for mental health workers. Perceptions about peer support workers varied based on previous peer support experience, ranging from considering peer support workers as equal team members to viewing them as service users.

Conclusions: Taking local context into account is essential in order to understand mental health workers' views on the cooperation with peer support workers. Especially in settings with less prior experience of peer support, implementers should make extra effort to promote interaction between mental health workers and peer support workers. In order to better understand the determinants of successful implementation of peer support in diverse settings, further research should investigate the impact of contextual factors (e.g., resource availability, cultural values).

Concept of a new model of low-threshold psychotherapeutic care at work: first results of an RCT

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Introduction: Although mental disorders are of increasing relevance to work ability and enormously impact socioeconomic issues, there is a considerable treatment gap worldwide.

Methods: To analyze the effectiveness of early psychotherapeutic intervention at work, the German nationwide multicentered RCT project “friaa” (“Frühe Intervention am Arbeitsplatz”) was implemented (Weber et al., 2021). It is a short-term psychotherapeutic offer for stressed employees. Core elements are low-threshold initial contact, counseling in all phases of mental illness, workplace relevance and networking with co-treaters (Rothermund et al., 2022). To determine which users are reached, participants’ demographics and illness behavior are described. Change of sickness absence days serve as primary and self-efficacy as secondary outcome from enrolment to fifteen months afterwards. Participants were recruited from small, middle, and large-sized companies around five study centers Germany-wide. Prerequisites included a F-diagnosis (ICD-10) or a functional level < 81 (GAF scale).

Results: Of 550 participants (55% female; mean age = 46, SD = 11), 73% worked full-time, 13% in shifts and 21% had managerial responsibility. 62% were employed in large companies, where the topic of mental health was addressed significantly more frequently (Psychosocial Safety Climate). The average number of sick days before study participation was 22. The depression indicator PHQ-9 had an average value of 13, the work-related self-efficacy scales ERA (return-to-work self-efficacy) and SOSES (short occupational self-efficacy) showed values of 3.5 and 3.9. 85% of the participants met the criteria for at least one mental illness, the GAF mean value was 66. First results of the ongoing studies’ effectiveness will be presented.

Discussion/Conclusion: Descriptive baseline data indicate a high level of mental strain. This points to the acute need for intervention which might improve slightly positive existing work-related self-efficacy. As the intervention provides early, work-related treatment, implementation into practice could be of large public health and economic relevance.

Generalized access to psychotherapy upon GP referral in France: results from the pilot study

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In France, despite clinical guidelines supporting psychotherapy as the main treatment for mild to moderate anxiety and depressive disorders, general practitioners (GPs) have long relied on psychotropic medications as first line treatment, in the absence of available reimbursed psychotherapies.

In 2018, the French Social Health Insurance organisation (CNAM) set up a large-scale pilot study to address this issue. General practitioners (GPs) from four French territories (départements) could refer patients with incident mild to moderately severe anxiety or depressive disorders, and no psychiatric comorbidity, to registered private-practice psychologists/psychotherapists, for an initial evaluation followed by up to 20 sessions of ten supportive and then ten structured psychotherapy (with mandatory advice from a psychiatrist) if needed. All sessions were funded by the CNAM and free of charge for the patient.

In order to assess the benefits of and fine-tune these new referral pathways, before a possible roll-out, a broad interdisciplinary evaluation framework was set up in 2019, relying on qualitative (interviews) and quantitative data (surveys and two cohorts), addressing the implementation (uptake, adaptation, acceptability), clinical benefits, and opportunity for roll-out (improvements, support, efficiency) of the pathway.

By 31 March 2022, 4,042 general practitioners and 947 psychologists and psychotherapists had been involved in the pathway; 37,841 patients had been enrolled, and had undergone 405,674 psychotherapy sessions in total. Patients in the pilot pathway received less antidepressant prescriptions, with clinical benefits that matched usual care. Large groups of GPs and psychologists/psychotherapists were supportive of the experimental pathway and asked for its roll-out, albeit with adjustments, notably regarding administrative burden, patient inclusion criteria, psychiatric advice and particularly the low tariff of psychotherapy sessions.

Overall, the evaluation supports the roll-out of the updated GP-pscyhologist/psychotherapist referral pathway that took place in April 2022, in the wake of the COVID-19 pandemic, and underlines remaining challenges.

"Two are better than One" The contribution of Dyadic coping and couples therapy to Personal Recovery

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The contemporary concept of personal recovery when dealing with mental illness emphasizes the changes in an individual's attitudes, beliefs, values and abilities. In addition, there is importance in building personal resources and personal meaning to the experience of recovery. This approach is primarily focused on the individual. Importantly, the impact of a marital (or significant other) relationship and its resources has been hardly studied or identified in the literature.

I would like to introduce two key variables: "Dyadic Coping" and "Couple Therapy".

Both Dyadic Coping and Couple Therapy fall under the purview of "WE-DISEASE". In 2013, Bodenman and coworkers proposed this term for a disease that belongs to both spouses. According to this concept, in addition to identifying personal coping strategies that the individual uses for managing the illness, one should also focus on Dyadic coping strategies involving the couple.

In my Doctoral dissertation, Dyadic Coping and Couple Therapy have been found positively related to personal recovery from mental illness. Our findings are pioneering in nature, and will be detailed in this talk.

This presentation highlights the centrality of the dyadic process in the journey of personal recovery. Based on my Doctoral Thesis, this talk will spotlight the need for expertise in couple therapy for people with mental illness in a marital (significant other) relationship. This approach encourages them to maintain their relationship and mobilize personal and couple strengths for their personal recovery.

Primary care psychology in Belgium: a public health innovation in the national healthcare reform

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INTRODUCTION

Against the treatment gap (60%) and the long delays in seeking treatment for mental health problems in Belgium (on average 10 years), primary care psychology (PCP) was added to the reimbursed outpatient mental health delivery system in Belgium in 2019. This reimbursement measure included both primary and specialized short-term psychological treatment, both individually and in group. The purpose of the EPCAP (Evaluation of Primary Care Psychology) study is to describe the characteristics of patients treated within the measure of reimbursement of PCP.

METHODS

A total of 2,637 patients participated in an online survey at the start of their intervention, with follow-up assessments after 3, 6 and 12 months, across all the 31 mental healthcare networks. Information on sociodemographics, mental disorder status, suicidal thoughts and behaviors (STB), patterns of prior service use, and delays in seeking treatment were collected.

RESULTS

More than 70% of all patients screened positive for a lifetime and 12-month DSM-5 mental disorder, mostly anxiety and depressive disorders. Over 1/3 were experiencing STB in the last 12 months. For 43.9% of patients, PCP was the first treatment ever. The median delay in seeking treatment was 4 years. The idea of solving the problem yourself was a major reason for delaying seeking help.

DISCUSSION-CONCLUSION

PCP in Belgium serves mostly a clinical population with high proportions of lifetime and 12-month mental disorders and STB; many patients have been in mental health treatment before. PCP was associated with a considerable reduction in treatment delay. These findings raise the question whether PCP can be further optimized and contribute to the early detection and intervention of mental health problems in Belgium.

Contextual factors influencing coercion in mental health care: Insights from Nigeria and Portugal

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Introduction: Understanding the contextual factors has the potential to enhance our comprehension of broader macro- and meso-level factors that contribute to the use of coercive measures in mental health care. The presentation is from a PhD research that explored the contextual factors influencing the use of coercion using Nigeria and Portugal as case studies for developing and developed countries.

Methods: Focus group discussions and semi-structured interviews were used to obtain information from both service users and providers in both countries. The selection of research methodologies was guided by practical considerations of what was feasible in each context. A narrative synthesis of literature was also conducted.

Results: The narrative synthesis showed that various factors beyond patient characteristics, such as mental health legislation, demand and supply of mental health resources, impactful events like economic recessions and COVID-19, and staff-related factors like attitudes, traits, and qualifications, along with public attitudes and stigma, contribute to the use of coercive measures in mental health care. These factors interact with each other, rather than independently, to reinforce their impact on the reliance on coercive measures for the care of mental disorders. In Nigeria, the outdated mental health law, limited accessibility to mental health care and social services, deeply rooted stigma and misconceptions surrounding mental disorders, and public attitudes were important factors influencing the use of coercive measures in mental health care. In Portugal, socio-legal factors, staff-related factors, inefficient services, and insufficient resources were identified as contextual factors influencing the use of coercion in mental health care.

Discussion: Fundamental problems within the mental health care system must be resolved to deliver high-quality mental health care. By involving all stakeholders, and fostering collaboration, all countries, regardless of income level, can strive for reform and establish mental health systems that prioritize human rights, dignity, and recovery.

Benefits of a national register to understand the use of seclusion and restraint in France

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Introduction

Seclusion and restraint in psychiatry are controversial practices with no evidence-based therapeutic benefit that should only be considered as a last resort according to guidelines. However, their use is insufficiently documented and knowledge on the associated factors is fragmentary worldwide. Taking advantage of a rare standardized nationwide register recently made available in France, our objectives were to document the extent of the use of seclusion and restraint in psychiatry, its variations across hospitals and the associated factors.

Methods

We focused on seclusion and mechanical restraint during an involuntary psychiatric hospitalization in line with the applicable national legislative framework. We estimated the number of measures for adult patients in 2022 in the whole of France, the number and characteristics of patients concerned, and variations in use across hospitals. Based on a conceptual framework drawn from the literature on medical practice variations adapted to those with ethical stakes, multilevel logistic regressions were conducted to identify patient, healthcare provider and contextual characteristics associated with the use of seclusion and restraint in psychiatry.

Results

The availability of a recent national register allows estimating that one third of involuntary hospital stays in psychiatry were associated with seclusion measures, while mechanical restraint concerned 8% of these stays. There were significant variations across hospitals in their use, with some hospitals never resorting to them. While restrictive measures were more commonly used for young male individuals with complex care needs, patient characteristics explained only a limited share of variations across hospitals.

Discussion

A better understanding of the use of restrictive measures in psychiatry is a critical first step to inform effective public policies to reduce this use, as supported by international guidelines. The availability of national registers should be encouraged worldwide.

Benefits of a longitudinal register to understand the use of coercive measures in Germany

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Introduction

In Baden-Wuerttemberg, supplying data on coercive measures to a central register has been mandatory since 2015. We introduce the central register, show which data is collected and how it can be used for benchmarking and to answer research questions. We present data for the years 2015-2022 and answer two questions:

(1) What influence does a mandatory judicial authorization for mechanical restraint in 2018 have on the frequency of coercive measures?

(2) Was the Covid-19 pandemic in 2020 associated with changes in the percentage of patients exposed to coercive interventions?

Methods

Data for the years 2015-2022 were analyzed calculating:

(a) The proportion of cases with coercive measures.

(b) The proportion of cases with involuntary placements.

(c) The cumulative duration of coercive measures per affected case.

Results

(1) The percentage of patients subjected to any kind of freedom-restricting coercion (restraint or seclusion) decreased from 6.7 (average 2015-2017) to 5.8 in 2019 ($p < 0.001$). Following the mandatory judicial authorization for mechanical restraint, the percentage of patients subjected to such measure decreased from 4.8 to 3.6% in 2019 and the percentage of patients subjected to seclusion increased from 2.9 to 3.3%. The median cumulated duration of restraint and seclusion per affected case decreased from 12.7h to 10.9h.

(2) From 2019 to 2020 (year most affected by the pandemic) the number of cases in adult psychiatry decreased by 7.6%. The percentage of involuntary cases increased from 12.3 to 14.1%, and the number of coercive measures increased by 4.7%. The percentage of cases exposed to any kind of coercive measure increased by 24.6% from 6.5 to 8.1%.

Determinants of limited resort to coercive measures: on-site research in four French hospitals

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Introduction

In France, hospitals with psychiatric departments resort to coercion and more specifically to seclusion and restraints in varying degrees across the country. Considering the recent legislative developments and renewed authority of a judge, some French hospitals with higher coercion levels aim to lessen their use of it. Meanwhile, other French hospitals historically resort significantly less to coercion in comparison with national rates, and yet are surprisingly little studied. Based on the PLAID-Care research, this presentation aims to shed light on four hospitals with limited resort to coercive measures.

Methods

The investigation is based on the collection of systematic data relating to hospitals, as well as socio-anthropological methods (70 semi-directed interviews, 62 days of observations and documentary method).

Results

Findings reveal that resorting less to coercion is linked to specific practices and representations such as a priority given by professionals on making themselves available to patients; the centrality of activities; or a positive representation of psychiatric patients. This care work is made possible by an organization at both the department level, such as integration policies or horizontal relationships between professionals; and at the hospital level, such as attractiveness or employment policies or a structured medical steering committee. This becomes a virtuous circle in which the care work provides professional satisfaction, commitment and team stability, while the involvement of the hospital level guarantees the sustainability of policies supporting less resort to coercion. Additionally, an openness culture, collegiality and risk-taking, are other values and principles underpinning these policies in some hospitals.

Discussion

This presentation highlights determinants and levels leading to less resort to coercion in psychiatry and analyzes the links between these different levels. It provides levers for action based on on-site research, which can be of benefit to other facilities aiming to reduce coercion.

Citizen Science and Youth Mental Health: Co-creating Future Research

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Youth mental health is a global priority challenge. Meeting this challenge will require mental health researchers to involve young people, not merely as participants in their studies or recipients of their findings, but as partners and leaders in their own right. This requires the innovation of citizen science, to adopt radically different ways of working with young people, that empower them to contribute equally throughout the research process. Beyond the direct impacts of enhancing both researchers and young peoples' knowledge and skills, this can ensure more relevant, accessible and impactful research is conducted and communicated.

Through Youth LIVES (Youth Lived experience of Evidence Synthesis), a UKRI-funded Citizen Science Collaboration award, we have brought together young people, as citizen scientists with lived experience of mental health problems, with mental health researchers, to work together through a programme of workshops to discover evidence gaps and to co-create mental health based research proposals that meet the needs and priorities of young people themselves.

As a result of the project, there have been two levels of unique contribution to knowledge: firstly, research proposals that provide new, innovative, and relevant angles on mental health research, with new research insights developing from the youth co-researchers lived experience and perspectives. Secondly, the contribution of learning from the project itself, where the embedded formative and summative evaluation process has enabled us to capture and share our learning about participatory methods with communities in mental health research, policy and practice.

Although there are many perceived benefits to embedding co-creation within mental health research, in the current UK climate there are also significant barriers to conducting citizen science within research institutions. This talk will explore both the contribution citizen science can make to mental health research, alongside the challenges this method poses.

Empowering citizens and communities to make meaning from mental health service narratives

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Introduction: Personal experiences describing the impact of mental health service use (or its absence) have been shared on a substantial scale, including in published narratives, and through systems collecting feedback from service users. Knowledge of collective experiences described in mental health service narratives (MHSN) could be used to create meaningful health service change, but MHSN remain under-used, including due to limited analyst capacity. We believe that empowering citizens to make meaning from MHSN, including through identifying collective experiences, could transform mental health service policy and practice.

Methods: With Rethink Mental Illness, we convened workshops exploring how to empower citizens, attended by people with lived experience of mental illness, organisations who advocate for policy and practice change, organisations who collect service user feedback, and citizen science researchers.

Results: We learnt that enabling citizens to make meaning from MHSN requires careful attention to supportive structures, as MHSN can describe distressing experiences, and citizens may lack knowledge on how to engage with content. We developed a preliminary change model with two central components: 1) mechanisms to elicit, curate, and analyse SU experiences; 2) mechanisms to influence decisions and change mindsets. Citizen may be supported to engage with MHSN through two frames of reference: 1) Utilitarian (using MHSN to identify practical changes to systems that create benefit); 2) Human rights (drawing on collection of MHSN to identify systemic abuses of human rights in mental health treatment). Training will be needed to enable citizens to work withing these frames of reference, and should be designed to provide a residual benefit to citizens. How to aggregate knowledge at scale is a central challenge, particularly given varied access rights for MHSN (from confidential to public).

Conclusion: Enabling citizens to lead the process of making meaning from mental health service narratives is achievable with care and adequate resourcing.

Findings from the C-STACS Mental Health Citizen Science Study

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Introduction

Mental health research can drive innovative approaches to providing care through mental health services. The Citizen Science To Achieve Coproduction at Scale (C-STACS) study explored the use of citizen science to create new mental health knowledge relevant to service provision.

Methods

We conducted four work packages (WPs) to understand, inform and develop a mental health citizen science programme. These were: a systematic review (WP1- https://doi.org/10.3389/fpsyt.2023.1175311); semi-structured interviews with people with lived experience of mental health, carers, mental health workers and researchers (WP2); and two proof of concept citizen science projects (WP3&4). WP3 and WP4 seek to understand the self-management approaches that people use in managing their mental health and what mental health recovery means to them. We further co-produced a theory of change model with stakeholders to evaluate and guide the citizen science projects.

Results

We developed guidance for reporting mental health citizen science projects to complement existing European Citizen Science Association guidance. Analysis of semi-structured interviews identified five broad themes on the use of citizen science in mental health: (1) Safeguarding, (2) Feedback, (3) Complexity of citizen science planning, (4) Implication of Citizen Science on mental health research, (5) Data Quality. The citizen science projects produced a list of common self-management approaches people use to manage their mental health and generated narratives describing what a recovery-oriented mental health system looks like to people with lived experiences of mental health problems.

Conclusion

We found that citizen science is a mechanism for developing inclusive participation in mental health research and practices but is resource-intensive and requires systematic planning and complementary IT infrastructure. The approach requires matching it with appropriate participatory approaches such as co-production to ensure the buy-in of stakeholders and planning for potential risks.

How to estimate need for mental healthcare in a psychiatric network?

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INTRODUCTION

Estimating the de facto use of mental health services and referrals to inpatient and outpatient treatment are essential components of population monitoring in ongoing healthcare reforms. These form the potential for a better understanding of the different care pathways used, and may provide care planners, clinicians, and stakeholders with essential information This study focuses on monitoring the number, nature, and types of referrals within a psychiatric healthcare network in Belgium and aims to track changes in the notified population, thereby providing a robust tool for population monitoring.

METHODS

The study implements a template-based approach to estimate patient referrals, referring symptoms, treatment sectors and treatment types, and delays in initiating treatment after referral. Data collection involves periodic monitoring of the number, nature, and specific types of referrals. This approach allows for the systematic observation and analysis of population dynamics and patterns. Additionally, the tool developed through this method serves as a means to track and evaluate evolutions in care pathways over time.

RESULTS

The estimated de facto proportion of referrals in the psychiatric network where the study took place was 3.9% per year on the level of the adult general population. Psychiatric hospitals and emergency rooms were major entry points for patients with emotional problems (46.6%). Anxiety and mood problems accounted for 41%, substance use for 25%, suicidal thoughts and behaviors for 13%, and externalizing problems for 3-4% of the referrals. 7/10 referred patients started treatment within a month upon referral. Patients referred to sheltered housing, community mental health centers, and mobile crisis teams had the longest delays in starting treatment.

DISCUSSION-CONCLUSION

The actual proportion of treatment need is estimated at 3.9% of the adult population. Monitoring service use and track changes in the notified population are key to ensuring equitable access and improving outcomes in mental health care.

Long-term Efficacy of Continuity-of-care Treatment Model for Severe Mental Illness Patients

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Background: Despite its significance, ensuring continuity-of-care demands substantial resources, which might not be readily accessible in many public healthcare systems. Studies indicate that continuity-of-care remains uncertain in numerous healthcare systems.

Aims: This study aimed to assess the effectiveness of a continuity-of-care model for patients with severe mental illness (SMI), providing seamless treatment from discharge from a closed word to subsequent psychiatric, psychological and rehabilitation services.

Methods: Data from patients discharged before (January 1st to December 31st, 2018) and after (June 1st, 2021, to May 31st, 2022) full implementation of the model were analyzed and compared in terms of average duration of hospitalization, emergency room visits within 90 days of discharge, rehospitalization rate within one-year post-discharge, and initiation of rehabilitation process.

Results: In the post-implementation period (n=482), compared to the pre-implementation period (n=403), the average admission time significantly decreased from 30.51±29.72 days to 26.77±27.89 days (p=0.029). Emergency room visits within 90 days following discharge decreased from 38.70% to 26.35% of discharged patients (p<0.001). The rate of readmission decreased from 50.9% to 44.0% (p=0.041) for once and from 28.3% to 22.0% (p=0.032) for twice in the year following discharge. Additionally, the proportion of patients entering formal rehabilitation increased from 7.94% to 12.03% (p=0.044).

Conclusions: This study highlights the effectiveness of a continuity-of-care model spearheaded by senior psychiatrists and involving paramedical personnel. These findings underscore the significant potential of the model to substantially enhance mental health services and outcomes. Moreover, they emphasize its relevance for patients, clinicians, and policymakers.

Definition of a guideline-based treatment for case vignettes using an expert-based Delphi process

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In the context of a new assessment of personnel requirements in psychiatry in Germany, minute estimates are to be made for the work activities of all professional groups in psychiatry. For this purpose, a guideline-based treatment should serve as the basis for the minute estimates. In order to be able to take detailed guideline-based treatment into account, catalogues of relevant guideline-based treatment options were created for 70 psychiatric case vignettes. For each case vignette, all potentially relevant guideline-based treatment options were rated by experts from all professional groups in psychiatry and by patient and family representatives using a two-stage Delphi process (RAND/UCLA Appropriateness Method). At the end of the Delphi process, all treatment options rated as relevant were compiled into a catalogue. Treatment options whose relevance was judged to be uncertain were listed separately. All irrelevant options were removed. In the next step, the catalogue of guideline-based treatment options will be used as a basis for estimating minutes of work for all professional groups in psychiatry. In conclusion, the expert-based Delphi method is well suited to derive evidence-based, guideline-concordant treatments for case vignettes as a basis for estimating minutes of work activities. Missing and outdated guidelines were a limitation.

Views and experiences of service users and family carers on mental health services in Australia

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Introduction: Service users and carers face barriers to accessing mental health supports. Learning from their experiences is crucial to identifying ways to innovate and implement system change. This study aims to explore the views and experiences of service users and carers on the services they have used for their mental health challenges and their suggestions for service reform.

Methods: A qualitative study was conducted of service users and carers. Data were analysed inductively using thematic analysis.

Results: Twenty participants (15 carers and 5 service users) were interviewed for the study. Eight categories emerged from the data. They were: Several gaps in the system, Barriers to accessing services, Services are not fit for purpose, Services operate in isolation, System is not person focused, Service users and carers are treated poorly, Services are overloaded and under resourced and Recommendations for service reform. Key findings included no services available to identify those who remained isolated and refused to leave their residence, no services for transgender people, a lack of information on community supports for those who were discharged from hospital, general practitioners were not considered part of the mental health team and personal recovery-oriented training was needed for mental health professionals.

Conclusion: The public mental health system in Australia for persons with severe and persistent mental health challenges has several shortcomings. A persistent lack of funding and resources for services are the root cause of these shortcomings. Additionally, innovations are needed to re-orient services to enable continuity of care and training of mental health professionals is needed for a better understanding of the needs of service users and their carers.

Recovery Colleges Characterisation and Testing in England (RECOLLECT): overview

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Background

Recovery Colleges are a relatively recent initiative within mental health services. They are based on principles of personal recovery in mental health, co-production between people with lived experience of mental health problems and professionals, and adult learning. Student eligibility criteria vary, but all serve people who use mental health services. Previously we developed a Recovery College fidelity measure and a preliminary change model identifying the change mechanisms and mental health outcomes for this group. The Recovery Colleges Characterisation and Testing (RECOLLECT) study is a five-year (2020-2025) research programme in England. The aim of RECOLLECT is to determine Recovery Colleges' effectiveness and cost-effectiveness, and identify organisational influences on fidelity and outcomes.

Methods

RECOLLECT comprises i) a national survey of Recovery Colleges, ii) a prospective cohort study to establish the relationship between fidelity and psychosocial outcomes, iii) a prospective cohort study to investigate effectiveness and cost-effectiveness, iv) a retrospective cohort study to determine the relationship between Recovery College use and outcomes and mental health service use, and v) organisational case studies to establish the contextual and organisational factors influencing fidelity and outcomes. The programme was developed with input from individuals who have lived experience of mental health problems. A Lived Experience Advisory Panel will provide input at all stages.

Discussion

RECOLLECT will provide the first rigorous evidence on the effectiveness and cost effectiveness of Recovery Colleges in England, to inform their prioritising, commissioning, and running. The validated RECOLLECT multilevel change model will confirm the active components of Recovery Colleges. The fidelity measure and evidence about the fidelity-outcome relationship will provide an empirically-based approach to development of Recovery Colleges, to maximise benefits for students.

Conclusion

Findings will shape policy on how Recovery Colleges can help those with mental health problems lead empowered, meaningful and fulfilling lives.

Two multisite studies on Recovery Colleges in England

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Introduction

Existing research on the benefits of Recovery Colleges for people who use specialist mental health services covers a small proportion of Recovery Colleges, and many are from single sites using uncontrolled cross-sectional or pre-post designs. No formal economic evaluation of Recovery Colleges exists, and costing studies have focused on the impact on service use, rather than wider potential economic effects, such as employment.

Methods

1) An uncontrolled multisite prospective cohort study (target n=625) 2) A controlled multisite prospective cohort study (target n=660).

Results

As these studies are ongoing, we will present methodological issues and how we have approached them, rather than results. Challenges with recruiting new service user students include the eligibility criteria of some Recovery Colleges; the rate at which they attract new students; the registration process; and students' willingness to disclose to staff that they use services and are therefore eligible. Recruitment of controls is influenced by the number of National Health Service mental health service providers with Recovery Colleges and the requisite IT infrastructure, and whether they have a process for advance consent to be contacted about research.

Discussion

Our study highlights the potential for multisite quasi-experimental designs when randomisation is not possible. However, the research and development infrastructure for this is only partially developed such that this potential cannot yet be fully realised.

Conclusion

The fidelity measure and the data gained concerning the fidelity-outcome relationship from the uncontrolled study can facilitate an empirically-based approach to the development of Recovery Colleges, to maximise benefits for students. The controlled study will also provide the first rigorous evidence on the effectiveness and cost effectiveness of Recovery Colleges, to inform their prioritising, commissioning, and running.

The impact of lived experience on the RECOLLECT programme

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Introduction

Patient and public involvement (PPI) is an important aspect of research but is often not implemented to its full extent.

Methods

RECOLLECT has a Lived Experience Advisory Panel (LEAP) of 10 individuals, who have been actively involved in the design, collaborative data collection and analysis of interview data, interpretation and feedback on quantitative data, and the dissemination of findings.

Results

A LEAP member will outline their experiences of RECOLLECT after involvement for 24 months, including their previous experiences of Recovery Colleges, why they joined RECOLLECT, and how the LEAP contributes and enhances the programme.

Discussion

Special attention will be paid to reflections on being involved in collaborative data collection and analysis of interviews exploring the impact of Covid-19 on Recovery Colleges.

Conclusion

This overview will provide a template to help researchers to fully collaborate with those who have lived experience

Contextual factors influencing Recovery College fidelity, mechanisms of change & student outcomes.

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Introduction: Recovery Colleges (RCs) are a relatively recent initiative within the mental health care system and currently established in 22 countries, internationally. Key principles include collaborative, strengths-based, person-centred, inclusive, and community-focused approaches, supporting people with mental health problems, their carers, and mental health staff via adult-education. Individuals with lived experience co-produce all aspects of the RC including curriculum development, quality assurance and delivering courses, alongside a trainer with topic-specific expertise. The aims of this study are to establish key contextual and organisational factors influencing fidelity and variation in outcomes and to finalise the RECOLLECT 2 multilevel change model.

Methods: This study encompasses a set of organisational case studies, utilising qualitative methods to assess the contextual and organisational factors influencing delivery and fidelity of six Recovery Colleges, as well as perceived outcomes for their students. Semi-structured interviews were conducted with RC managers, commissioners and other members of staff. A diverse group of current and former students were invited to Focus Groups (FGs) to explore perceived impact and outcomes of attending respective RCs. Collaborative data analysis involving LEAP members using framework analysis was employed, using NVivo in co-produced sessions. Cross-case comparison elaborates the key contextual and organisational factors influencing the delivery of service and explaining variation in access, fidelity and outcome.

Results: 10 members of staff in different roles were interviewed per RC. Up to four FGs of 6-8 participants per RC were conducted to represent varying groups of service users, carers and staff attending courses.

Discussion/Conclusion: Preliminary findings of the conducted interviews and FGs will be presented. Themes relating to the impact of RCs on their staff, students, and communities as well as variation in organisational aspects will be outlined and discussed in regard their influence on implications for future research and practice.

Adherence to manualised peer support for people with mental illness: the UPSIDES fidelity scale

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Introduction

Fidelity describes the extent to which an intervention is delivered as intended. Assessing adherence to core ingredients of peer support is vital for successful implementation and intervention delivery. Modifications to the implementation of peer support are needed when scaling up to different social, cultural and resource settings. There is a need to develop psychometrically sound scales which measure fidelity to established core principles of peer support. This presentation describes stages of development of the UPSIDES fidelity scale, and reports its psychometric properties.

Method

After construction, scale refinement involved site-level expert consultation, resulting in a service user and a peer support worker version. Both versions were translated into six languages and evaluated at six study sites across five countries (Germany, Uganda, Tanzania, India, Israel). The scale was piloted with a total of 315 participants (257 service users and 58 peer support workers). Psychometric evaluation included analysis of internal consistency, construct validity, and criterion validity.

Results

The final versions the scale consist of 28 items (service users) and 21 items (peer support workers) resp. Both are divided into two subscales (implementation and active ingredients). Item statistics showed a skewed distribution of fidelity values but no restriction of range. The scale showed good levels of internal consistency for both the service user and peer support worker version. The confirmatory factor analyses suggest acceptable fits of the proposed factor structures for both versions. Correlations with relevant external criteria were moderate to high.

Discussion

The UPSIDES fidelity scale is a feasible, reliable, and valid tool to assess fidelity to manualised peer support. The scale will advance process and outcome research on peer support, by supporting a multi-informant perspective on fidelity, enabling exploration of similarities and differences in fidelity ratings between providers and recipients of peer support.

Funding: EU H2020, GA 779263.

SP-07 | The international growth of peer support II: real-world effectiveness and cost-effectiveness - Chalotte HEINSVIG POULSEN, Copenhagen Research Center for Mental Health, Mental Health Center Copenhagen

Effectiveness of peer support for people with severe mental health conditions (UPSIDES-RCT)

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Background: Peer support involves a person in recovery from a mental health condition supporting others with mental health conditions. Some trials have evaluated peer support in high-income, mainly English-speaking countries, but the quality of the evidence is weak, and no trials have been conducted in low- or middle-income countries. This paper presents findings of a multi-centre randomised controlled trial testing whether participants who received UPSIDES peer support experienced improvements in social inclusion (primary outcome), empowerment, hope, recovery, and health and social functioning (secondary outcomes), when compared to a wait-list control group.

Methods: We report a pragmatic multi-centre parallel-group wait-list randomised controlled trial which tested the effectiveness of UPSIDES peer support at three measurement points (baseline, 4 and 8 months). Participants were adults with severe mental health conditions recruited at six study sites comprising two sites in Germany, and one each in Uganda, Tanzania, Israel, and India. The trial was pre-registered (ISRCTN26008944).

Findings: 615 participants were recruited. 305 were randomised to the intervention group, and 310 to the control group. Those allocated to the intervention group received an average of seven sessions of peer support over four months. Intention-to-treat analysis showed effects on two of the three subscales of the Social Inclusion Scale (SIS), Empowerment Scale, and Hope Scale. Per-protocol analysis showed an effect on the primary outcome.

Discussion: Peer support beneficially impacts on social inclusion, empowerment and hope of people with severe mental health conditions across diverse settings. As social isolation is a key driver of mental ill-health, and empowerment and hope are both crucial for recovery, peer support can be recommended as an effective component of mental health care.

Funding: EU H2020, GA 779263.

SP-07 | The international growth of peer support II: real-world effectiveness and cost-effectiveness - Chalotte HEINSVIG POULSEN, Copenhagen Research Center for Mental Health, Mental Health Center Copenhagen

Effectiveness of peer support for adults with ill mental health in a civil society setting (RCT)

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Introduction: We aimed to investigate the effect of a co-created “Paths to Everyday Life” (PEER) group intervention led by volunteer peers added to service as usual (SAU) targeting adults with mental health difficulties compared to SAU alone in a Danish municipality civil society setting.

Methods: A two-armed, investigator-initiated, multi-municipal, parallel-group superiority trial. Participants were randomly assigned to receive PEER added to SAU from Dec 2019 to Oct 2022. Participants allocated to PEER received a 10-week manualized group course and an offer of individual companionship for up to 6 months. SAU received either other municipal offers or no service. Follow-up on self-assessed questionnaires at the end of the intervention was finalized Feb 2023. The primary outcome was the self-assessed Questionnaire about the Process of Recovery (QPR-15) at the end of the intervention. The secondary outcomes were the Empowerment Scale, the Manchester Short Assessment of Quality of Life (MANSA), and the Work and Social Adjustment Scale (WSAS). Exploratory outcomes were the State Hope Scale (SHS), the General Self-efficacy Scale (GSE), the Self-advocacy Scale (SAS), and the modified Copenhagen Social Relations Questionnaire (CSRQ).

ClinicalTrials.gov identifier: NCT04639167.

Results: Of the 296 included participants, 145 participants received PEER + SAU and 151 participants received SAU. Intention-to-treat analysis showed an effect on personal recovery, functioning, and quality of life at end of the intervention. Results of the explorative outcomes showed an effect on general self-efficacy and hope. There was no statistically significant difference between the groups in relation to measures of empowerment, self-advocacy, and social relations.

Discussion: The group-based peer support intervention delivered by volunteer peers in a municipality civil society setting beneficially impacts the personal recovery of people with mental health difficulties. Implementation of the peer support group course following the principles of the PEER manual is recommended.

Funding: VELUX FOUNDATION [Grant number: 26723, 2019].

SP-07 | The international growth of peer support II: real-world effectiveness and cost-effectiveness - Chalotte HEINSVIG POULSEN, Copenhagen Research Center for Mental Health, Mental Health Center Copenhagen

Cost-effectiveness analysis of an international peer-support intervention: the UPSIDES trial

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Objectives

In the last decade, peer-support in mental health services gained raising international attention. Information regarding the cost-effectiveness of peer-support interventions in low-, middle and non-Anglophone high-income countries are lacking. This analysis tries to close this research gap, by analysing the cost-effectiveness of an international RCT – the UPSIDES trial.

Methods

Data was collected at six study sites in Germany, Israel, India, Tanzania and Uganda. Mental health services were assessed with the Client Sociodemographic and Service Receipt Inventory (CSSRI). Inpatient, outpatient, wellfare and justice services, as well as information about taken medication were collected. Quality of life was measured with the EQ-5D-3L and quality of life years (QALYs) were calculated, using the corresponding utility value sets. Difference in costs and QALYs were calculated and a cost-utility-ratio (ICUR) estimated. The trial was pre-registered (ISRCTN26008944).

Results

The intervention group generated about I$ 600 less costs in comparison to the control group and reached higher QALY values. It was not possible to estimate site level specific ICURs due to insufficient number of persons in each study arm.

Conclusions

No significant cost or QALY difference between intervention and control group have been detected. The point estimate is located in the lower right quadrant (intervention dominates treatment as usual), but did not reach statistically significance. Therefore, no clear conclusion regarding cost-effectiveness of the UPSIDES intervention is possible.

Funding: EU H2020, GA 779263.

Researchers access to linked health administrative databases in Sweden and Canada

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The researchers have access to the following linkable Swedish databases: i) National Patient Register (NPR, maintained by the National Board of Health and Welfare, inpatient and specialized outpatient care, diagnoses); ii) disability pensions and sickness absences from the MiDAS register (maintained by the Swedish Social Insurance Agency); iii) Prescribed Drug Register (PDR, maintained by the National Board of Health and Welfare, prescription drug purchases); iv) Causes of Death Register (maintained by the National Board of Health and Welfare; v) the LISA register (maintained by Statistics Sweden, demographic characteristics). All Swedish residents have been assigned a unique personal identification number which is utilized in the linkage of Sweden registers. For each study accepted by institutions ethics committees, researchers are provided with a pseudonymised large dataset for analysis.

The Quebec's Chronic Disease Surveillance System comprised the linkage through provincial health number of 5 databases: i) physician billing (specialists and GPs; settings, diagnosed, procedures); ii) hospital separations; iii) public medication insurance; iv) health plan registration (age; sex; local area; 98% of the population is registered); v) death and causes. Linkage is done by the physician billings agency and sent to the Quebec's public health institute (INSPQ) without personal identifiers of individuals. INSPQ officers operate the maintenance, updates and exploitation of the databases in the secure perimeter of Quebec's offices. The Quebec's Private Information Commission has authorized the exploitation of the databases by INSPQ for its surveillance of chronic disorders mandate, but also to collaborate with academic researchers and publicly funded research networks. Analysis can only be done in the secure perimeter in Quebec by INSPQ statisticians or vetted students and researchers; all outputs to outside academic research groups must be verified by INSPQ officers for confidentiality conformity to security rules.

SP-29 | The value of public health care systems large linked health administrative databases (registers) - Alain LESAGE, Centre de recherche Institut universitaire en santé mentale de Montréal

Real-world studies generating hypothesis for new treatment options

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Utilization of so called real-world data on effectiveness and safety of medications is increasingly popular. By combining data from dispensed medications, hospital admissions and diagnosis, and causes of death, the safety and effectiveness of medication use can be evaluated on a population-level. Real-world studies have presented their value: i) when investigating certain subpopulations which are excluded from clinical trials due to various reasons; ii). for detecting medication safety issues that have not been observed in randomized clinical trials, especially concerning long-term risks; iii) revealing new insights on effectiveness of medications. Recent published examples with Sweden registers include borderline personality disorder and (met)amphetamine use disorder which both lack indicated pharmacotherapies for their treatment.

Most patients with borderline personality disorder receive psychopharmacological treatment although clinical guidelines lack consensus on the role of pharmacotherapy. From Swedish nationwide registers, we identified all patients diagnosed with borderline personality disorder and followed their treatment outcomes with various medications. All major psychopharmacotherapies were associated with an increased risk of psychiatric hospitalization or suicide attempts/ death, including antipsychotics, antidepressants and benzodiazepines. However, treatment with ADHD medications was associated with decreased risk of psychiatric hospitalization, all-cause hospitalization/ death and suicide attempt/ death. The use mainly consisted of stimulant medication.

There are no medications approved for the treatment of amphetamine dependence. By utilizing Swedish registers, we investigated treatment outcomes among patients diagnosed with amphetamine use disorder when using vs. not using specific psychopharmacotherapies. Most promising results were found to be for a stimulant medication which was associated with decreased risk of hospitalization due to substance use, all-cause hospitalization/ death and all-cause and overdose-related mortality.

Both studies challenge current clinical guidelines and conceptualisation of substance use disorders psychopathology as chronic diseases.

SP-29 | The value of public health care systems large linked health administrative databases (registers) - Alain LESAGE, Centre de recherche Institut universitaire en santé mentale de Montréal

Quebec's i) surveillance of ECT and ii) large urban areas equitable resources allocation indicator

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Electro-convulsive therapy (ECT) remains now a controversial treatment for refractory severe depression. In 2003 the Quebec's Health Technology agency (now INESSS) conducted an effectiveness and social acceptability assessment at the request of the Ministry of Health. The report confirmed the evidence of short-term efficacy, comparable utilisation rates internationally and regional diverse rates of utilization. It recommended constant surveillance in real life, collaboration with patients' groups and continued professional development. In 2011, mental health university institutes created a center of excellence on ECT (CEECTQ) to meet some recommendations. Its advisory committee included the College of Physicians, the Patient Ombudsman, Schizophrenia Society's parents, patient with lived experience with ECT. Reports and papers by INSPQ and CEECTQ showed a decennial decrease in utilisation: in 2017-2018, 1 000 people received ECT, 14,9 persons/100 000 inhabitants; during the same period, each year, over 900 000 persons out of a population of 8 millions inhabitants, received treatment for mental disorders: ECT is an exceptional treatment.

In a paper on schizophrenia and environment Pr Jim Van Os (also ENMESH2024 keynote speaker) discussed the higher incidence of schizophrenia in large urban areas as not due so much to the higher specialist services availability or drift to downtown. In any case, the prevalence is higher in urban areas and shall better indicate higher costly psychiatric services needs (hospitalisation; long term care facilities; intensive community care). The CCDSS interactive databases for schizophrenia indicate a 1% prevalence in Canada, with higher prevalence in the 3 provinces with large urban cities (Montreal; Toronto; Vancouver). Comparisons of Montreal (25% of Quebec's population) with the rest of Quebec indicate 50% higher incidence and 60% higher prevalence of schizophrenia. An indicator of need more easily accessible for planning and allocating financial resources for the array of services required by severely mentally ill.

How Recovery-Oriented is the Content of Intakes? Recovery Oriented Intake vs. Intake as Usual

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Introduction

The Recovery Oriented Intake (ROI) was developed in 2017 to apply recovery oriented principles from the beginning of treatment. The present study examines to what extent the focus on recovery during the ROI translates into its actual documentation. Specifically, if there is a difference between the ROI and intake as usual (IAU) in how thoroughly all recovery domains are assessed and how well the collected information is integrated into clients' case conceptualization and translates into measurable treatment/recovery goals. Finally, differences between ROI and IAU patients' experiences are examined of how these goals are formulated and to what extent they are achieved during treatment.

Methods

A total of 58 clients' screening and intake reports (ROI: 29 patients; IAU: 29 patients) were randomly selected and examined by the primary researcher. An independent researcher also rated a subset of these reports to determine interrater reliability. Reports were rated according to the following elements: i) number of aspects addressed, ii) level of detailedness and thoroughness per aspect, iii) global score of the overall use beyond the biopsychosocial model, and iv) quality of the treatment/recovery goal(s). Further, both ROI and IAU patients were interviewed about their process of (collaborative) goal formulation and achievement.

Results and conclusion

Preliminary results and implications of this study will be presented for the first time during the symposium.

Timely Adjustment of Treatment: When and How do We Stop or Change our Treatment Approach?

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Introduction

In specialized mental healthcare a group of patients does not recover well, despite prolonged periods of intensive specialized mental health care. In order to prevent long-term treatment stagnation in this group, the project 'Timely Adjustment of Treatment' was started in 18 specialized mental health-care teams. Goal of this project was to overcome stagnation by identifying those individuals at risk of treatment stagnation and offer periodic assistance to the treatment team of selected patients by an external expert.

Methods

Mental health-care professionals identified several indicators that could point at treatment stagnation in patients receiving care for more than 2 years. These include:

- lack of improvement on measures of symptomatic, societal and/or personal recovery

- treatment coordination meetings between professionals more often than once a month during the last year

- frequent patient – therapist contact (> 25 hours in the last year)

- one or more inpatient admissions

- polypharmacy (>= 3 pharmaceutical interventions)

A dashboard was developed to present information about patients with three or more treatment-stagnation indicators. Teams were encouraged to select patients for which they needed external consultation, often resulting in recovery-oriented diagnostics, treatment adjustment or a treatment closure process. Furthermore, all professionals were trained in how to complete treatments and gained insight into which patient, therapist and organizational factors contributed to their decisions to stop or continue treatments.

Results and discussion

During this project both subjective outcome measures, including professional attitude regarding treatment completion and adjustment, as well as objective measures, including the number of stagnated treatments, were monitored. These preliminary project-evaluation results will be shown and discussed. A secondary gain of this project was that teams also gained insight into patients showing a stable recovery process which may facilitate the discussion to determine the right time to complete individual treatments.

The Learning Organization KNOWS: KNOWledge Sharing Together. An Evaluation.

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Introduction

In September 2017, GGZ Noord-Holland-Noord introduced the 'Specialists Together in the Community' (STIC) model. The model involved a restructuring of FACT teams and treatment centers into a district-oriented, integrated approach in which specialized expertise is assured. Alongside STIC, the organization implemented KNOWS (Knowledge Sharing Together) to maintain and increase expertise through expert networks. An earlier evaluation identified the need to revise KNOWS for better specialized knowledge utilization.

Methods

The systematic evaluation aimed to collect experiences and improvement suggestions to enhance the learning network for all users/employees. Using both qualitative and quantitative methods in three phases, the evaluation included i) an online questionnaire, ii) focus groups, interviews, and iii) dialogue sessions.

Results

Results revealed employees' belief in GGZ NHN's expertise and a strong willingness to invest in learning. Learning needs, particularly among nurses and counselors, also became evident. Preferred knowledge-sharing methods included consultation and co-treatment. However, concerns were raised about the number, overlap, and varying quality of expert networks. Diagnosis-focused networks were seen as the most useful. Five dilemmas emerged, with the key contradiction being between the valued diagnosis-focused networks and the transdiagnostic recovery-oriented approach. Currently, ongoing dialogue sessions in the third phase are addressing these dilemmas.

Discussion

In summary, the evaluation reveals a rich pool of expertise within GGZ NHN, coupled with a commitment to learning. The identified dilemmas form the basis for ongoing discussions, contributing to the organization's dedication to continuous improvement in knowledge-sharing practices. The findings will provide insights into potential solutions and improvements for KNOWS. The ultimate goal is continuous enhancement through a Plan-Do-Check-Act (PDCA) cycle. The organization plans to present the outcomes, including developed solutions, at the conference.

Impact of Recovery-Oriented Training on Working Behavior of Family & Youth Recovery Coaches

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Introduction

The recovery expert network was established to advance recovery-oriented practices. To actualize the recovery vision across all divisions, the expert network collaborated with peer experts and other stakeholders to design the training program 'Recovery: From Paper to Practice.' The ambition of the expert network is to deliver this training to all teams. The Youth & Family Division took the lead among the three divisions and trained recovery coaches within all their teams with the goal of catalyzing the recovery movement throughout the entire division. The objective was to assess the impact of the recovery training on coaches' work practices and to understand the factors that facilitate or impede coaches from adopting different approaches in their practice.

Methods

The Success Case Method was applied to measure the impact of the training, which involves making changes in work practices, leading to tangible and valuable outcomes. After the training, recovery coaches completed a questionnaire regarding their work behavior and participated in interviews discussing factors contributing to the impact.

Results

Almost all recovery coaches shared impact stories, citing specific changes in their work practices. The variations primarily lied in the extent of tangible results achieved by each participant and whether these changes were predominantly at an individual or team level.

Discussion

The operational goals of the division have not been fully realized; however, through the division-wide training of recovery coaches, a movement has been set in motion to advance the development of recovery-oriented work within the Youth & Family Division.

Mental health supported accommodation services- what works and what more do we need to know?

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This presentation will provide an introduction for the subsequent presentations in this symposium. I will give an overview of the different types of mental health supported accommodation that have been developed internationally since the deinstitutionalisation era of the 1990s, and the evidence for their effectiveness. I will highlight findings from the literature that provide evidence for specific approaches or interventions in mental health supported accommodation that are associated with better client outcomes and that therefore inform what best practice in these service should encompass. I will also also summarise the limitations of the studies to date, including the importance of taking account of the socioeconomic, political and cultural context of the varied study settings. Finally, I will provide a brief summary of the areas where further research is needed to inform practice and service development in this field.

Performance of step progressive care pathways in Italian supported accommodation services

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Background

In Italy, a growing number of people with severe mental illness (SMI) require care in residential facilities (RFs), a key component of the care pathway. However, despite their development, studies about resident samples have been very few.

This study, the VALERE-REC Study (eVALuation of outcomE in Residential - use of clinical data with REsearch objeCtives) aims to identify the characteristics that increase the probability to move patients living in RFs to a more independent setting.

Methods

A survey involved 167 patients hosted in 25 RFs of the Verona Mental Health Department. Forty-five patients were residents (27%) in Comunità Terapeutico Riabilitativa Protetta (CTRP); 56 (34%) in Comunità Alloggio (CA), 14 (8%) in Gruppo Appartamento Protetto (GAP), 52 (31%) in Comunità Alloggio Estensiva (CAE). They were assessed for their care pathway after 30-months. The Quality Indicators for Rehabilitative Care – Supported Accommodation (QuIRC-SA) evaluated the quality of 19/25 (76%) RFs. Descriptive analyses were done.

Results

According to the mission stated by the Veneto Region guidelines, RFs hosted patients with different needs and clinical profiles. The mean stay was longer than expected, most patients were unemployed, unmet needs were related to self-management and patient's social contacts, and recovery-oriented practices were not implemented.

Conclusions

Despite the appropriate admission of patients in different RFs considering their psychopathology, functioning, and needs, the progressive step care pathway did not result effectively pursued. To improve the effectiveness of residential interventions a major task should be to focus on the acquisition of the necessary skills to live independently

Development and evaluation of the `Everyday Life Rehabilitation´ model in supported housing context

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(This abstract is part of the symposium entitled: Complex mental health supported accommodation services across Europe)

Background: Persons enduring complex psychiatric disabilities and impaired autonomy, living in supported accommodations, generally lead sedentary, solitary lives, indoors, and have significantly poorer health than others in the population, while additionally, they do not have access to equitable and cost-effective health care, including rehabilitation efforts. Engagement in everyday activities, is important for the recovery towards a meaningful and active life, but difficult to sustain in supported accommodations.

Methods: Against this background of activity-deprivation and health-inequity, the Everyday Life Rehabilitation (ELR) model has been designed and evaluated in different phases, and the program theory has been revised in iterative processes, involving stakeholders, and carefully considering the context. ELR is a person-centered, activity- and recovery-oriented intervention-model, designed for the context of integrated, personalized, long-term, and time-set rehabilitation for residents living in supported accommodations, supported by active collaboration between the resident, occupational therapist, and housing staff. ELR includes a web-based training package for housing staff, rehabilitation staff, and housing managers, as well as tools for collaboration, and methods for collegiate learning.

Results: ELR has shown significant outcomes in feasibility studies, and currently an RCT is underway in northern and middle Sweden, for the purpose of establishing the effect of ELR, along with cost-effectiveness. In parallel, qualitative studies and process evaluations are conducted to explore the usefulness and implementation aspects of ELR.

Preliminary results will be presented and discussed, in light of residents´ personal recovery pathway, and quality of life. Additionally, implementation and organizational readiness will be illuminated.

Discussion: This project offers insights into the significance of engaging in meaningful activities for the personal recovery process.

Effectiveness of psychiatric outreach teams for supported accommodation in Denmark

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Background: People with severe mental illness living in supported accommodation often have a diagnosis of schizophrenia with complications such as treatment resistance, substance use, and physical health comorbidities. The complex needs of this population underline the need for interventions that effectively coordinate health care treatment. However, supported accommodation is generally staffed by employees with a non-medical background. The Capital Region of Denmark has established psychiatric outreach teams to improve the coherence of support between mental health care and supported accommodation services. This study aimed to investigate the clinical effectiveness of psychiatric outreach teams for people living in supported accommodation.

Methods: We used a mirror-image design to compare outcomes occurring before the index date (the implementation date of the psychiatric outreach teams) with outcomes after the index date. Pre-index outcomes were collected at the beginning of September 2020, and post-index outcomes were collected every six months until two years of follow-up. Outcomes included antipsychotic polypharmacy, antipsychotics in combination with benzodiazepines, high-dose (above-recommended level) antipsychotic treatment, and substance use. Furthermore, we examined the proportion of people with untreated or dysregulated physical disease who needed further examination or treatment by their general practitioner or at the hospital.

Results: A total of 74 individuals have been included in this study. Results are expected soon and will be ready to be presented at the ENMESH conference. We expect that the introduction of psychiatric outreach teams will improve the quality of pharmacological treatment, reduce the number of individuals with substance use, and facilitate access to treatment for physical disease.

Conclusions: This study will generate new knowledge on whether psychiatric outreach teams for supported accommodation can improve clinical outcomes for individuals with severe mental illness living in supported accommodation.

Barriers to implementing scalable mental health interventions. The M(H)IND project inSouth Sudan

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Introduction: The M(H)IND [Mental Health INtegrated Development] initiative aims to contribute to the achievement of Sustainable Development Goal No. 3 with regard to its mental health component (Overall Objective). The project, lasting three years, is carried out by Amref Health Africa in partnership with Caritas, BBC Media Action, and the University of Verona. It aims to fight stigma, establish dedicated community-based and clinical services, and build the capacity of social and health personnel to offer mental health care. The research component aims to evaluate the real-world effectiveness and scalability of the WHO's psychological intervention named "Self Help Plus" (SH+) in South Sudan, where it will be implemented for the promotion of mental health and psychological wellbeing in the general population. Secondary aims include the evaluation of the implementability of SH+ and its degree of fidelity, as well as assessing factors associated with its implementation and effectiveness. Methods: A prospective hybrid type-1 non-randomized follow-up study design will be used in a large-scale, nationwide intervention (expected N > 5000). Each participant will undergo a baseline assessment before taking part in the SH+. A follow-up evaluation will take place immediately after the completion of the intervention. Measures include: the Kessler Psychological Distress Scale (K6); the World Health Organization-Five Well-Being Index (WHO-5); the Patient Health Questionnaire-9 (PHQ-9); measures of appropriateness, feasibility, and acceptability. Results: Qualitative and quantitative results from the formative research will be presented. A summary of the general and country-specific barriers to implementation will be presented following the researchers' in-loco field mission in the areas of intervention. Conclusion: Scalable mental health intervention models are needed for emergency settings, low-income countries, and countries with no or very limited mental health care systems. Common and country-specific barriers can hinder the implementation of effective, scalable models.

Improving access to mental health care through a revision of the who list of essential medicines

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Introduction:

Despite the huge burden related to mental disorders, there is a huge treatment gap, especially in low- and middle-income countries. The WHO Model Lists of Essential Medicines (EML), updated every two years, aims to support countries in selecting a list of medicines that are considered essential for a basic health-care systems. However, the mental health section has seen limited revisions in the past 45 years. Aiming to address this gap, a proposal for a comprehensive revision of the entire mental health section was submitted to the WHO Expert Committee in 2022

Methods:

We submitted nine evidence-based applications to the WHO Expert Committee on the Selection and Use of Essential Medicines in December 2022, advocating for a substantial revision of the WHO EML mental health section. We conducted systematic reviews of the literature, meta-analyses and network meta-analyses on safety and effectiveness, GRADE assessment of the certainty of evidence, and cost-effectiveness evaluations.

Results:

All nine applications on psychotropic medicines for mental disorders were accepted by the WHO and contributed to the update of the EML. For psychotic disorders, first and second-generation antipsychotics were added. Substantial changes were made for mood and anxiety disorders as well, with the addition of second-generation antipsychotics for bipolar disorder and the removal of old tricyclics for depression and the addition of SSRIs to the option for obsessive-compulsive disorders. The list of benzodiazepines was also reduced to diazepam and lorazepam.

Discussion-Conclusion:

The comprehensive revision of the WHO EML mental health section will enhance access to the most effective, safe, and cost-effective medicines for mental disorders worldwide. Implementation of the proposed changes signifies a pivotal step toward ensuring that individuals worldwide have access to optimal treatments for mental health conditions, fostering a more inclusive and equitable approach to mental health care on a global scale.

Personalizing care for people with common mental disorders: a meta-analytic approach

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Introduction: The global burden associated with common mental disorders is high, especially for people living in low resource settings. Although psychosocial interventions delivered by locally available lay or community health workers are effective, mechanisms of intervention response are poorly understood. Our aim is to systematically review all the randomized controlled trials (RCTs) that have tested the efficacy of psychosocial interventions delivered through the task shifting modality to treat people suffering from common mental disorders (depression, anxiety, and related somatic complaints), dismantle the intervention protocols creating a taxonomy of active intervention components, and re-evaluate their efficacy.

Methods: We will use the component network meta-analysis (cNMA) methodology. cNMA increases statistical power by combining direct and indirect comparisons while respecting the randomized structure of the evidence. According to the additive cNMA model which we will implement, adding a component “c” to a composite intervention “X” will lead to an increase (or decrease) of the effect size by an amount only dependent on “c”, and not on “X”. We will denote the corresponding component specific incremental standard mean difference (iSMD) so that iSMDc = SMD(X+c) v. (X). Combining these component-specific iSMDs will allow the estimation of SMD between any two composite interventions.

Results: A network of comparisons and a hierarchy that includes all intervention components expressed as iSMD, indicating the added benefit of adding a component to an intervention, will be presented.

Discussion/Conclusions: By selecting the most effective components it will be possible to outline a novel task shifting psychosocial intervention to be tested in future RCTs. These findings will set the basis for further investigations in the field of precision medicine.

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The Recovery College model as a collaborative space for learning and building capabilities

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Introduction: The Recovery College (RC) model is an innovative approach to mental health education, providing a collaborative learning environment within an adult education program. The learners collectively learn and empower themselves to better address issues of psychological well-being and mental health. The RC model defines four mechanisms of action operating within the training program to achieve the desired outcomes. These mechanisms are linked to a variety of learning models which represent the main focus of this research. This research aims to explore how learners who have participated in RC training courses describe their learning experience. Findings will be compared to existing models of learning in educational science and ergonomics, particularly through work on adult education.

Methods: This qualitative research is based on a secondary analysis of 28 interviews with RC learners in Quebec (Canada). Data are analyzed using an inductive approach and Goldsmith's (2021) qualitative research analysis framework.

Preliminary results: Learners on RC training courses report a rewarding learning experience, emphasizing its enriching content, collaborative, safe and egalitarian relationships, and mutual support among learners. They appreciated the interactive and participatory approach, which focused on lived experiences, different types of knowledge and fostered empowerment and enhanced mental health skills.

Conclusions: The discussion explores how RC integrates elements of different learning models and their impact on mental health recovery. It proposes a preliminary positioning of the RC model, highlighting its potential role in improving mental health pedagogical methods and supporting individuals' recovery journeys.

SP-20 | Understanding the effects of the RC model: a learning space with different results - Julie BELLEMARE, Centre de recherche de l'institut Universitaire de Santé Mentale de Montréal / Université du Québec à Trois-Rivières

Identifying outcome groups in Quebec's Recovery College learners using cluster analysis

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Introduction

In the face of mental health challenges and the global reduction in funding for mental health services, innovative health promotion strategies are imperative. Since 2020, in response to this situation and during the pandemic, the Health and Recovery Learning Center (Recovery College model, Perkins et Repper, 2017) has been delivering online training courses. A study conducted on a sample of 315 participants showed promising results: 1) significative effects on wellbeing, anxiety, self-esteem/self-efficacy, disclosure/help-seeking; and 2) a slight effect on resilience and optimism/control over the future (Briand et al., submitted). However, given the diverse groups of learners (people with lived experience, family members, healthcare workers, managers, citizens), examining specific outcome trajectories is the next step in better understanding the effects of the Recovery College model. The aim of the present study is to identify different set of outcomes according to learner profiles.

Methods

This pre-experimental study used a one-group pretest-posttest design with repeated measures. Each participant was assessed before attending the course (T0), after completing the course (T1) and three months in follow-up (T2). Data were collected across 10 training sessions delivered between December 2020 and October 2023. Self-administered assessments were used to measure wellbeing, anxiety, empowerment, self-management, stigma and resilience. To identify sets of outcomes, a k-means type clustering algorithm was used. Once the clusters were obtained, descriptive statistics for each outcome set were computed to depict clusters' meaning.

Results

548 participants were included in the study. The expected results are to identify various set of outcomes and different learner profiles, and thus better understand the effects of Recovery College on diverse groups of learners, with various experiences.

Discussion

The results provide useful information for understanding the RC model, which promotes a mix of learners. Depending on learner's characteristics, specific outcomes can be expected.

SP-20 | Understanding the effects of the RC model: a learning space with different results - Julie BELLEMARE, Centre de recherche de l'institut Universitaire de Santé Mentale de Montréal / Université du Québec à Trois-Rivières

The Recovery College model perceived as a transformative tool for recovery-oriented interventions

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Introduction:

When implementing recovery-oriented interventions, healthcare professionals need support to adopt and adhere to best practices (Piat et al. 2022). Recovery-oriented interventions involve different dimensions of professional practice: values, attitudes, skills, specific interventions, etc. (Shepherd et al., 2008). The Recovery College (RC) training model can be used as a tool to support reflection and changes in professional practice (Perkins et Repper, 2017). Although the effects of the RC model are widely documented (Briand et al. in preparation), few studies focus on the effects of training on healthcare professionals' knowledge, skills, attitudes, and practice.

Objective: The aim of this exploratory study is to document 1) the experience of healthcare professionals who have participated in online RC training courses, 2) the perceived effects on their professional practice and 3) their understanding of the model's principles and mechanisms of action.

Method: Participants were 13 healthcare professionals working in community-based organizations or healthcare institutions in Quebec. Data were collected through semi-structured interviews and analyzed using Miles and Huberman's stepwise content analysis method.

Results: The results support the use of the RC model to develop and nurture recovery-oriented interventions. Participation in RC supports reflection on professional's relational stance and attitudes, as well as several reported changes in professional practice. Healthcare professionals increased their understanding of people's needs, reduced their implicit biases, acquired new tools, and recognized the value of experiential knowledge and self-determination. Taking part in RC also enabled personal growth, leading to actions that promote health and well-being.

Conclusions: RC courses are described by healthcare professionals as being different from the training courses usually taken. Participants explain the perceived benefits in terms of the principles and mechanisms of action of the RC model, i.e. the heterogeneous composition of learning groups, the egalitarian stance, and the complementarity of theoretical, clinical and experiential knowledge.

Friday 5 July

The RADAR trial: methods and results

Maria LONG[1,5], Joanna MONCRIEFF[1,5], Stefan PRIEBE[3], Nadia CRELLIN[1,4], Jacki STANSFELD[1,5], Ruth COOPER[1,2], Nicola MORANT[1]

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Introduction

Long-term antipsychotic treatment is the standard treatment for people diagnosed with schizophrenia and similar, recurrent psychotic conditions. It has been shown to reduce rates of relapse but most trials involve abrupt discontinuation. Antipsychotic medication also has significant side effects so minimising unnecessary exposure is important. The RADAR trial was a randomised trial set up to evaluate the effects of gradual reduction of antipsychotic medication compared to maintenance treatment. The trial included qualitative studies of participants' and carers' experience of the antipsychotic reduction process, and had a Lived Experience advisory panel. This presentation sets out the main results of the study as context for the lived experience aspects of the trial.

Methods

The RADAR trial consisted of a randomised, open trial comparing gradual antipsychotic reduction to maintenance treatment in people diagnosed with schizophrenia and related conditions. The primary outcome was social functioning. Relapse, symptoms, quality of life and other outcomes were assessed. The final follow-up was at two years. Assessments and analysis were conducted blind.

Results

The trial enrolled 253 participants. Results showed relapse rates were higher in the reduction group compared to the maintenance group, with no differences in social functioning or other outcomes. However, only a minority of people who reduced or stopped antipsychotics relapsed. New data on the relationship between relapse and social functioning will be presented.

Discussion

Results were consistent with other studies that show increased risk of relapse following reduction and discontinuation of antipsychotics over the short-term. No benefit of antipsychotic reduction was shown in the current trial. The trial results can inform people's decisions about whether to take or continue on long-term antipsychotic treatment. A long-term follow-up is in process.

Experiences of gradual reduction / discontinuation of antipsychotic medication in the 'RADAR' trial

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[5]Service user and independent peer researcher, London, United Kingdom

Introduction

Little is known about users' experiences of gradually reducing and potentially stopping antipsychotic medication when this is done gradually with clinical guidance. The 'RADAR' randomised controlled trial (RCT) (results of which are presented by Moncrieff in the same symposium) provided a unique opportunity to investigate these experiences. Participants with recurrent psychosis in the trial intervention arm gradually reduced and sometimes discontinued their antipsychotics over a two year period.

Methods

Semi-structured interviews were conducted at trial end with 26 people sampled purposively for diversity in sociodemographic characteristics, trial variables, and pre-trial medication and clinical factors. Data were analysed using thematic analysis.

Results

Experiences of antipsychotic reductions over two years were dynamic and diverse. Most participants reported reduced adverse effects with dose reductions, primarily in mental clouding, emotional blunting and sedation, and some positive impacts on social functioning and sense of self. Over half experienced mental health deteriorations, of whom nine had a psychotic relapse. Medication reduction as an explicit part of clinical care was often experienced as novel, and the trial provided various learning opportunities. Some participants were highly engaged with reduction processes, and despite difficulties including relapses, developed novel perspectives on medication, dose optimisation, and how to manage their mental health. Others were ambivalent about reduction or experienced less overall impact.

Discussion

Service users reported a complex array of challenges, benefits and new insights related to antipsychotic reductions. Findings show how qualitative investigations of participants' experiences complement quantitative trial findings and provide pointers to future research about who may be most suitable for dose reduction attempts and how to successfully implement reduction processes. Together with quantitative trial results, findings add to the evidence base that clinicians and service users seeking to optimise antipsychotic medication can draw on.

Family and informal carers' views and experiences of antipsychotic reduction / discontinuation

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Introduction

Family members and informal carers play important roles in supporting or monitoring medicine-taking for people with schizophrenia and associated disorders. However, their views on antipsychotic medication are under-researched, particularly in relation to reduction processes that are gradual and clinically guided. This study explored family members' views and experiences of gradual antipsychotic reduction / discontinuation within a medication reduction research trial.

Method

Semi-structured interviews were conducted with 15 family/informal carers of people with recurrent psychosis who reduced / discontinued antipsychotics with clinical guidance over 24 months as part of the 'RADAR' randomised controlled trial. Data were analysed using thematic analysis.

Results

Most carers observed improvements in social engagement, daily functioning or identity when their loved one started reducing antipsychotics. Some experienced challenges related to mental health deteriorations or relapses in the person they cared for. Carers described a state of vigilance about their loved one's mental health that was heightened during the medication reduction period. They often felt they were better able to detect warning signs of deterioration than clinicians. Many carers wished they had known about the trial earlier and been more involved. Some expressed cautious optimism for future clinically guided medication reductions, although complete discontinuation was deemed less viable by many.

Discussion

The study highlights the importance of family/informal carers' knowledge and support in medication management. Carers bring valuable perspectives that differ from those of both service users and clinicians. Findings suggest that services should endeavour to include carers' views in decisions about, monitoring and support of changes or reductions to antipsychotics.

Understanding the experiences of family, friends and carers attending Recovery Colleges

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Introduction Recovery Colleges take an educational and recovery-orientated approach, offering co-produced courses to mental health staff, service user family, friends, and carers. Studies have demonstrated benefits for students in general, but do family/friends/carers experience Recovery Colleges in the same way, and can they be made more relevant or accessible for them?

Methods Through exploring the experiences of family, friends and carers as well as staff at Recovery Colleges, we aimed to identify perceived benefits and contributors to these, to inform practice.

Family, friends and carers and Recovery College staff were recruited from different Recovery Colleges across England, to attend online focus groups/interviews. Questions were codesigned with a family/friend/carer co-researcher. Transcripts were analysed collaboratively with two family/friend/carer co-researchers using thematic analysis. Findings were presented in an interactive webinar to gain further insights about how Recovery Colleges implement findings.

Results Thirteen family/friends/ carers and ten Recovery College staff with varied characteristics participated. Six key themes were developed; 'What is a carer?', 'Benefits of sharing lived experience', 'Educational focus is appealing', 'Recovery ethos applies to family, friends and carers too', 'Family, friends and carers deserve recognition and provision', 'Reaching out to family, friends and carers'. Participants shared how attending courses gave them new understandings, caring and wellbeing strategies, for themselves and those they cared for. Importantly, family carers described the College as supporting their own personal recovery journeys. Learning alongside service users was beneficial, but Colleges need to recognise carers specifically. Colleges should raise awareness about what a Recovery College can offer, to make this available to more family, friends and carers.

Conclusion The identified needs of family, friends and carers aligned well with the unique characteristics of Recovery Colleges. Further resources and increased awareness are required to further develop this potential for supporting more family, friends and carers in their own recovery.

Creating 'consumer Choice' through co-design. Lessons learnt

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Introduction

Although co-design is becoming common practice in the development and design of mental health services, the focus tends to be on why it is important rather than on what to do and how to do it. In 2021, the Victorian Department of Health, Australia funded a pilot initiative aimed to improve the exercise of meaningful choice for consumers in a local adult mental health inpatient setting. The first stage of the pilot involved a comprehensive multi-phase consumer-led co-design process. This presentation will discuss the practicalities and participant views of the co-design process which was conducted during the peak of the COVID-19 pandemic in Melbourne, the world's most locked down city.

Method

The co-design approach undertaken aimed to engage and empower various stakeholders, address any power imbalance, in particular between staff and consumers, and participation challenges due to COVID-19 restrictions. The approach included workshops, an education day, and a pre- and post- workshop survey. Participants included consumers, carers and mental health care staff and was led by a consumer project officer.

Results

Although the project team sought to use a holistic and inclusive approach, gaining a broad range of views was challenging resulting in poor representation. Consumers and carers who participated reported feeling "seen and heard" but noted a lack of staff involvement and staff views.

Discussion/Conclusion

The team was cognisant of their efforts to ensure consumers and carers felt empowered to participate, however, on reflection, it appeared this resulted in a lack of 'buy-in' and participation by staff. Our findings highlight how efforts to address a power imbalance between two groups can result in a reversal of power. We conclude that successful co-design and project implementation should be sensitive that empowering some can disempower others. We recommend an iterative, reflective process to address such challenges as they arise.

Supported accommodations for people with serious mental disorders: care pathways and experiences

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Introduction

Supported accommodations (SAs) are key to community mental health care, but little is known about residents' care pathways and the experiences and expectations of residents and professionals of SAs. This study aimed at analysing the care pathways of residents of SAs in Portugal and factors associated with their age of entry and length of stay; and, to explore the experiences and expectations of residents and professionals regarding the care provided by SAs.

Methods

On a first step, a random sample of 213 residents of 43 SAs responded to a specifically developed questionnaire aimed at assessing their care pathways. Associations between sociodemographic and clinical characteristics, age of entry, and length of stay, were analysed using hierarchical regression. On a second step, a purposeful sample of 11 residents and 11 professionals from 11 different organisations managing SAs were included. Semi-structured interviews were conducted to explore their experiences and expectations and thematic analysis was used.

Results

Most residents were male, single, pensioners, and had early-onset psychotic disorders. On average, they integrated the current SA at around 50 years old and had a 4.5 year length of stay. Most had been in another SA before and expected to stay at the SAs in the long term. Most residents were satisfied with care, while professionals suggested several improvements, such as having more time allocation to work with the residents and revising limits of lengths of stay.

Conclusions

Findings suggest that residents spend several years in the residential pathway, with a significant proportion moving to more supported SAs; they are seldom involved in decision-making; and, most hoped to remain in the SAs. Implications apply to the political level (regarding the financing of SAs and the provision of community mental health care and other social supports) and the clinical level (regarding training and family interventions).

What impact did the COVID-19 pandemic have on the delivery of early intervention psychosis services?

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Background: The COVID-19 pandemic brought challenges for early intervention psychosis (EIP) services. In Australia, the first nationwide lockdown occurred in March 2020. Evidence on the impact of COVID-19 on treatment outcomes among EIP clients remains limited.

Methods: This prospective cohort study analysed routine data from 15 headspace Early Psychosis programme centres in Australia. Participants were 12 to 25 years, meeting criteria for First Episode Psychosis (FEP) or Ultra High Risk of psychosis (UHR) comparing those who commenced treatment 'pre-COVID-19' (between 16th August 2018 and 15th August 2019), and 'during-COVID-19' (between 1st March 2020 and 15th September 2020). Clinical symptoms at treatment commencement were assessed using the Brief Psychiatric Rating Scale (BPRS) and the Kessler Psychological Distress Scale (K10). with outcomes after 6 months compared between cohorts using linear mixed-effects regression, controlling for confounders.

Results: 1246 young people were analysed (653 FEP, 596 UHR). Baseline FEP clinical presentation were comparable. UHR clients had lower BPRS negative symptoms during-COVID-19 ($p=0.020$). Significant improvements were observed with treatment pre- and during-COVID-19 in both groups (5 to 13-point reduction in BPRS score per 6-months treatment). Treatment effectiveness reduced during-COVID-19 for psychosis symptoms, with the FEP BPRS treatment effect lower by 4.3 points (95%CI: 0.5, 8.1). Service contacts and duration of contacts increased during-COVID-19, with increased telehealth services ($p<0.001$).

Conclusions: These findings support the efficacy of early intervention for FEP and UHR. Treatment effects were evident despite the pandemic and transition of EIP services to virtual service delivery. Reduced treatment efficacy in FEP psychosis symptoms may suggest the shift to telehealth was less effective than in person service delivery. Further research to examine longer term clinical and functional outcomes due to the pandemic is required.

Beyond support: unveiling the journey of recovery post-supported accommodation services

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Introduction: Supported accommodation organizations cater to individuals with severe psychosocial issues, delivering diverse services primarily through ambulatory support or accommodation-based assistance. Emphasizing rehabilitation and recovery, these services aim to enhance clients' independent living and practical skills. While studies affirm the positive impact of supported accommodation on quality of life and unmet needs, there is a scarcity of research on the effects post-exit, leaving gaps in understanding the recovery process of clients. Therefore, we aimed to explore recovery narratives, focussing on participation, care needs, and quality of life.

Methods: Between May 2021 and February 2022, we conducted 29 semi-structured interviews with clients leaving Dutch supported accommodation services or transitioning from supported housing to ambulatory support at least a year prior to the interview. Interviews were guided by the Lifeline Interview Method and analysed using thematic analysis. 17 clients had left supported accommodation services and 12 transitioned from supported housing to ambulatory support. The majority was male (66%). On average, clients received support for 1.5 years.

Results: Participants reflected on crucial moments in their recovery process, expressing their current state, achievements, and future aspirations. Achieving independence or transitioning to independent living emerged as an inherently rehabilitative aspect. Participants emphasized how reclaiming autonomy contributed significantly to their overall well-being and personal recovery. Moreover, participants consistently highlighted the influential role of their social connections in maintaining stability, fostering a sense of belonging, and aiding in the ongoing process of recovery.

Discussion and Conclusion: Understanding the experiences of clients who have transitioned away from intensive support is crucial for tailoring effective assistance. Our study sheds light on the nuanced aspects of recovery, care needs, and social participation, providing insights to better support clients on

their path towards independence. It also underscores the importance of the cultivation and sustenance of a robust social support system for individuals leaving supported accommodation services. This research offers a foundation for future interventions and policies to enhance the long-term well-being of individuals in supported accommodation services.

What are the ingredients for Intensive Home Support? When and how does it work according to clients?

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Introduction: Deinstitutionalization in mental health care for individuals with severe mental illness (SMI) has been a continuous process in Europe since the 1970s. In the 1980s, the supported housing (SH) sector emerged as an alternative stay for long-term stay in clinics. In recent years, more people with SMI currently live independently in their own homes in the community. In the Netherlands, the deinstitutionalization process was given an impulse by the Dannenberg Commission's report in 2015 in which the residential SH sector needs to be renewed with the goal of greater autonomy through more flexible and intensive offers in the community: Intensive Home Support appeared. This qualitative study about IHS aims to investigate how (un)intended interventions guide desired outcomes such as recovery, social inclusion, and participation. We attempt to answer the following research questions: (1) What are the important ingredients of IHS according to clients?; (2) How does IHS works for these clients?; and (3) Under what circumstances does IHS work for these clients? Methods: We conducted longitudinal semi-structured interviews with 42 clients of three organizations for SH about their experiences with IHS, participation in society, and living independently. The transcripts were analyzed according to the CAIMeR-theory (a further development in realist evaluation) and thematic analysis. Results: We found 8 ingredients for IHS according to clients: (1) working alliance between support provider & client; (2) citizenship & autonomy; (3) significant others; (4) recognition & acknowledgment; (5) mental & physical health; (6) being part of society; (7) housing & living environment; (8) influence of government decisions on client's life. Discussion: At the time of submitting this abstract, the paper is still work in progress. Discussion points will be available for discussion at the conference.

Scoping the field of Mental Health Social Care

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Introduction – for truly biopsychosocial mental health systems we need to understand the social dimensions of people's lives and how to better support those and help people lead fulfilling lives. The social care sector in England as it relates to mental health encompasses local authority care and support, the work of social workers and others, and the work of voluntary and community (third sector) organisations. These latter comprise a hugely diverse range of organisations e.g. size (national to very local groups) and populations supported, often working directly with/in marginalised communities. The social aspects of recovery and delivery of support, and of the potential of these organisations to help people deliver their hopes for a meaningful life have been neglected in research and policy in England.

Methods – we scoped understanding of MHSC through semi-structured interviews with leading figures from policy and practice (including local authorities and third sector organisations), and with people with lived experience of mental health problems and/or of being a carer. The interviews were thematically analysed to understand what MHSC is, what its potential could be and what are its research priorities.

Results – participants understand of mental health social care sat across key frames, including legislation, organisational boundaries, and the social model of disability. Articulation of these provides a coherent base for developing research programmes to enhance the sector's evidence-base.

Discussion – building on this scoping work we are developing a coherent identity for the field of MHSC, enabling progress towards a stronger evidence base from which to have great impact on improving policy and practice.

Conclusion – MHSC has been a neglected field which has undermined the development of better local systems of care and support for people. By developing the identity of MHSC we aim to collaboratively have greater impact.

Developing research capacity in Mental Health Social Care in England

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Introduction – as a neglected field in England, mental health social care (MHSC) has been in a weaker position to develop its evidence base and, hence, in shaping policy and practice development. This is despite the sector holding a social focus, crucial to living a meaning life, and strong traditions of innovating and working with people and communities. Failure to develop research capacity in MHSC means organisations in this vital sector are far removed from research.

Methods – building on the scoping research in a previous presentation, we have been developing the field of MHSC with partners, including people and organisations with lived experience of mental health problems, of being a carer, of frontline practice and of policy making. We have established a network and collectively enhanced the identity and profile of MHSC in policy and research.

Results – We have been co-producing an understanding of the research priorities, challenges and opportunities for MHSC and are now collaboratively address this agenda. We have established an NIHR-funded MHSC Research Incubator as infrastructure to develop research capacity. In this presentation we discuss the shape of MHSC as a system, the strengths and weaknesses and paths to build a stronger field, and the place of the Incubator in this.

Discussion – We have developed a more coherent and shared understanding of the challenges in developing research capacity in MHSC. From this base we can co-produce programmes around the Incubator to help develop capacity.

Conclusion - By establishing MHSC as an identity and network we can better understand the challenges the field faces in developing research capacity, are able to share across the network opportunities for engaging in research that some people and organisations currently far removed from research would not have otherwise known about, and can collaboratively develop this vital research agenda.

Social interventions in mental health: evidence review and development of a conceptual framework

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Background: People with serious mental health conditions (SMI) are often socially excluded. They face increased risks of unemployment, homelessness, poverty, crime victimisation and social isolation. Poor social circumstances are bi-directionally associated with poor mental health. Evidence is needed regarding effective models of care and support to improve the social circumstances of people with SMI.

Methods: We conducted an evidence synthesis of systematic reviews and trials of social interventions for people with SMI designed to improve social outcomes in one or more of eight life domains: poverty and debt, housing, employment, family relationships, social isolation, crime victimisation, offending, rights and citizenship. We then scoped non-trial literature and conducted an online call for evidence to identify additional social intervention models. Through stakeholder discussion and with reference to our identified models, we developed a conceptual framework to support description and evaluation of social interventions for people with SMI.

Results: There is convincing trial evidence for the effectiveness of employment and housing support models for people with SMI. Evidence is lacking regarding effective models of support in other life domains. We identified 92 distinct models of support across our eight life domains and developed a conceptual framework which distinguished five different sources of support and five different types of support, which were necessary and sufficient to describe and categorise our identified models.

Discussion: Implications of this project will be considered, regarding promising directions for policy and practice, priorities for future research in mental health social care, and the utility of our conceptual framework to support future intervention development and evaluation.

Power plan, a digital signaling plan of the client in good and bad times

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A crisis signaling plan is a tool for clients with severe mental illness to increase self-management and to prevent relapse. However, both clients and care professionals experience obstacles in creating and using a crisis signaling plan. For clients, the focus on negative developments in personal functioning and working with a hard copy, which is not readily available, are perceived as barriers. Clients also indicate that the plan is often outdated, written in professional care language rather than in their own words, and family or friends are often not involved or familiar with it.

In an iterative design process in collaboration with various stakeholders Parnassia Group psychiatric institute and Therapyland, an e-health designer, developed a digital version (app) of a signaling plan. This signaling plan, called Power Plan, focuses on what the client needs to feel healthy and comfortable. In the app, the client can fill in habits and helpful actions for different mood conditions. In addition, clients can record as often as they wish what they are doing, thinking or feeling and share this information with care professionals and family members or friends. The app is a guide for conversation and together with care professionals and family members or friends agreements can be made about the desired help.

Since 2023, a pilot with Power Plan takes place within a number of teams of the Parnassia Group. In a qualitative study, interviews are being conducted with clients and care professionals about their experiences with Power Plan. A topic list and thematic analysis are used. Based on the findings, (final) adjustments are made to the Power Plan app and recommendations are formulated for further implementation in mental health practice.

Development of a Self-Advocacy Resource for Consumer's Mental and Physical Health Needs

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Introduction: People living with mental and physical health concerns are less likely to have their health needs met, resulting in preventable morbidity and mortality. To address this problem, Equally Well Australia have been funded by the federal government to co-produce a health resource to support people living with mental and physical health concerns to have their healthcare needs met.

Methods: Over 12 months, the research team recruited and met regularly with a co-design group of people living with physical and mental health concerns. The co-design group was responsible for making decisions related to the conduct and direction of the research. The co-design group co-constructed a brief for a professional web developer to develop the resource.

Results: The resource developed by the consumer group focuses on prompts for users to identify and speak up about their health needs to clinicians. Members of the co-design group identified regular health checks, medication review, and broad socio-cultural wellbeing as integral to managing physical and mental health needs and consequently, these have been reflected in the resource. Strategies were also included to manage difficult interactions, or to manage not having needs met during appointments.

Discussion: The co-production process resulted in a resource that reflects the needs of those intended to use it. This may increase uptake, authentically reflect needs and gaps in care for individuals living with physical and mental health concerns, and promote better health outcomes and collaborative care.

Conclusion: Consumers engaged in the project shared their values and challenges and made decisions about how these should be reflected in the resource. For this reason, the resource and the associated research should be considered a meaningful contribution to resolving health inequality for people living with mental illness.

A minimally guided ehealth program for individuals waiting for mental health care

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Background: The long waiting time in (specialist) mental health care (MHC) presents an important problem and causes much suffering for those waiting (reduced hope, connectedness and empowerment), clinicians and referrers (perceived stress and work pressure). To address this suffering, in 2020 Wacht@ctief has been developed; an eHealth program for individuals who are on the waiting list for specialist MHC. Using action research, Wacht@ctief has since been adapted based on user evaluations, by for example, adding solution-oriented coaching. This substudy examines whether (1) use and evaluation of Wacht@ctief has improved over time, and (2) how Wacht@ctief could be adapted to better meet the needs of clinicians and referrers.

Methods: Wacht@ctief is currently implemented at nine departments of a large MHC in the Netherlands, and consists of an informative basic module, elective modules on positive health (e.g., lifestyle, purpose/meaning), self-help modules, coaching by an applied psychologist, and (possible) contact with an experience expert. User evaluations entail usage data (n=2565) and evaluation questionnaires at intake (n=500). (Trends in) usage and evaluation data are described. The needs of practitioners have been examined with semi-structured interviews. Interview data were transcribed and analyzed using thematic analysis. Interviews with referrers are ongoing (results expected March 2024).

Results: In total, 58% of the individuals invited (n=1481) started Wacht@ctief, and 506 (34%) fully completed the basic module. Completion rates increased over time. User evaluations of Wacht@ctief did not change over time (mean ≈ 7, min-max= 1- 10). Practitioners expressed the need for an easy way for the client to transfer personally important lessons learned from Wacht@ctief to the intake.

Discussion: Wacht@ctief is increasingly used over time. A new round of qualitative interviews is necessary to assess (further) needs of users. Practitioner's suggestions fit with the goal to empower clients in their recovery process.

SP-21 | Results from a research program investigating peer support and recovery in the North Denmark Region - Mike SLADE, University of Nottingham / Nord University

Presentation and overview of a 4-year research program investigating peer support and recovery

Rikke JØRGENSEN[1,7], Alice Katrine BURHOLT[1], Kirsten JOHANSEN[1,2], Mike SLADE[3,4], Stynke CASTELEIN[5,6], Birgitte LERBÆK[1]

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In September 2020 peer support workers were employed in eight new FACT teams in mental health services in the North Denmark Region. The peer support workers were all paid workers in permanent positions, employed 20 h pr. week working alongside the non-peer professionals in the teams.

Shortly hereafter, a 4-year research program “Peer Support and Recovery 2021 - 2024” was initiated with the overall purpose to investigate peer support and recovery in four work packages from the perspectives of the peer support workers, non-peer professionals and patients.

The overall design for the research program was exploratory using qualitative and quantitative methods. The data collection was completed November 2023 and analysis within and between the four work packages is ongoing and planned to continue through 2024 resulting in publication of scientific manuscripts.

This presentation will give an overview of the research program including elaboration of the rationale for conducting the research program and will present an illustrative timeline of the data collection and the participants including researchers/co-researchers to show the flow and the connection in and between work packages. Furthermore, the presentation will contribute with insights into organizational complexities and challenges experienced during the execution of the research program.

SP-21 | Results from a research program investigating peer support and recovery in the North Denmark Region - Mike SLADE, University of Nottingham / Nord University

Personal experiences with mental health issues or as being a relative - application into research

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In September 2020 peer support workers were employed in eight new FACT teams in mental health services in the North Denmark Region. The peer support workers were all paid workers in permanent positions, employed 20 h pr. week working alongside the non-peer professionals in the teams.

Shortly hereafter, a 4-year research program “Peer Support and Recovery 2021 - 2024” was initiated with the overall purpose to investigate peer support and recovery from the perspectives of the peer support workers, non-peer professionals and patients. The idea for the research program emerged by “coincidence” and evolved fast in the presence of dedicated and committed persons, all with lived experiences with mental health conditions or with lived experiences being a relative to a person with a mental health condition.

The presentation will address how lived experiences are applied into the research process together with a discussion of potentials, barriers, and ethical issues of lived experiences in research.

Issues that the presentation will touch on:

- Overall barriers and challenges of application of lived experiences into the research process
- Disclosure of lived experiences when conducting interviews with peer support workers and patients
- Contributions to the interview guides with ethical considerations
- Using experiential knowledge in coding and analysis of qualitative data.

Furthermore, the presentation will address suggestions for future use of involvement of persons with lived experiences in research in mental health services.

SP-21 | Results from a research program investigating peer support and recovery in the North Denmark Region - Mike SLADE, University of Nottingham / Nord University

Peer support and recovery: Insights from peer support workers, patients, and non-peer professionals

Kirsten JOHANSEN[1,2], Birgitte LERBÆK[1], Alice Kathrine BURHOLT[1], Mike SLADE[3,4], Stynke CASTELEIN[5,6], Rikke JØRGENSEN[1,7]

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Abstract

In September 2020 peer support workers were employed in eight new FACT teams in mental health services in the North Denmark Region. The peer support workers were all paid workers in permanent positions, employed 20 h pr. week working alongside the non-peer professionals in the teams.

Shortly hereafter, a 4-year research program “Peer Support and Recovery 2021 - 2024” was initiated with the overall purpose to investigate peer support and recovery from the perspectives of the peer support workers, non-peer professionals and patients.

The overall design for the research program was exploratory using qualitative and quantitative methods. The peer support workers were interviewed shortly after employment and again after two years about their recovery process, their motivation for becoming a peer support worker and the peer support worker role. The non-peer professionals were interviewed right after employment of the peer support workers and two years later about implementation of FACT, understanding of recovery, attitudes towards peer support and peer support workers. Selected patients were interviewed about their experiences receiving peer support; and all patients were invited to participate in a longitudinal study investigating personal recovery over time.

The presentation will report on the most important findings from each perspective and also touch on preliminary results from ongoing analysis of the recently collected data.

SP-21 | Results from a research program investigating peer support and recovery in the North Denmark Region - Mike SLADE, University of Nottingham / Nord University

Peer support and recovery: perspectives of peer support workers, patients and non-peer professionals

Birgitte LERBÆK[1], Alice Katrine BURHOLT[1], Kirsten JOHANSEN[1,2], Mike SLADE[3,4], Stynke CASTELEIN[5,6], Rikke JØRGENSEN[1,7]

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In September 2020 peer support workers were employed in eight new FACT teams in mental health services in the North Denmark Region. The peer support workers were all paid workers in permanent positions, employed 20 h pr. week working alongside the non-peer professionals in the teams. As all other newly employed staff, they were appointed a mentor.

Shortly hereafter, a 4-year research program “Peer Support and Recovery 2021 - 2024” was initiated with the overall purpose to investigate peer support and recovery from the perspectives of the peer support workers, non-peer professionals and patients.

The overall design for the research program was exploratory using qualitative and quantitative methods. Research questions within and across perspectives guided the data collection. However, new possibilities for secondary analysis emerged through the coding and analysis of the qualitative data.

This presentation will shortly address the preliminary analysis of the stated research questions across perspectives in the research program and address the emergence of three secondary analysis.

- “The first steps”: to gain insight into how peer support workers, non-peer professionals and FACT managers experienced and handled the initial phase of peer support.

- “Not just something they read in a book”: what is peer support and how is this different from traditional practice? – perspectives from peer support workers, non-peer professionals and patients, that have received peer support.

- “The prism of the “mentor function”: to explore how the “mentor function” is perceived and operationalized in the teams from the perspectives of mentors, peer support workers and non-peer professionals.The emergence of secondary qualitative analysis added new insights on peer support and recovery to the research program.

SPOT: co-created study among youngsters. Exploring effects of artistic practices on mental health.

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Adolescents, dealing with mental health issues created SPOT as project: a safe place to discover talents while developing art skills. SPOT offers a low-threshold programme with various communal artistic activities (like drawing, drama, music etc.), supervised by art teachers and supported by users and (trained) persons with lived experience. At SPOT the art is a goal itself instead of a kind of treatment like art therapy, in which art is intended as a means of expression for feelings.

The SPOT project is evaluated by researchers with peer expertise. Our exploratory study aims to gain insight into the effects of participation in artistic activities at SPOT as workplace and the psychological well-being of youngsters and young adults with mental health struggles. And to get a better idea of the underlying mechanisms. The study was co created, the youngsters were actively involved from the start (including the design) and consisted a concurrent quantitive and qualitive part. Questionnaires and semi-structured in-deph interviews were conducted to inquire personal experiences at the SPOT workplace, related to possible changes in mental well-being.

In this case, participants' mental well-being was often below average and no overall changes in well-being could be demonstrated. However, the majority of the participants indicated that participation at SPOT at least once a week did have a positive impact on their well-being during the week. Furthermore, they report positive on social and creative experiences at SPOT and on the impact of SPOT on their lives, such as discovering new talents, gaining more self-confidence and making new friends. The low threshold, the pressure-free ambiance and the clear focus on arts itself create a safe environment where youngsters feel free to express themselves creatively and socially.

"Stepping Through": Participatory Interactive Storytelling for Shared Experiences in Mental Health

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The talk proposed illustrates how non-linear storytelling (characterised by multiple viewpoints and perspectives coexisting within the same stories), typical of interactive media, can be co-created with people who have lived experience of mental illness in order to allow them to shape personalised accounts of their experiences, especially when those experiences are complex and nuanced, and can be only superficially tackled by traditional linear storytelling. Non-linear storytelling can also support participants in creating modalities of audience involvement that favour self-reflection and empathy.

These creative possibilities will be illustrated through the case study of an interactive poetic documentary called Stepping Through, which was written, directed, and produced by five men who experienced mental illnesses. The film explores multiple perspectives on recovery where viewers can choose resonant feelings to explore participants' experiences of mental illness while also reflecting on their own wellbeing. Stepping Through was evaluated by audiences with varying levels of mental health awareness and showed potential for this type of storytelling to be applied to support and therapy, to mental health training, to service evaluation, and to campaign for stigma reduction in general audiences.

This research was carried out at the Digital Creativity Labs, University of York (UK), in collaboration with community partner Converge, a provider of educational and creative courses for people with mental health problems. The research outcomes are currently being disseminated through a follow-up yearlong project at the Institute of Mental Health Research, University of York.

The talk will illustrate the main research phases, methods, and outcomes. As part of this live talk, some segments of Stepping Through and its interactive features will be shown.

Artful Bonds: Unveiling the Next Wave of Recovery in Mental Healthcare - Resilience and Citizenship

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Introduction: Exploring the dynamic concept of recovery, this abstract delves into the landscape of long-term mental health care, focusing on person-centered care, independence, hope, and inclusion. It traces the development from rehabilitation and protected living to the emergence of recovery colleges as inclusive social hubs. The authors, drawing from their life experiences, recognize ordinary interests as a unifying thread and see potential in amateur art communities for the next wave of recovery and citizenship in mental healthcare.

Methods: All authors, engaged in art participation, experienced positive impacts on mental well-being and belonging in artistic social hubs. Inspired by daily interactions and personal experiences in repetitions, coproductions, projects, and social activities, they collaboratively wrote this abstract. A literature search further supported their ideas. Involving three amateur art community organizations with dancers, actors, and vocalists, participants encompassed community members and their teachers/coaches from various professions, ages, and cultural backgrounds.

Results: Findings reveal that the artistic environment fostered intergenerational connections, embracing inclusivity, mentoring, equality, reciprocity, and friendships. Their membership to the art communities and intrinsic driven interactions normalized inclusivity, leading to meaningful connections within and outside the communities. Participants engaged in social activities, such as dining, outdoor cultural events, and coffee outings. Notably, personal and professional support emerged among participants, exemplified by teachers advising parents and members sharing personal experiences.

Discussion: The authors highlight the transformative potential of integrating artistic pursuits into the recovery narrative, fostering camaraderie and social cohesion. Advocating for a broader perspective on citizenship and inclusion, the study underscores ordinary elements as shared foundations in the normalization process. Reflection on the broader implications for mental health care is prompted, emphasizing the value of community engagement, shared activities, and mutual support in promoting well-being and recovery.

Self-perceived relations between creativity and mental illness: a study into lived experiences.

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Introduction: The idea that mental illness and artistic creativity are somehow related dates back to ancient times. There is some evidence for an actual correlation, but many questions remain unanswered on the nature and direction of the relationship. Qualitative contributions to the debate are scarce.

Methods: In this qualitative study, 50 participants of which 24 professional artists with self-reported experience with mental illness, and 26 participants of participatory arts initiatives for/by people with mental illness, were interviewed. Transcripts were subjected to interpretive analysis.

Results: Both professional artists and consumer-artists within art initiatives experience various connections between artistic creativity and mental illness. In both groups, making art influences the way mental illness is experienced, and mental illness influences what is created. These relationships are ambiguous and sometimes contradictory, but essential in giving meaning to one's own life course. A major difference between the two groups is that making art among professionals is not without obligation, can take on a more obsessive character and is subject to certain expectations and therefore creates its own dynamics and impact on mental health. For consumer-artists, art practices are experienced above all as liberating and contributing to recovery, not only because of the change in role from patient to artist, but also because of the beauty of art that can function as a counterbalance in a generally dark or struggling existence.

Conclusion: Understanding the experiences of artists with mental illness can help shape the role of art in mental health care in a way that does justice to the meaning of and multi-layered interactions between creativity and mental health.

Spatial analysis for the study of addictions in Andalusia

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Background/Objectives

Addictions have a high human and social cost. It also has an impact on the public system of care and treatment. To manage these services efficiently, it is necessary to develop decision-support tools that provide relevant information about the care landscape. Mental health atlases have a long history of providing data for planning in this area. In the first phase of developing the addictions atlas of Spain, the spatial analysis of the treatment initiation rate in outpatient centres in Andalusia was carried out.

Materials and methods

A spatial analysis was carried out to locate clusters with similar values of treatment initiations, broken down by sex, addiction group, municipality of residence of the user and their treatment centre as spatial units. The data come from the Andalusian Plan for Drugs and Addiction (SIPASDA) information system for 2022. To this end, global and local spatial autocorrelation analyses (Moran's I and Geary's C) were used to identify spatial concentrations of treatment admissions (hotspots/coldspots).

Results

The geographical distribution of treatment initiations shows that most of Andalusia is around the regional average. However, some areas stand out as having significantly high rates. The geostatistical analysis identified spatial clusters in all Andalusian provinces, which tend to be concentrated in rural and less accessible areas. In contrast, urban and coastal areas, where most of the population is concentrated, largely lack these concentrations.

Discussion/conclusions

The maps show the geographical distribution of treatment initiation in a broad and detailed way. Spatial clusters can be characterized using multivariate methods that relate them to risk factors and indicators of care provision.

Tool to support mental health planning: Interactive Atlases

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Background/Objectives

Mental health atlases are integrated planning tools for studying social and health policies in mental health. They allow different types of analysis to be carried out to provide managers with information for designing potential interventions and health policies. In previous work, this research team has developed mental health atlases in different regions of Spain and the world. Until now, these atlases have taken the form of technical reports with data relating to a specific period. However, thanks to technological advances, it is possible to include real-time data, which provides valuable information for optimising processes and speeding up decision-making. Interactive atlases are tools that improve and enhance the usability of products that allow the visualisation of raw or processed data, as they provide new ways of interacting with the tool to update the information and create customised maps to support decision-making.

Methodology

The interactive mental health atlases integrate indicators of service context and use a standard classification of services and cartographic location. Data was collected from the mental health atlases previously produced in Andalusia in 2023.

Results

The tool allows users to consult data on the distribution, accessibility, and use of mental health services in a territory. In addition, users can modify, reorganise, generate complex maps, and analyse any element of information based on the expert judgement of the managers.

Conclusion

Interactive mental health atlases comprehensively examine the care ecosystem and contribute to supporting and improving the management of mental health services.

A tool for Analyzing Addiction Services in Spain: Health Atlas

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Introduction/Objectives:

In Spain, the absence of a standardized national catalogue for addiction treatment services complicates the comprehension and comparison of offered services. This deficiency presents two primary challenges: first, the variability in terminology leads to services with different activities sharing the same name or, conversely, two services with similar activities having different names. Second, incommensurability arises from using distinct units of analysis in comparative research. To identify unmet needs and prevent care duplication, decision-makers must understand the actual provision of activities across services. The Atlas of Addiction in Spain aims to offer a comprehensive overview of the autonomous systems of addiction care.

Methodology:

The Addiction Atlas employs the international DESDE-LTC system (Description and Evaluation of Services and Directories for Long Term Care) to evaluate and describe social and health services. This study classified services into broad types of care groups, the least detailed level within the DESDE classification. Additionally, it utilizes a geographic information system to manage, analyse, and map geo-referenced information. The methodology incorporates demographic and addiction services statistics from the National Statistics Institute and its regional counterparts, as well as the Spanish Observatory on Drugs and Addictions. Officially registered addiction services are also part of the analysis.

Results:

The atlas examines the care context by studying geographical, demographic, and socio-economic factors in selected geographical areas. It offers a standardized assessment and description of addiction services in large care groups. Lastly, it analyses service provision and care patterns based on population and area.

Conclusions:

The Atlas of Addictions seeks to generate scientific evidence and knowledge on addiction care, providing information to support decision-makers and managers in the planning of addiction services in Spain.

Spatial Analysis of the Performance and Mental Health Services Integration in Andalusia

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Introduction: Evaluating the performance of Mental Health (MH) services is a recent research focus, often relying on resource and utilization rates within geographical areas for an MH reference service. Andalusian MH in Spain adopts a community-based care model for service integration. Due to the absence of clear efficiency score cut-offs, determining statistically significant differences among units for each care type poses a challenge. This research aims to understand service complementarity and identify spatial units with high (hotspots) and low (coldspots) performance in Andalusia. **Methods:** This study analyzed small mental health areas in Andalusia using a hybrid model with Monte-Carlo simulations, artificial intelligence, and Data Envelopment Analysis. Input variables included services, the number of beds/places, psychiatrists, nurses, and total professionals in outpatient, acute hospital, and day care services. Outputs were the number of visits (frequentation) and the total cases (prevalence) treated in outpatient care. Four scenarios assessed the potential balance of care in outpatient community care by integrating acute hospital and day care. Model results were analyzed with global and local autocorrelation indexes, identifying spatial clusters and projecting them on maps. **Results:** The findings comprised maps illustrating RTE score distribution and another set revealing hotspots and coldspots for each scenario. Spatial clusters were identified at both global and local scales throughout Andalusia. Local clusters were found for outpatient care (Baseline – Scenario 1) and outpatient and acute hospital care (Scenario 2), while global and local clusters were identified for outpatient and day care (Scenario 3) and all three care types together (Scenario 4). **Discussion:** The results identify areas with significantly different types of care integration and performance, assisting planners and decision-makers in pursuing efficiency, quality, and equity in mental health care.

Defining recovery in schizophrenia: A review of outcome studies

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Background: Schizophrenia management has transitioned towards recovery-oriented strategies, challenging its long-standing perception as a chronic condition. This meta-analysis delves into the intricate dynamics between symptomatic remission, functional recovery, and personal recovery within schizophrenia spectrum disorders.

Method: A meta-analysis until December 2020 reviewed studies meeting DSM-5 criteria for schizophrenia spectrum disorder in at least 90% of samples. Symptomatic remission, functional recovery, and personal recovery were assessed using PANSS, BPRS, GAF, and the Recovery Assessment Scale. Among 1716 initially identified articles, 29 were included after eligibility screening. Effect sizes quantified relationships between recovery domains. Analysis focused on correlating symptom severity with personal recovery and functionality with personal recovery. Pearson's correlation coefficient (r) calculated effect sizes transformed into a common metric (dIG+).

Results: The meta-analysis involved 6727 outpatient participants, primarily men (64.7%), averaging 40.61 years. Limited longitudinal studies and predominant PANSS use for symptom assessment were noted. Symptom severity displayed a small, significant inverse correlation with personal recovery (dIG+ = -0.18), while functionality exhibited a moderate positive association (dIG+ = 0.26). Moderator analysis highlighted methodological factors influencing effect size heterogeneity.

Discussion Findings reveal a weak and inverse connection between symptom remission and personal recovery, suggesting limited correlation from the patient's perspective. Conversely, the moderate relationship between functionality and recovery emphasizes the importance of long-term relationships. The diversity in results prompted exploration of moderators, identifying the symptom remission measurement tool (PANSS), educational level, and functionality measurement tool as significant factors. This raises questions about the need to review instrument characteristics. Results underscore the non-equivalence of recovery measures, emphasizing its scope beyond clinical or social improvements, encompassing symptomatology, community functioning, and personal recovery. While the meta-analysis is valuable, it faces limitations such as the absence of longitudinal studies and exclusion of critical perspectives, with publication bias resistance being notable. In conclusion, the study highlights the need to broaden the recovery perspective beyond clinical improvement, prioritizing the patient's voice, and suggests more integrated methodological approaches for future research.

Conclusion: This study underscores the importance of adopting a holistic recovery approach in schizophrenia management, which prioritizes patient perspectives and calls for methodological rigor in research endeavors.

Social anxiety and self-stigma in schizophrenia: associations with self-compassion and self-esteem

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Self-stigma in the context of serious mental illness is defined as the internalization of stigmatizing attitudes into one's identity. Studies have shown that about one third of people diagnosed with serious mental illness, such as schizophrenia, have high levels of self-stigma which is associated with diverse negative self-perceptions. Although studies have established the association between self-esteem, self-compassion, and self-stigma among people with schizophrenia, the role of social anxiety – including withdrawal behaviors – in predicting self-stigma and its implications has been less addressed. The reported study exaimned the associations between self-compassion, self-esteem, social anxiety, and self-stigma among people with schizophrenia. The baseline data of 56 adults with schizophrenia who were enrolled in a Metacognitive Reflection and Insight Therapy trial were used. Participants filled out self-report questionnaires measuring self-compassion, self-esteem, social anxiety, and self-stigma. Self-esteem and self-compassion were negatively correlated with self-stigma and social anxiety. Self-compassion was not found to contribute beyond self-esteem to the prediction of self-stigma. Importantly, self-esteem and social anxiety were found to mediate the effects of self-compassion on self-stigma. Thus, it seems that social variables, in addition to self-variables, may lead to the formation of self-stigma among people with schizophrenia. Given the significance of the mediation model and the role that social anxiety might have in the formation of self-stigma, it seems important for therapies aimed at reducing self-stigma to include therapeutic elements related to coping with social anxiety, in addition to addressing elements of self-esteem and self-compassion.

Financial problems of people with psychosis - Experiences of patients, caregivers & professionals

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Introduction

Finances are a key challenge for people with psychosis. Yet, remarkably, literature on this topic is scarce. The few existing quantitative studies showed financial dissatisfaction and financial competence deficits in people with psychosis. To fully understand the financial problems these people experience, however, a qualitative approach is needed, focusing on the perspectives of people with psychosis and important stakeholders. Therefore, this study aims to qualitatively investigate perspectives of people with psychosis, family members and mental healthcare professionals (MHPs) on people with psychotic disorder's financial problems and risk factors for these problems.

Methods

Fourteen people with psychosis, 15 family members and 16 MHPs were recruited using purposive sampling. Semi-structured, one-on-one interviews were conducted. The Qualitative Analysis Guide of Leuven served as an iterative guide for data-analysis. Themes are illustrated with relevant quotations.

Results

Interviews revealed five overarching themes of financial problems, namely problems with: (1) Covering expenses, (2) Financial self-management, (3) Living conditions and Housing, (4) Personal conflicts and Victimization, and (5) Regulations and Legislation. Furthermore, six overarching themes were generated as risk factors for financial problems: (1) Psychotic symptoms, (2) Indirect consequences of psychotic vulnerability, (3) Substance use and Addiction, (4) Overspending, (5) Personal contextual factors, and (6) Societal contextual factors. People with psychosis, family members and MHPs largely agreed on the wide-ranging financial problems and risk factors that people with psychosis face.

Discussion and conclusion

Financial issues and risk factors often co-occur, potentially creating a vicious cycle. These issues can have serious consequences, such as reduced engagement in social activities, society and treatment. This study is an important step towards early detection of financial difficulties and risk factors among individuals with psychosis. Collaborative efforts among stakeholders and timely recognition of these challenges are essential to breaking the vicious cycle of financial problems for individuals with psychosis.

Factors Affecting Community Treatment Orders Research Study: Understanding variation in CTOs

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Introduction: There is international evidence that forced community treatment in the form of community treatment orders (CTOs) is applied arbitrarily within and across jurisdictions, disproportionately affecting marginalised groups. FACTORS aims to explain the drivers underpinning these variations. This presentation is an overview of the study and a summary of preliminary findings.

Methods: FACTORS is a mixed methods project with several arms including qualitative analysis of routinely collected administrative data, analysis of legal and policy documentation, and a qualitative study of services that have high and low rates of CTO use. FACTORS incorporates lived experience perspectives through including a consumer lead investigator, research fellow, and lived experience advisory panel.

Results: The legal and policy analysis already indicates that jurisdictions in Australia vary in relation to alignment of legislation with the UNCRPD and the emphasis placed on people having capacity. We have found that there is a lack of policy to guide practice and implementation in some jurisdictions– and an abundance in others. Administrative health data has been difficult to obtain for a study of this size and complexity and each jurisdiction has required a bespoke approach to the application.

Discussion: Undertaking a large-scale investigation of CTO implementation has significant challenges. CTOs have tended to be invisible in discussions about mental health reform in Australia and the early stages of FACTORS is revealing why this is the case. Lack of monitoring and accountability may be contributing to the amount of variation in the use of these orders that lead to a significant impact on human rights and the very nature of mental health service delivery.

Conclusion: The data associated with the FACTORS project will generate social and cultural benefits for those directly affected and the broader community, and to create new knowledge and innovate law and policy processes.

Advance Choice Documents for Black African and Caribbean people with previous compulsory admission

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Introduction

Advance Choice Documents have been recommended based on legal and ethical arguments and evidence that advance statements can reduce use of compulsory psychiatric admission. The aim of the project was to develop and implement an Advance Choice Document (ACD) resource for Black African and Caribbean people who have previously been detained under the Mental Health Act and the people that support them.

Methods

Three stakeholder workshops (including service users, carers/supporters and mental health staff) informed the development of an ACD template; the Trust's Recovery College course to provide information on ACDs; and skills training delivered with the Simulation training team on how stakeholders could create and use an ACD. To support the development of the ACDs, a facilitator manual was also developed for the project facilitator, as was a job description for future facilitators.

Results

The ACDs developed were largely reported as appropriate, acceptable, and feasible to staff and service users. The ACD template was also able to inform the development of a digital ACD. The information provision training and skills training were generally considered to be informative by attendees. Attendees of the Recovery College course appreciated the involvement of a peer-trainer. Those attending the Simulation training valued enacting scenarios in realistic settings.

Discussion

Flexibility was necessary throughout the project to adjust to staff capacity to attend training or attend ACD development meetings, facilitator capacity, and accessibility of trainings for service users and carers/supporters.

Conclusion

The project developed an ACD development resource that was agreeable to all stakeholders and provides an example of the importance of co-production in producing resources meaningful to all involved. It also highlighted the need for facilitators to supported to keep strictly protected time or full-time availability to help support the development of ACDs.

Police, Ambulance, Clinician Early Response (PACER) model and involuntary detentions

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Background: Involuntary detention is a common method of enforcing mandatory mental health assessment for people experiencing mental health crisis in the community. However, it is associated with poor patient outcomes, high emergency service and emergency department demand, and restrictive practice which can cause trauma and distress. The primary aim of this study was to examine the association between a novel Police, Ambulance, Clinician, Early Response (PACER) model and involuntary detentions when compared with standard police and ambulance response to mental health crisis.

Methods: We used a retrospective observational study design using three cohorts (PACER, police, ambulance). Our sample included all mental health crisis presentations in an Australian metropolitan city from December 2019 to December 2020 that were responded to by PACER, police or ambulance services (n = 8577). Risk of involuntary detention was examined using Relative Risk (RR) in each cohort. We used logistic regression to estimate the probability of being involuntarily detained or diverted from hospital using an odds ratio (OR) using Gender, Age and primary presenting condition as independent variables.

Results: Over a 12-month period 8,577 people received crisis mental health intervention in the ACT. We observed an 18% increase in the relative risk of being involuntarily detained by police, and a 640% increase in the relative risk of being detained by ambulance. The PACER team detained 10% of their total presentations, as compared with 12% by police and 74% by ambulance. Involuntary detentions enacted by PACER were more likely to convert to a post-detention hospitalization (72%) when compared with police (27%) and ambulance (17%).

Conclusion: PACER was associated with lower rates of involuntary detention of people experiencing mental health crisis when compared to police and ambulance response.

Mental health crisis care systems: emerging models and critical components

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Background: Mental health inpatient admissions are costly and often experienced negatively by service users. Community crisis service models have proliferated in recent years but for many models, evidence of effectiveness has yet to be established. Best configurations and critical ingredients of community crisis care systems are unclear.

Methods: We conducted an online survey of managers of community Crisis Resolution Teams to map mental health crisis care systems in England. We then used our survey data and publicly available NHS data about local area psychiatric hospital admission rates to explore associations between local system characteristics and service models, and hospital admission and detention rates.

Results: We received survey responses from 184/200 (92%) of managers. The composition of local mental health crisis systems varied greatly across England and the prevalence of service models seemed unrelated to the strength of evidence regarding their effectiveness. No clear typology of catchment area crisis care systems emerged. Provision of a crisis telephone service and provision of a crisis café within the local crisis system were associated with lower admissions rates. Provision of a crisis assessment team separate from the crisis resolution and home treatment service was associated with higher admission rates.

Discussion: Implications of the heterogeneity of community crisis care systems in England will be discussed. Our findings generate hypotheses about potential critical components of crisis systems, and suggest priorities for research and policy.

The societal/economic case for individual placement and support implementation in northern Norway

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Introduction: Facilitating opportunities for competitive employment can be an important element in promoting recovery and inclusion for people with lived experience of mental health conditions. One evidence-based, supported-employment approach, Individual Placement and Support (IPS) has been shown in multiple contexts to help promote employment for individuals, but less is known about its broad cross-sectoral societal impacts. This analysis estimates the economic benefits to society of the implementation of IPS at a municipality level in northern Norway.

Methods: Economic modelling analysis, making use of Norwegian registry data in a longitudinal interrupted time series quasi-experimental design, that estimated the difference in differences for number of additional workdays associated with IPS over a four year period. IPS implementation, in the Bodø municipality of Norway, was compared to ten control municipalities where IPS had not been implemented. Detailed monitoring data on resources/costs associated with implementation of IPS in Bodø were collected, with resource use and costs of usual employment support elsewhere in Norway obtained from published contracts and documentation. The economic analysis modelled the impacts of changes in employment on housing and welfare support needs.

Results: There was a positive economic return on investment, with implementation costs more than covered by societal gains from the implementation of IPS. This was driven by a significant, positive, causal effect on employment outcomes, equivalent to 12.7 years of increased work per year for the total study population in Bodø, compared to municipalities without IPS. This economic case is strengthened further if expected reduced use of menta and physical health services is taken into account.

Conclusion: In looking at the economic case for investing in IPS, it is important to identify multi-sectoral impacts in addition to changes in health outcomes. These positive economic benefits in Norway for IPS were made possible by effective multi-sectoral collaboration and dedicated financing.

Feasibility of a health-climate-economic decision model for depression care

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The interaction between climate change and health is gaining increasing attention. This concerns not only the adaption to global warming, but also the impact of the health system itself, which is between 4 and 8% of total carbon emissions in Europe. In this context, health systems are currently preparing to include the carbon footprint of treatment options into their decision making, both at the provider and the governance level. Our objective is to develop and test a decision making tool that takes into account carbon emissions to the same extent as the currently established evaluation criteria, i.e. clinical benefit and economic cost, for depression care.

To this end, we have chosen to build and adapt a Markov decision model, which is one of the most frequently used tools to assess the value of new and existing treatment options. The model simulates, over the course of five years, the clinical, economic and climate effects of three treatment options for depression: pharmacotherapy, psychotherapy, and the combination of both.

Preliminary results indicate that the model is feasible, but that several assumptions that have to be made – for example, on patients' distance to services and mode of transport – heavily impact the outcomes. Overall, the work undertaken so far suggests that the lessons from a bottom-up analysis for a single disease can contradict conclusions inferred from country-level, top-down carbon footprint assessments. The latter generally distinguish sectors (hospital, ambulatory) or functions (logistics, care) only. These differences raise important questions about the priority setting for decarbonizing health systems, as well as the data, tools and expertise needed.

Stress management intervention for leaders of SMEs in Germany - a health-economic perspective

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Introduction:

Leaders in small and medium-sized enterprises (SMEs) are exposed to a twofold burden of high occupational stress and high responsibility, leading to a higher risk of stress induced health effects, like cardiovascular diseases, depression or burnout. Preventing these with a stress intervention could play a significant role in reducing costs for SMEs as well as in the healthcare sector. The objective of this health-economic evaluation was to examine the cost-effectiveness of the intervention from a societal and employers' point of view.

Method:

Data for 94 participants in the intervention group and 100 participants in the control group was collected before the intervention, after six and twelve months using the German version of the Client Sociodemographic and Service Receipt Inventory (CSSRI-D). Calculation of quality-adjusted life years (QALYs) was measured with EQ-5D-5L. The current German utility values set was used. The Cost-utility ratio (ICUR) was calculated and non-parametric bootstrapping was used to take into account stochastic uncertainty.

Results:

Average annual costs of overall health care use for the intervention group amount 2.189,56 € (SD 3.065,76 €) and 1.858,87 € (SD 3.166,69€) for the control group ICUR reached -92.603,45. The ICUR is located in the upper left quadrant and the variance reveals a distribution over all four quadrants of the cost-effectiveness plane without an estimable 95% confidence interval indicating an inconclusive result of the cost-utility analysis (CUA).

Discussion-conclusion:

The inconclusive result of the cost-utility analysis due to the stochastic uncertainty made it impossible to draw clear conclusions regarding the cost effectiveness of the stress intervention. Since stress related diseases are a major health risk and a financial burden further studies are needed.

Managing innovation in mental health recovery research

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Introduction

The current mental health system faces multiple challenges including over-use of compulsion, low satisfaction with services, supporting outcomes such as recovery and wellbeing, and system-level phenomena such as health inequalities and human capacity limitations. Innovation is needed.

Method

The ambition of the Recovery Research Team, based in the Institute of Mental Health at University of Nottingham, is to conduct first-in-field research relating to mental health recovery. To maximise impact, this means that our research group has had to develop approaches to managing innovation. The aim of this talk is to describe our approach to developing and conducting innovative research in relation to mental health recovery.

Results

We identify four components needed for managed innovation. First, strategic ambition needs to be explicit, visible and shared. Our approach is to develop related programmatic studies, where each programme is specified in relation to one or more of topic, methodology or population. Second, the aspect of innovation needs to be consistent, to build expertise over time. Our approach is to look at mental health issues from a non-standard perspective. This counter-cultural thinking will be illustrated using multiple funded studies conducted by RRT. Third, all team activities, processes and, most importantly, culture need to be aligned with the strategic ambition. We describe our resulting specific approaches in relation to (a) interdisciplinary research and (b) lived experience involvement throughout our research. Finally, effective management is vital for high performance, both to maximise reach and significance of findings and as a moral imperative in any tax-payer funded research group.

Conclusions

The Recovery Research Team is at the forefront of global innovation in understanding and supporting mental health recovery, both within and beyond the mental health system. Our approaches to managed innovation may have relevance to other related research groups.

Posttraumatic growth in psychosis: Influence of individual and ecological factors

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Introduction: People with psychosis report are more likely to report experiences of adversity. However, some people report positive changes because of adversity. This is called posttraumatic growth (PTG). PTG is defined as the positive psychological changes that an individual experiences because of an emotional struggle with adversity. There has been limited evaluation of what individual and ecological factors facilitate PTG.

Methods: A two-step approach was undertaken. First, a seven-language systematic review examining the predictors and perceived facilitators of PTG following psychosis. Based on a registered protocol, papers were identified through six information sources. Quantitative studies were included if examining correlates, mediators, and temporal relationships. Qualitative studies were included if describing PTG arising from psychosis. Narrative synthesis was conducted to identify facilitators on qualitative studies. Second, we extend systematic review findings through a commentary piece, by applying Bronfenbrenner's bioecological model to discuss relevant ecological factors to PTG in psychosis.

Results: Thirty-seven papers met the inclusion criteria for the systematic review. Significant correlates and mediators between psychosis symptoms and PTG were identified. Significant mediators included meaning in life, coping self-efficacy, core beliefs, and self-reported recovery. No studies explored temporal relationships between psychosis and PTG. Seven facilitators of PTG in psychosis were identified; Personal identity and strength, Receiving support, Opportunities and possibilities, Strategies for coping, Perspective shift, Emotional experience and Relationships, giving the PROSPER framework. Despite a robust search strategy, findings indicated that most of the research focused on the influence of individual-level factors. Ecological factors for consideration in future research include the effect of personality traits, online communities, mental health services, policy, mass media, and culture.

Conclusion: The PTG in psychosis literature focuses on individual-level facilitators. A greater focus on ecological factors may provide insights into areas in which public mental health and policy can focus to support growth after adversity.

The process of posttraumatic growth in psychosis: A qualitative study

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Introduction: People who experience psychosis can also experience post-traumatic growth (PTG); positive changes from difficult experiences. There is limited research into the specifics of how PTG occurs and manifests in people with psychosis. The PROSPER framework, developed from a systematic review, delineates seven domains of facilitating factors (Personal Identity and Strength, Receiving Support, Opportunities and Possibilities, Strategies for Coping, Perspective Shift, Emotional Experience, and Relationships). This study aimed to investigate 1) the process of growth in individuals with psychosis, 2) validate the PROSPER framework, and 3) identify additional mechanisms of growth.

Methods: A semi-structured interview schedule was produced with input from the Lived Experience Advisory Panel. Interviews were conducted with 25 people who had experienced psychosis and who self-reported positive changes. Data was analysed using both deductive and inductive thematic analysis.

Results: The findings from the analysis were utilised to develop a model of positive change for people with psychosis. In brief, psychosis was described as a disruption, which was influenced by determinants such as personal and trauma factors. Movement from disruption to positive change was described as a process of acceptance influenced by four mechanism categories (cognitive processes, social factors, personal well-being, and external factors). Indicators of positive change manifested through the PROSPER framework.

Conclusions: People who experience psychosis do indeed experience PTG, and a model has been developed to illustrate the process for these participants. This model can serve as the foundation for further research aiming to understand PTG in individuals with psychosis, and the identified mechanisms can be utilised in interventions to support PTG.

Mental health recovery narratives increase meaning in life and quality of life:NEON-O Trial findings

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Introduction: The Narrative Experiences Online (NEON) programme [https://www.researchintorecovery.com/research/neon/] investigated whether mental health recovery narratives are helpful for people affected by mental health problems.

Methods: We developed the NEON Intervention, a web-application providing access to a diverse collection of 659 recovery narratives [https://doi.org/10.2196/24417]. We evaluated the intervention in a parallel group online randomised trial recruiting adults in England experiencing non-psychosis mental health problems [NEON-O Trial, https://www.isrctn.com/ISRCTN63197153]. Intervention arm participants received immediate access, control arm participants received 52-week delayed access, participants were not masked to treatment allocation, and outcome assessment was through web-based questionnaires. The primary objective was to evaluate effectiveness in improving quality of life (QoL) at 52-week follow-up, controlling for usual care. The primary analysis was a linear regression model of outcome. The economic analysis compared costs and Quality Adjusted Life Years (QALYs) gained between arms, from a healthcare provider perspective. Analyses were baseline-adjusted, using a modified Intention To Treat principle [https://doi.org/10.1186/s13063-023-07246-8].

Results: 1,023 participants recruited from March 2020 to March 2021 (Intervention 507, control 516). 80.8% White British; 79.3% female; mean age 38.4±13.6 years. Mood disorders (61.2%) and stress-related disorders (14.9%) were the most common primary mental health problem. At week 52, we found a significant baseline-adjusted difference of 0.13 (95% CI: 0.01-0.26, p=0.041) in the Manchester Short Assessment score between arms, and a significant baseline-adjusted difference of 0.22 (95% CI: 0.05-0.40, p=0.014) in the Meaning in Life Questionnaire [presence subscale]. We found an Incremental Cost-Effectiveness Ratio of £12,526 per QALY, lower than a £20,000 threshold used by the NHS in England, indicating a cost-effective intervention.

Conclusion: We have provided first-in-field evidence that online mental health recovery narratives provide meaningful benefits to people experiencing non-psychosis mental health problems. The increased presence of meaning in life may protect against mental health distress. Future studies could examine alternative narrative delivery mechanisms.

Current situation of mental health services in Tanzania; call for support and collaborative research

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Like many other countries, Tanzania is also affected by mental health conditions. Recent reports have described the need for interventions due to a rapid increase in severe mental illness cases such as depression, schizophrenia, bipolar, suicide rates, and high rates of gender-based violence, especially sexual abuse, intimate partner violence, and substance abuse. In 2015, Tanzania ranked 3rd in eastern and southern Africa for high alcohol and cannabis abuse.

While the nation has made progress in mental health services, with psychiatry units available in all regions and methadone-assisted opioid dependence treatment offered in various health settings, a shortage of mental health professionals impedes service delivery. In 2020, there were 38 psychiatrists per 100,000 people, highlighting the need for increased mental health workforce capacity.

Lack of mental health services within the national health information system poses challenges in assessing the true scope of mental health issues and service effectiveness. The stigma surrounding mental health disorders further hinders high-quality and equitable care in communities and healthcare settings.

Considering the current situation of mental health services, there is an urgent need to address the key areas to achieve improvement in the provision of mental health services in Tanzania. Including the following: -

1. Conducting a country-wide mental health situational analysis to learn the true magnitude of mental health conditions.

2. Integrating mental health services into primary care settings by training non-mental health professionals, especially on user-friendly screening tools and brief interventions for patients with mild mental health conditions.

3. Scaling up the UPSIDES intervention model. Increasing peer-to-peer support services will narrow the gap of limited personnel.

4. Strengthen the capacity of health workers to provide mental health services to increase the number of mental health professionals in the country. In conclusion, the government of Tanzania calls for increased collaboration for mutual learning with local and international partners to improve mental health services.

What happens when we implement experiential knowledge as an equal source of knowledge

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In several mental health organisations in the Netherlands users'lived experiences are seen as a source of knowledge: experiential knowledge, that can be used professionally. As a 'third source of knowledge', it is seen as a necessary equivalent source to that of scientific and professional knowledge. Our research team has seven years of experience in action research implementing experiential knowledge in five mental health organisations. Experiential knowledge has six characteristics, summarised in the acronym PEPPER. Experiential knowledge is Practical, Existential, Political-Critical, Personal, Ethical and Relational. In the presentation, we give practical and artistic examples of these six characteristics. We describe what happens when experiential knowledge is implemented as a source of knowledge in mental health organisations. Experiential knowledge is also potentially present among nurses, social workers, psychologists and psychiatrists. To learn how to use experiential knowledge properly, they can take training courses. The first master Experiential Knowledge started September 2023 at Windesheim University of Applied Sciences. When experiential knowledge is given space, interesting dynamics take place between clients, professionals and management. It contributes to a more equal and reciprocal contact between clients and professionals. It promotes recovery-oriented work and reduces the stigma attached to psychiatric disorders and addiction. To give experiential knowledge real space, a number of conditions are needed. In our presentation, we will discuss some dilemmas and questions we encountered in our action research. At the moment there are about 400 educated professionals-with-experiential expertise working in the mental health sector in the Netherlands and about 1000 educated professional peer support workers. The dutch Association of Experiential Experts (VvED) promotes the professionalisation of experiential experts. The presentation will be given by professor dr. Alie Weerman, three researchers from her research group and by the president of the Dutch Association of Experiential Experts.

Peer support for adults with mental health issues:What components were adapted after implementation?

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Introduction

In healthcare, adaptation refers to the alteration of an intervention's design or delivery to improve its fit or effectiveness based on the local context. Throughout the implementation process, a mental healthcare intervention might be modified, successfully or not, for several reasons. If these modifications are not fully recorded or understood, then their successful implementation, effectiveness evaluation and sustainment will likely be hindered. The exploration of the adaptation concept in relation to the implementation of mental health recovery-oriented interventions is nascent despite the proliferation of research on the implementation and evaluation of mental health recovery into services.

Methods

Following a multisite multiphase project on implementing mental health recovery guidelines in Canada, 19 staff members who were involved in implementing and sustaining peer support in housing services for people with mental illness participated in a mixed methods study. Participants completed questionnaires and were interviewed between 2022-2023. Data collection and analysis draw on the Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) and the Program Sustainability Assessment Tool (PSAT).

Results

We will report on the adaptations made to peer support that emerged after initial implementation and its fidelity to the core principles of peer support and mental health recovery.

Discussion

Adaptation is a core component of sustainability. In terms of mental health recovery, the type and nature of adaptations will determine the level of sustainment of recovery-oriented interventions. Sustainment cannot be achieved if the adaptations compromise the core principles of mental health recovery, including self-determination of users of mental health services.

Conclusion

Findings from this research contribute to the uptake and sustainment of mental health recovery-oriented innovations since interventions are adapted throughout the implementation cycle.

Multicultural experiences of service users receiving UPSIDES peer support

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Introduction: UPSIDES is an multinational research initiative aimed at developing and implementing a peer support (PS) intervention across diverse socio-economic status, cultures and organizational contexts. The intervention is committed to universal core peer principles, while maintaining local flexibility. However less is known about the experiences of service users (SUs) receiving peer support. The current study investigates the experiences and attitudes of SUs who received the UPSIDES peer support intervention.

Methods: Using a mixed method design 'edge' participants were purposively selected based on self-report measures which indicated either high or low changes in the main outcome measure . Thirty-four semi-structured interviews were conducted at six study sites (Germany, Uganda, Tanzania, Israel, & India). Transcripts were analyzed using qualitative content analysis.

Results: Data analysis revealed four themes: (1) Variations in settings (e.g., place, duration, frequency of meetings) highlighting both advantages of flexibility and downsides such as different service-user/peer-support-worker preferences and uncertainty. (2) Positive outcomes of PS such as improvement in intra-personal (e.g., self-care, treatment adherence) inter-personal (e.g., family relationships, social inclusion), and behavioral (starting a job) aspects. (3) 'Active ingredients', such as the experience of being seen and cared for and having a role model of recovery. (4) Barriers, such as personal resources invested, criticism of PSWs, and feeling obliged to participate.

Discussion: SUs experienced a wide variety of benefits following UPSIDES peer support intervention. For some, the mere experience of having a person to talk to was rare, more so in low-income-countries. Others highlighted processes of non-judgmental acceptance and having a recovery role model. Barriers suggest that a careful matching process between the PSW and SU could improve benefits.

Conclusion: Findings lead to important insights on the value of PS, and highlight further steps to implement PS services in various cultural and organizational contexts.

Measuring PROMs and PREMs in substance use treatment for improving outcomes and quality of services

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Patient-Reported Outcome Measures (PROM) and Patient-Reported Experience Measures (PREM) are important sources of information for improving quality of care and developing patient-centered treatment and monitoring. Outcome studies of substance use disorder (SUD) treatment traditionally focuses on drug use and deficits in functioning, overlooking other aspects of human functioning and the personal and non-linear process of recovery.

The OMER-BE study (Outcome Measurement and Evaluation as a Routine practice in alcohol and other drug services in Belgium has been set up as a naturalistic multicentric study assessing and monitoring 200 service users in alcohol and drug treatment services at baseline and 45, 90 and 180 days later. The ICHOM Standard Set for Addictions (2020) is used to measure PROMs and PREMs, a set of brief, validated questionnaires to measure and monitor treatment outcomes routinely.

Preliminary findings show significant improvements in quality of life and several recovery indices 90 days after starting treatment. Other outcome indicators (e.g. employment, social connections) remained rather stable over the 3 month follow-up period. Service users are generally very satisfied with services received, but are less satisfied with the privacy they get and opportunities for individual counselling.

While still ongoing, the OMER-BE study shows that it is feasible to routinely monitor PROMs and PREMs in alcohol and drug services and by doing so, monitoring and supporting the recovery process of individuals with alcohol and drug problems.

Multi-professional practices in Occitanie's health centers for addiction care

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Introduction : The causes found for GPs' lack of involvement in addiction care are a feeling of lack of training, negative representations and a lack of interdisciplinary. The primary objective was to assess the current state of multi-professional addiction care in the ambulatory health centers ("maisons de santé pluriprofessionnelles" and "centres de santé" of Occitanie), and the secondary objective was to evaluate the interest of these structures for the development of "microstructures médicales addiction" (MSMAs).

Method: This descriptive cross-sectional epidemiological study surveyed health centers in 2023, using a self-administered questionnaire consisting of 33 questions, and divided into 3 parts (characteristics of the structures / multi-professional addiction care / interest in the MSMA concept).

Results: 136 structures (including 20 MSMAs) responded, giving a response rate of 43.4%. 65.2% of these structures used in-house multi-professionality for addiction care. The main professions involved were nurses and psychologists (56%). Nearly 40% of the structures took part in the tobacco-free month, and 19.8% organized other addiction-related activities. The promotion of addiction care via health projects/actions and the creation of addiction protocols were associated with the age of the structures and with being an MSMA. 74% of respondents thought it would be interesting to hold specific multi-professionnal concertation meetings for addictions. 58.1% wanted training in addictology, and 56% were interested in setting up an MSMA in their facility.

Discussion - conclusion : Despite a selection bias, our study included a substantial number of structures. The vast majority worked on addiction care as a team, but few addiction-related projects/actions were in place. Given the interest in the MSMA concept, and the link between the development of projects and the maturity of the structures, we can expect to see an evolution in addiction care and new multi-professional practices in the years to come in primary care.

Please, see me : Informal and professional support of students with relatives with addiction problems

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Introduction

Addiction problems also affect the lives of family members, referred to as Affected Family Members (AFMs). This study aims to examine: (1) AFMs' experiences with informal and professional support in coping with the impact of relatives' addiction problems and (2) how these experiences evolve.

Methods

Four rounds of in-depth, semi-structured individual interviews were conducted over three years. Thirty students of a University of Applied Sciences in the Netherlands, aged 18-30 years, participated in the study at baseline. 93% participated in at least two interviews, and 80% participated three or four times.

Results

Four main themes were extracted from the data: (1) Informal support; (2) Educational support; (3) Health care support; and (4) Support needs. Most AFMs in our study received support from various people in their social environment and a wide range of professionals. Informal and educational support were described as helpful more often than health care support, although half of the AFMs did not discuss their experiences at high school or university. Only a few participants had long-term relationships with professionals they trusted. Finding helpful healthcare support was often a long road through various therapies and therapists. Some participants perceived professionals as lacking in knowledge, awareness, or even sympathetic understanding. Participants were not attracted to group interventions.

Discussion

Teachers and study coaches should be trained to identify students suffering from the addiction problems of their family members, to discuss these experiences, to gain knowledge of services, and to refer them adequately. Healthcare professionals should be better informed about the experiences of AFMs and the strain on their physical and mental health. This would prevent negative reactions and promote empathy from professionals. Therefore, it is recommended to train healthcare professionals to understand AFMs' experiences, recognize their support needs, and help them to cope.

The accessibility of mental health care for persons with substance use problems in Belgium

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Background – Persons with substance use problems make up a considerable proportion of mental health care service users worldwide. Since 2009, Belgian mental health care underwent a nation-wide reform ('Title 107') aiming at realizing a mental health care system that fosters more adequate collaboration, promotes de-categorization between and across different services, and is more responsive to the support needs of all service users. Despite the fact that persons with substance use problems were named as a prioritized target group, the way this reform impacted the lives and recovery journeys of persons with substance use problems remains understudied. The presented qualitative study focuses on the lived experiences of persons with substance use problems and aims to unravel the underlying dynamics impacting the accessibility of mental health care services. **Methods –** Data were collected by means of in-depth interviews with a heterogeneous sample (n=52) of persons with substance use problems, including persons who do not have access to services, recruited from five regional mental health networks. Interviews were analyzed thematically. **Results –** Five dynamic themes influencing the accessibility of mental health care for persons with substance use problems come to the fore: fragmentation of care and support, the importance of "really listening", balancing between treatment-driven and person-centered support, the ambivalent role of peers, and the impact of stigma. **Discussion –** Despite the 'Title 107' reform, participants still experienced mental health care services as 'islands in the stream', pointing to four priorities for future policy and practice development: breaking the vicious cycles of waiting times, organizing relational case management, tackling stigma and centralizing lived experiences, and fostering recovery-promoting collaborations.

Exploring the salience of mental health issues in pandemic decision-making: a qualitative analysis

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Introduction: To examine stakeholder perspectives on the attention given to mental health in the COVID-19 pandemic, particularly trying to understand the role that stakeholders' ideologies, world views, beliefs and interests played in the decision-making processes.

Methods: In-depth semi-structured interviews were held with a range of stakeholders including selected public health and mental health policymakers in eight European countries. Interviews investigated the salience of mental health issues, stakeholder beliefs and how and when their interactions affected the way mental health and wellbeing issues were addressed during the COVID pandemic. A modified version of a six-step reflexive thematic analysis approach, informed by the Advocacy Coalition Framework approach to the policy making process, was adopted.

Results: The narrow focus on actions to reduce the transmission rate of the virus, particularly at the beginning of the pandemic, meant that wider concerns including mental health only tended to emerge over time, rather than being taken into account in planning. Previous pandemic preparedness plans did not focus on population mental health. Over time financial and other social welfare measures, addressing social isolation, as well as the importance of keeping schools open, were also recognised as being important for mental health.

Discussion: Mental health was not a major consideration for policymakers during the first wave of COVID in Spring 2020. Over time policymakers more actively and explicitly acknowledged the importance of impacts on mental health when formulating policy, including for example, when balancing virus containment with the impacts of reopening schools and the wider economy.

Conclusion: There is a need to put mental health protection plans in place for future pandemics and other public health shocks, including measures to help support the long-term recovery of population groups whose mental health is most affected.

Balancing health and mental health in a pandemic : A Discrete Choice Experiment in 8 EU Countries.

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Background. Policy decisions, often made hastily and prioritising short-term considerations with a focus on physical health, raise questions about the alignment of policymakers' choices with the preferences of the general population. This study addresses this uncertainty through a discrete choice experiment (DCE), examining the preferences of both the population and stakeholders regarding four well-being attributes (physical health, mental health, employment and liberty) during a pandemic. The aim is to uncover the core values guiding mitigation policies.

Method. The DCE method, rooted in random utility theory, modelled individuals' choice behaviour. An online survey gathered responses from 1,600 individuals, representative of the general population and 250 health stakeholders across eight European countries (Belgium, France, Germany, Italy, The Netherlands, Spain, Sweden, United Kingdom). Respondents assessed two fictitious countries (A and B) in six blocks, each representing pandemic mitigation policy consequences differing on four attributes: hospital admissions(low, medium, high), psychological distress, job loss, movement restrictions.

Results indicated that most respondents engaged in trade-offs between attributes, with psychological distress exerting the greatest influence and mobility restrictions the least. Stakeholders prioritised psychological distress more than the general population ($Chi2=15,7$, $p<0.01$), while the opposite was true for mobility restrictions mobility ($Chi2=22,5$, $p<0.01$). Respondents with higher stigmatisation of mental health issues were less sensitive to psychological distress.

In conclusion, this study reveals divergent preferences between stakeholders and the general population regarding mental health and civil liberties restrictions, providing insights into essential considerations for shaping effective mitigation policies.

SP-26 | Navigating Well-being: Policy Approaches and Mental Health in the COVID-19 Era - Vincent LORANT, Institute of Health and Society, Université catholique de Louvain

Preparing health systems to reduce mental health problems during public health and economic shocks

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Introduction: Public health crises and economic shocks raise profound challenges for population mental health. There is much to learn from different policy approaches to the COVID pandemic across Europe. We sought to identify strengths and weakness of these responses and make recommendations to aid in health system preparedness for future crises.

Methods: Mixed-methods analysis, including a mental health impact assessment of health and wider system policy responses to the COVID-19 pandemic in eight European countries, informed by findings from observational studies, policy documentation, media reports, literature reviews and semi-structured interviews.

Results: Variation in stringency of pandemic responses is likely to have influenced population mental health. There were some adverse impacts from school closures, social distancing, lockdowns and measures to protect vulnerable people, on mental health, particularly on depression and anxiety. Adverse impacts disproportionately fell on several high-risk population groups. There were also improvements in mental health and wellbeing associated with pandemic policy responses for some population groups. It is likely that additional income/social protection measures, which mitigated immediate economic impacts of the pandemic, may have cushioned some of the mental health impacts of the pandemic.

Discussion: In planning for future crises, additional resources to protect the mental wellbeing and resilience of individuals at high-risk of not being in employment, education or training are likely to be needed. Our analysis highlights the value of real-time measurement of population mental health and wellbeing during the pandemic. It made it easier to identify positive and negative impacts of changes in stringency of policy responses for mental health.

Conclusion: Policy responses need to be multi-sectorial, which implies cross-sectorial planning, which was not always evident during the pandemic. It is also important not only to plan for future pandemics and other public health emergencies, but also plan for continued recovery after these emergencies have ended.

What do women with FGM_C need? A qualitative study among women with FGM_C living in Germany

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Although Female Genital Mutilation_Cutting is forbidden by law in Germany, the number of girls and women affected by different forms of FGM_C living in Germany are rising (). This is why the German health care system must adapt and develop treatments for the many different health problems (somatic as well as mental) that can arise during and after the practice. In the past years, there have been many initiatives to promote information on the topic and to improve accessibility in care for women in need- mostly done by NGO's. The topic of FGM_C has become a regular part of the midwifery training in 2021, other medical areas did not make it an obligatory part of the curricula yet. This means that usually gynecologists, urologists and general practitioners have not been trained on the topic. There have been trainings for social workers who work with refugees, but usually psychologists, sexual therapists, trauma therapist, psychotherapists trained in Germany have not learnt about it. Experiences of FGM-clinics in other European countries have shown that a multidisciplinary treatment approach is the most efficient and successful.

Since there is a development to include FGM_C in the curricula, the voices of the women who are affected by the practice should be involved in the process. That is the goal of this qualitative study, in which women who are affected by different forms of FGM_C with different symptoms will be asked about their needs, wishes, experiences and expectations regarding the German health care system. The semi-structured interviews will take about 60-90 minutes and will be translated by an experienced interpreter if needed. The first findings of the qualitative impact analysis (method by Kuckartz and Rädicker) will be part of the presentation.

Implementing the Patient Carer Race Equality Framework : Reducing the use of Restrictive Practice

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Introduction Individuals identified as belonging to racialised ethnicities in the UK (African, Caribbean and Asian) requiring access to mental health care, have long reported ethnic disparities in the access, experience and outcomes of mental health services (Bansal et al 2022). As populations characterised as 'Black', when they do access care, they are more likely to report negative experiences that often result in poorer outcomes. The Patient Carer Race Equality Framework (PCREF) is a new legislative, regulatory and accountability framework that now applies to all statutory mental health trusts in England. With an expressed service-wide transformation objective targeting leadership, governance, organisational competence, culture and feedback of service offerings to racialised communities, it is driven by a co-produced, anti-racist and human rights mandate. Spearheading the challenge against ethnic inequality within mental health services, it seeks to respond to the concerns of the local community and service users. Sheffield's PCREF delivery plan has therefore focused its sights on the reduction of the use of restrictive practice within in-patient care for racialised individuals, in particular for black and brown men.

Method The research on which this presentation is based comprises five work packages; a stakeholder mapping, development of an initial logic model describing the implementation resources, activities, outputs, outcomes and anticipated impact of PCREF; a process evaluation and completed logic model. The third work package (presented today) comprises a 'nested' process evaluation using an implementation science approach. Comprising four PCREF activities, a 5 month evaluation of (1) Enhanced monitoring of inpatient restrictive practice and post-incident reviews ; (2) Cultural advocacy on inpatient wards; (3) Improving access and pathways to mental health care in racialised communities; and (4) Improving protected characteristics data collection methods is undertaken. With the support of senior researchers, recruited peer researchers will use the Stanford Lightning Report method, a pragmatic qualitative rapid assessment and reporting tool, to collect data reflecting a Plus, Delta and Insight synthesis of each PCREF activity. Drawing on their inclusion, and supervision as part of the research team, and methodology training, the peer researchers will take the lead with this package of work.

Results From the results of the first work package, an emerging picture of the Trust at the 'foothills' of race equity change emerges. With a small implementation team, awareness of PCREF is gradually spreading throughout racialised communities. Conversations regarding the reduction of restrictive practice are becoming more readily and easily broached, enabling the implementation landscape to reveal its 'green shoots' of epistemic justice as the beginnings of racial equity.

Conclusions With the continual championing of lived experience and human rights practice for reducing the use of restrictive practice, and beyond, PCREF's race equity ambitions become realised.

Comparing outcomes of psychiatric rehabilitation between ethnic-religious groups in Israel

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Psychiatric rehabilitation for people with severe mental illness (SMI) has many documented benefits, but less is known about cultural related aspects. To date, no comparison of psychiatric rehabilitation outcomes between Israeli-Jews and Arabs was carried out. Thus, the purpose of the present study was to compare the outcomes of Israeli-Arabs and Jews consuming psychiatric rehabilitation services. As part of the Israeli Psychiatric Rehabilitation Reported Outcome Measurement project (PR-ROM), a cross-sectional study comparing between different ethnic-religious groups was performed. Data is based on 6,751 pairs of psychiatric rehabilitation consumers and their service providers. The consumers filled questionnaires on quality of life (QoL) and functioning, and their providers completed mirroring instruments. The findings revealed that QoL and functioning ratings were lower among Muslim-Arabs compared to Jews on both consumers' and providers' ratings. Among Muslim-Arabs, differences in outcomes according to the service's location were indicated. The observed differences between Israeli-Arab and -Jews with SMI in the PR-ROM point to the need for culturally adapted rehabilitation services that take into account how cultural differences may affect the benefits of such services.

Exploring barriers and facilitators to recovery among Afro-Caribbean mental health service users

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Introduction: Evidence suggests that minorities with mental distress underuse mental health services compared with the majority population. Such under-utilization, combined with other socio-cultural factors, can impede recovery from mental illness. The Afro-Caribbean community in Canada is a fast-growing population, but their mental health service experience has been under-researched. As such, we set out to examine perspectives and experiences among Afro-Caribbean service users, exploring (i) self-identified barriers and facilitators towards recovery; (ii) experiences within the official mental health care system; and (iii) use of alternative treatments and remedies outside the official system.

Methods: To meet these aims, we employed a qualitative community-based approach, conducting in-depth semi-structured interviews with 18 Afro-Caribbean service users with a variety of mental disorders. Data was analyzed using thematic analysis.

Results: Analysis revealed three themes. First, participants pointed to their Christian faith as a vital source of comfort and solace, which helped their recovery. Practices such as prayer, consulting scripture and church attendance were considered particularly helpful. Second, participants reported that some people in their social circle (especially older relatives, e.g. parents) held stigmatizing views of mental illness, including sceptical views about the reality of mental illness. This was a barrier to recovery, as it inhibited disclosure and delayed help-seeking. Third, many participants reported common issues within clinical services including (i) lack of understanding of Afro-Caribbean cultural norms; (ii) avoiding discussion of religion and spirituality, which was central to many participants' lives; and (iii) an overemphasis on medication as a solution. Subsequently, many participants reported seeking out alternative activities including Reiki, herbal medicine, dance, exercise and other naturopathic remedies. Participants typically praised these activities as facilitators of recovery, while downplaying the role of medication.

Conclusion: The results suggest an urgent need for religious and cultural competence for Canadian clinicians to better engage minority patients and facilitate recovery.

Predicting population risk of suicide using routinely collected health administrative data in Quebec

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Background: Suicide is a significant public health issue. Policy and decision makers can play an important role in suicide prevention. However, few prediction models for population risk of suicide have been developed.

Objective: To develop and validate prediction models for population risk of suicide using health administrative data.

Methods: We used a case-control study design to develop sex-specific risk prediction models for suicide, using the health administrative data in Quebec, Canada. The training data included all suicide cases (n = 8,899) that occurred from January 1st 2002 to December 31st 2010. The control group was a 1% random sample of living individuals in each year between January 1st, 2002 and December 31st, 2010 (n = 645,590). The developed model was converted into synthetic estimation models with community characteristics as predictors. The models were directly applied in the validation data from January 1st, 2011 to December 31st 2019.

Results: The sex-specific models based on individual data had good discrimination (Male model: C = 0.79; Female model: C = 0.85, and calibration (Brier score: male model = 0.01, female model = 0.005). With the regression-based synthetic models, the absolute difference between the synthetic risk estimates and observed suicide risk ranged from 0 to 0.001%. The Root Square Mean Errors were under 0.2. The synthetic estimation model for males correctly predicted 4 out of 5 high-risk regions in 8 years, and the model for females correctly predicted 4 out 5 high-risk regions in 5 years.

Conclusion: Prediction models built on routinely collected health administrative data can accurately predict population risk of suicide. This effort can be enhanced by timely access to other critical information at the population level.

Cluster B Personality Disorders: Age & Sex Differences in Psychotropic Medication Use

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Introduction: Psychotropic medications are commonly prescribed to patients with Cluster B personality disorders (PDs). However, sex- and age-specific patterns of medication use remain inadequately explored. This study aims to fill this gap by analyzing sex and age differences in psychotropic medication use in the year before and after the initial diagnosis of cluster B PD, alongside trends spanning recent decades.

Methods: We used the Quebec Integrated Chronic Disease Surveillance System database to identify individuals (≥14 years) newly diagnosed with Cluster B PDs between 2002 and 2018 covered by the provincial public drug plan. Yearly and monthly proportions of users of psychotropic medications pre and post-diagnosis were measured, focusing on antipsychotics, antidepressants, anxiolytics, mood stabilizers, and ADHD medications. Data were stratified by sex and age groups. Robust Poisson regression models were employed to investigate the association between sex and the likelihood of exposure to various psychiatric medication classes after the first cluster B PD diagnosis.

Results: The study included 87,778 new cases of cluster B PDs, with an average age of 44.5 years; 57.5% were female. Psychotropic medication use increased post-diagnosis compared to pre-diagnosis: antidepressants (from 51.6% the year before diagnosis to 54.7% the year after), antipsychotics (35.9% to 45.2%), mood stabilizers (14.8% to 17.0%), and ADHD medications (5.1% to 5.9%). This increased use was similar across both sexes. Women were more likely to use antidepressants and anxiolytics, whereas men predominantly used antipsychotics and ADHD medications. Younger patients tended to use ADHD medications, and older ones anxiolytics. Over the study period, there was a noticeable increase in ADHD medication use, while anxiolytic use showed a declining trend.

Discussion-Conclusion: Cluster B PD patients showed high psychotropic medication use with distinct patterns based on age and sex. Prescription trends remained consistent across sexes but shifted in the last decades, reflecting evolving clinical practices

Sex differences and age of onset in recovery and well-being in people with psychotic disorders

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Introduction

Considering the significant knowledge gaps regarding women's health, as highlighted by the World Health Organization, this study focusses on sex differences in people with psychosis. Women are thought to have a more favourable course of psychotic illness than men, although this might only apply to early onset psychosis. Next, little is known about sex differences in more subjective outcomes such as recovery and well-being. This study longitudinally examines sex related differences and age of onset in recovery and well-being of people with a psychotic disorder.

Methods

Routine outcome monitoring data of n=3843 patients were used from yearly screenings between 2012-2021. Clinical-, societal- and personal recovery were assessed, as well as quality of life and psychosocial functioning. Four groups were created: men (n=2276) and women (n=1111) with early onset psychosis (<41 years old) and men (n=217) and women (n=239) with late onset psychosis (>40 years old). Latent growth mixture modelling (LGMM) was performed to assess different patterns of recovery and well-being.

Results

LGMM identified five classes of recovery and well-being patterns. Sex had a significant main effect on the distribution across the five classes (χ^2=55.2; p<0.001), whereas there was no main effect for age of onset (χ^2=10.5; p=0.033). There was a sex-age of onset interaction effect where women with late onset had the highest chance to be in higher functioning classes (χ^2=65.8; p<0.001).

Discussion-conclusion

This study shows sex differences in long-term recovery patterns of psychosis. Women indeed showed more favourable recovery and well-being patterns, especially with late onset psychosis, while men with early onset of psychosis had the least favourable recovery patterns. The different recovery patterns were relatively stable and showed minimal changes over time. Addressing these sex differences in policy and treatment protocols might provide better mental health care to people with psychosis.

The impact of social connections on recovery in community mental health services.

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Introduction:

Feelings of loneliness and poor relationship satisfaction have been associated with a large range of negative physical and mental health outcomes. The wide-ranging implications of the various facets of social connections for public health are increasingly recognized, yet, there is limited research on how these factors affect recovery in real-world mental health services.

Methods:

A retrospective observational cohort study was conducted using data from 15,512 individuals aged 18 to 99 who sought in-, or outpatient help at GGZ Noord-Holland-Noord in the Netherlands between February 2010 and August 2023. The study examined demographic characteristics, perceived loneliness, social relationship satisfaction, symptom distress, role functioning satisfaction (using the Outcome Questionnaire-45), time to discharge, and mortality. Data were stratified by diagnosis, sex, and age, and univariate regression analyses were used to explore the association between social connections and mental health outcomes.

Results:

Both poor social relationship satisfaction and loneliness were independently linked to symptomatic distress at initial assessment and follow-up ($p<.001$), with slightly weaker associations for role functioning satisfaction. The impact of social factors on symptomatic distress was stronger in individuals diagnosed with psychotic or bipolar disorders than in those with other disorders (SRS baseline: $R^2=.004$, $p<.001$; follow-up: $R^2=.08$, $p<.001$, Loneliness baseline: $R^2=.002$, $p=.002$; follow-up: $R^2=.05$, $p<.001$)). Interestingly, older individuals reported lower levels of social relationship satisfaction and loneliness, yet, the negative impact of poor social connections on outcomes was similar across all age groups. No significant sex differences were found in these associations.

Conclusion:

Despite certain diagnostic groups and older individuals experiencing less loneliness and poor relationship satisfaction in our mental health service, the negative impact of these factors on mental health outcomes is profound across all age groups, highlighting the need for attention to the social network in mental health care.

PULSAR - RETAFORM Symposium Paper 1: PULSAR; a methodological perspective.

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Where Recovery Oriented Practice (ROP) interventions are team or organisation-based, Stepped-wedge cluster-randomised Controlled Trials (SW-cRCT) designs can offer advantages including ameliorating some sources of bias that may arise in other parallel groups designs. Experience with such designs and their analysis has been accumulating in the ROP field, including through the positive findings from the PULSAR project. But settling on an SW-cRCT design can leave open many questions about design and analysis. The PULSAR study (1) was a SW-cRCT which featured stratified randomisation with a combination of Complete and Incomplete, repeated cross-sectional and longitudinal data collection strategies. These design features contributed to the study being able to demonstrate positive findings in ways that will be considered and reviewed in the presentation. Also, drawing on a healthcare-specific implementation model, 'Promoting Action on Research Implementation in Health Services' (PARiHS) the PULSAR project undertook a process evaluation to understand the implementation and contextual processes that contributed to impact of the REFOCUS-PULSAR staff training on personal recovery among consumers receiving specialist care services. This presentation will include description of application of a tool based on the PARiHS framework to identify those service teams and contexts most responsive to the training intervention. The application of this approach can add value to team-based research work, including in trials of training interventions. This method may be particularly useful where teams are already strongly aligned with the desired direction of change and may in turn guide adaptation of such interventions to team.

(1) Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., Weller, P. J., Wilson-Evered, E., Edan, V., & Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. The Lancet Psychiatry, 6(2), 103-114.

Paper 2: Consumer views and experiences of services following REFOCUS-PULSAR staff training

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[1]Department of Occupational Therapy, School of Primary and Allied Health Care, Monash University, Melbourne, Australia

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The PULSAR study was a large scale Stepped-Wedge Randomised Controlled Trial using an adapted version of the REFOCUS training approach seeking to promote recovery oriented practice across a range of service sectors and teams in mental health services in Melbourne Australia (1) As part of the research program associated with PULSAR, a qualitative study (2) explored how consumers perceived their recovery following community mental health staff undertaking the co-delivered REFOCUS-PULSAR training in recovery-oriented practice, through one-on-one interviews with twenty-one adults receiving community mental health care. Findings have not previously been presented in this setting. The identified themes included connections to community and professional staff were viewed as important to support their recovery journeys; that seeking and striving towards a better life was personal and individual in how meaning around the idea of a better life was made; and that barriers to recovery primarily focused on lack of choice. Participants also expressed 'uncertainty' and struggled to identify not only what their recovered future might entail, but also to identify recovery focused language and aspects of recovery-oriented practice in their interactions with the service. In this presentation, we will discuss these themes, their implications for open, collaborative conversations around recovery between consumers and staff, and the development of specifically targeted recovery resources to facilitate such conversations.

(1) Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., Weller, P. J., Wilson-Evered, E., Edan, V., & Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. The Lancet Psychiatry, 6(2), 103-114.

(2) Kehoe M, Fossey E, Edan V, Chaffey L, Brophy L, Weller PJ, Shawyer F, Meadows G. Consumer Views and Experiences of Secondary-Care Services Following REFOCUS-PULSAR Staff Recovery-Oriented Practices Training. International Journal of Environmental Research and Public Health. 2023; 20(10):5894.

Paper 3: The RETAFORM study - REFOCUS in French service contexts.

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[3]Centre de Neurosciences Cognitive, UMR 5229, CNRS, Université Claude Bernard Lyon 1, Lyon, France

[4]Réseau Handicap Psychique, Grenoble, France

[5]Service de Psychiatrie de l'Enfant et de l'Adolescent, CHU de Saint Etienne, Saint Etienne, France

French national policy supports implementation of recovery-oriented practice in mental health facilities. But to date, there is no structured training on recovery-oriented practice in France and access to recovery-oriented services remains limited. Our research hypotheses are that implementation of REFOCUS in France i) will improve personal recovery at one year in people diagnosed with serious mental illness (SMI); ii) will improve other recovery-related outcomes at one year (perceived recovery orientation of MH professionals, perceived stigma, stigma stress, self-stigma, perceived coercion, wellbeing and psychosocial function) in people diagnosed with SMI; iii) will improve recovery-orientation and knowledge about recovery in MH professionals; iv) will reduce direct and indirect costs. The design is a Stepped-wedge cluster randomized controlled trial. Data collection has some similar features with the PULSAR study but here adapted to the different service context. Stratified randomization will be according to the nature of the 18 participating teams across southern and central France (community healthcare centres, daycare facilities, crisis management teams, assertive community treatment teams, etc…). Each centre will represent a cluster. Nine clusters will be randomized to receive the REFOCUS training the first year, the remaining clusters receiving the intervention in the second year. The experimental condition is REFOCUS training. The control condition is defined as routine clinical practice. A nested qualitative sub-study will investigate the respective experiences of: Trainers who trained mental health professionals to the REFOCUS intervention; Mental health providers who were trained to the REFOCUS intervention and manual; and Service users who received the REFOCUS intervention. The work is now well under way with training for Step 1 concluded and extensive participant recruitment that can be reported up to date at the time of the presentation.

Saturday 6 July

Conceptualising the role of community assets in addressing inequalities in mental health

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Background

Increasing proportions of individuals are recognising themselves as mentally ill. Workplaces, schools and universities are encouraged to help identify illness. A major problem however is that interventions such as antidepressants and psychological therapies are of only modest benefit compared to other medical interventions. Communities are now being asked to identify 'assets' (such as community groups, informal gatherings, hills, sea, parks) which might help address or prevent mental health problems and reduce inequalities.

Method

Examination of literature. Observational and interview work in three communities in South-west of England to understand the nature, role and sustainability of community assets. Workshops and discussions in communities and with academics to develop theories and models as to how community assets might address mental health inequalities. Reflection as a family doctor in a low-income setting.

Results

The nature of assets varied. Voluntary run groups were seen as important for people with mental health problems, but were often not led from low-income communities; resourcing groups was often a challenge. In an urban setting mental health need was very great despite large numbers of voluntary organisations; there was no consensus as to whether services or communities should be responsible for mental wellbeing, with some people more concerned about structural causes such as poverty.

Conclusion

A model for sustaining mental wellbeing and addressing inequalities needs to start with open dialogue with communities – acknowledging the limitations of medicine and potential for communities to have a key role. Communities should be supported to identify strengths. Current rapid access pathways to mental health care need disrupting; instead individuals with mild-moderate problems should be kindly directed to a range of self-help, tech based therapy and community assets. And people with ongoing severe mental health problems need communities to help identify them and be given proactive ongoing engagement.

Village Health Volunteers' mental health practice in Thai rural communities: A qualitative study

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Introduction: Thailand faces a 7.4% prevalence of mental disorders. The integration of mental health services into the broader healthcare system may lead to substantial accessibility gaps, particularly in rural regions. Village Health Volunteers (VHVs) are the backbone of primary healthcare, providing basic health care and gaining recognition for their diverse community activities. Despite their pivotal role, research on VHVs' mental health practice. and role is limited. While recovery orientation was endorsed in Thai national mental health policy in 2019, its implementation by VHVs remains underexplored. This study had two aims: (a) to describe and increase understanding of the current mental health practice and role of VHVs in communities, (b) to identify the enablers and barriers to implementing recovery-oriented mental health interventions by VHVs.

Methods: The research employed a qualitative approach, conducting semi-structured interviews with VHVs, individuals with mental illness, caregivers, and healthcare professionals in a rural sub-district in Northern Thailand. Data analysis involved reflexive thematic analysis and document analysis of VHVs job descriptions, training and recruitment policies.

Results: Preliminary findings highlighted a dominant medical orientation in VHVs' care for individuals with mental illness and a lack of clear job descriptions in mental health practices. Healthcare professionals trust VHVs' capabilities, and VHVs themselves express confidence in their skills. However, individuals dealing with mental illness and their caregivers perceive relatively lower levels of support from VHVs, impacting their trust and attitude towards these VHVs. Factors enabling successful implementation included intervention simplicity and healthcare provider support, while barriers encompassed VHV commitments and their attitudes toward those with mental illness.

Conclusion: The study highlights VHVs' limited experience and unclear job descriptions in mental health practices. These findings promise to enhance understanding about how to enhance and support VHVs' mental health practices and inform the development and implementation of recovery-oriented practice interventions in Thai communities.

Taking the therapist out of therapy: a sustainable future for global mental health care

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Introduction: The focus of this study is lay counselling - a therapeutic approach that creates a sustainable future for global mental healthcare.

Building on evidence that you don't need formal psychotherapy qualifications to deliver effective therapeutic talk, lay counselling programmes distil the 'active ingredients' of talk therapy into interventions delivered by lay people.

This presentation draws on recent research collaborations between UK-based lay counselling initiative Talk for Health*, Durham University, TPO Nepal and Burans India, It will explain why global lay counselling practice now urgently warrants further research.

*At the 2022 ENMESH Conference, T4H outlined the nature of, and evidence demonstrating mental health impact of, their group peer counselling initiative, funded by the NHS in the UK since 2014, now winner of the 2022 UK Mental Health and Wellbeing Award for long term impact.

Methods: Throughout 2023, Talk for Health has collaborated with global partners to explore commonalities between their approaches to lay counselling. This think piece draws from contemporary social theory, existing literature, and the proceedings of a 2-day workshop among project partners.

Results & Discussion: Use of psychotherapy skills by lay counsellors is normally understood as 'task-shifting' from professionals to lay people. However, drawing on practice-based approaches to disease ontology in the social sciences, we argue that the problems mental healthcare sets out to address are in fact being radically reimagined, and addressed in novel yet effective ways, through global lay counselling initiatives.

These initiatives are often at odds with biomedical or psychotherapeutic frameworks, yet still highly effective. This has important implications for how we understand, respond to and evaluate mental health interventions.

Conclusion: We highlight an urgent need for further research into global lay counselling initiatives since they enrich our understanding of mental distress and its solutions, and create a sustainable future for global mental healthcare.

"Like talking to friends" Young people`s experiences of councelling i Danish headspace centres.

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[2]National Institute of Public Health, University of Southern Denmark (SDU), , DK 1455 Copenhagen, Denmark

Introduction: Poor mental health amongst young people is a serious public health concern and traditional services are not equipped to address the barriers that young people often face, in accessing sufficient support. To address these challenges, headspace centers have been established in Denmark, by the non-governmental organization Det Sociale Netværk. The headspace centers offer young people between 12 and 25 years, free support, and counselling, primarily delivered by trained volunteers. Limited scientific knowledge exists, about how the counselling is experienced by the young people using headspace, and how the counselling affects their mental health and well-being.

Methods: The study is part of a process evaluation of headspace, where the overall goal is to investigate the implementation of key activities, their mechanisms of impact, and their interactions with contextual factors. Young people are recruited from headspace centers in Denmark, for semi-structured interviews. All interviews are transcribed ad verbatim and subjected to thematic analysis.

Results: Preliminary results will include, among others, descriptions of how the participants perceive the counselling and support they have received in the headspace centers, their perspectives on how the centers operate and are designed, and how they experience counselling have impacted their mental health and well-being.

Discussion: Study results will contribute to knowledge about mental health promotion initiatives, how they can be implemented to successfully match young people's preferences and needs, and how the volunteer-based counselling offered in headspace centers in Denmark might create an impact on youth mental health and well-being.

The Challenges of Inclusion Experienced by Students With Mental Illness in Universities in Israel

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Objectives: The inclusion of persons with severe mental illness (SMI) in universities has become a focus of policy initiatives and as an opportunity to advance their recovery. However, a limited knowledge exists regarding the actual experience of students with SMI in the areas of social and academic inclusion. Social inclusion relates to the integration of students with SMI with other students and academic inclusion relates to their active involvement in academic studies.

Method: A qualitative study was conducted with 80 students with SMI participating in Supported Education programs in the major universities in Israel. They responded to open-ended questions about the barriers and difficulties they experienced to advance their social and academic inclusion, to their experience of sucess and what helped them overcome the challenges and difficulties.

Results: The findings illuminate barriers to academic inclusion which stem primarily from the effects of the mental illness and barriers to social inclusion which also stem from the approach of students in universities towards students with SMI. The emotional support that the mentors in the Supported Education programs provided was a signficant factor in helping students in these two areas. They especially emphasized the value of the individualized relationships and the safe space they provided. However, they also indicated that providing support within the individual meetings may not be sufficient to overcome external barriers such as stigma.

Conclusions: The findings illuminate the significant contribution of the individual help provided by the mentors in coping with the inclusion challenges. However, it is not enough to ensure that the studies of students with SMI will necessarily engender their feeling socially included and integrated. Therefore, the social and academic inclusion of students with SMI must be addressed at a broader systemic level such as via a whole campus strategy to promote their inclusion.

"SCOPERTA_PSYCH: Promoting psychological well-being in students"

Nosè MICHELA [1], **Giulia MURIAGO**[1], Giulia TURRINI[1], Federico TEDESCHI[1], Corrado BARBUI[1]

[1]University of Verona, Verona, Italy

Adolescent mental health is a growing concern, with an increasing number reporting poor psychological well-being. Early manifestations of mental disorders often emerge during adolescence, a vulnerable period when stress exerts significant negative impacts. Poor mental health can impact many areas of adolescents' life, also influencing academic engagement and success. This study focuses on Verona's high school students, aiming to: 1) assess their psychological well-being, 2) determine the prevalence of psychological distress, 3) plan future interventions based on collected data.

Conducted as a cross-sectional study, the online survey involved 500 Verona's high school students participating in university orientation classes. The survey consists of four self-administered standardized scales (K-10, PHQ-9, GAD-7, WHO 5) assessing psychological distress, depression, anxiety symptoms, and psychological well-being. A descriptive analysis of the study population and the results of the questionnaires has been performed.

Results show a moderate degree of psychological distress (K-10 score mean 24.21; SD 6.98) indicating that they are likely to have a mild mental disorder), a moderate depression severity (PHQ-9 score mean 10.11; SD 5.29), a mild anxiety severity (GAD-7 mean 8.69; SD 4.57) and medium-low level of psychological well-being (WHO 5, score mean 11.97; SD 4.87).

Significant gender-related differences were observed, with females exhibiting higher distress, anxiety and depression levels and lower psychological well-being than males. Nonbinary students scored worse across all scales, indicating potential general distress, although we cannot draw conclusions for individual scales due to the small group size.

This study enhances understanding of Verona's high school students' psychological well-being. Although not indicative of psychiatric pathology, the findings signal the need for attention to students' mental health. The results are particularly important to early identify distress and to plan future studies for the implementation of interventions for promoting psychological well-being and for preventing distress from generating into more serious mental disorders.

CAMPUS study: Characterize and Address Mental health Problems in University Students

Michela NOSÈ[1], Giulia TURRINI[1], Giulia MURIAGO[1], Federico TEDESCHI[1], Corrado BARBUI[1]

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The transition phase from late adolescence to early adulthood, which corresponds with the period of university life, is a time that offers opportunities for personal growth, but concurs with the peak period of risk for mental disorders. For this reason, the literature clearly identifies university students as a vulnerable population for psychogical distress and mental problems. Digital psychological interventions are emerging as a promising solution; the WHO has developed several e-mental health tools, which has been consistently shown effective in various vulnerable populations (Purgato et al, 2021).

The main objective of this project is to adapt the WHO psychological intervention called “Doing What Matters in Times of Stress” (DWM) to university students and to evaluate its effectiveness, feasibility, and acceptability as a psychological strategy for effective mental health prevention and promotion. Secondary objectives include to evaluate the fidelity of DWM, to assess factors associated with its implementation and effectiveness and to co-create the necessary local conditions for implementation and up-scaling of DWM.

This study is a prospective follow-up study, involving university students attending the University of Verona. The online assessments, which are collected pre (T1) - and post DWM intervention (T2), consist of an ad-hoc sociodemographic information page, and four self-administered questionnaires assessing psychological distress, depression and anxiety symptoms, and psychological well-being. In addition, implementation checklists will be administered to assess the acceptability, appropriateness and feasibility of the intervention.

Preliminary results on a sample of 550 students show that the adapted DWM intervention promote students' psychological well-being and reduce the level of psychological distress as well as the risk for the later development of a psychopathology. These results provide valuable information for mental health promotion and support programs for university students, as well as insights into factors influencing its implementation and suggestions for future scaling of the intervention.

Bingein and purging behaviors in higher education: prevalence rates and help seeking behaviors

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Introduction: This study has been conducted on a large, representative group of volunteer students. It aimed at estimating the prevalence of bingeing and purging behaviors (BPB), the portion of these students who received treatments for their mental health, the type of treatment received, as well as barriers to treatment. The study also aims at comparing results between different BPB groups (bingeing only, purging only, bingeing and purging) and between these groups and other students suffering from other mental health problems. Methods: Web-based self-report surveys were obtained from 18,723 students in all the higher education institutions from the Flemish College Surveys (FLeCS) in Flanders, Belgium. As part of the World Health Organization's World Mental Health—International College Student Initiative, the survey uses validated tools and scales. We screened for lifetime and 12-month BPB, numerous other mental health problems, type of treatment (psychotherapy, pharmacological treatments, other), and a variety of possible barriers to treatment. Results: One in five (24.7%) of the respondents reported 12-month BPB. Lifetime and 12-month service use were low, with lifetime estimates of 52.6% and 39.0%, respectively. The most relevant barriers to treatment among students with BPB were: preference to handle the problem alone; sensation that costs are too high; and uncertainty regarding where to find help. Average scores were significantly different between BPB groups, with a dose-response association with the number of BPB symptoms they experienced. The relevance of barriers to treatment is qualitatively similar between the BPB group and students with other mental health problems. Quantitatively, however, BPB seems to have a boosting effect on all the barriers, with average scores in this group being significantly higher. Discussion: BPB prevalence has increased in the last few years. There is a high unmet treatment need for BPB among college students. A reallocation of treatment resources for higher education students might be warranted.

Support after coercive practice: perspectives of mental health service users, carers and staff.

Lewys BEAMES[1]

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Introduction:

Coercive practices (CP), such as physical restraint, are common mental healthcare practices. Yet their use is controversial due to associations with physical and psychological harms in service users and staff. Furthermore, there is evidence of health inequalities in use of CP with certain groups, for example, people from Black and racially minoritised backgrounds, more often subject to CP during contacts with mental health service.

To prevent harm, healthcare guidelines recommend holding post-incident reviews or debriefs with service users and staff after an incident of CP (National Institute for Health and Care Excellence [NICE], 2015). However, evidence, including from groups more often exposed to CP (e.g. people from Black and racially minoritised groups), to suggest what makes these discussions helpful for service users or staff and how this intervention should be delivered in mental health wards is limited.

This study aims to address this research gap by exploring lived experience views of mental health service users, informal carers, and staff, who have experience of CP in mental health wards, on CP and how to improve experiences for service users and informal carers who have been exposed to CP.

Methods:

Individual semi-structured audio recorded interviews undertaken with mental health service users, informal carers, and staff stakeholders. Interview data subject to framework analysis to elucidate convergence and divergence of perspectives across stakeholder groups.

Results and Discussion:

Preliminary themes: ‘owning narratives’, incident narratives always from staff perspectives; trauma, CP as traumatic with lasting impacts, and ‘right support, right time’, distinction between immediate practical and emotional support on the ward and a later space to process the experience. Key themes as they relate to use and impacts of CP in mental health services, availability and quality of support, and improving service user and carer experiences will be discussed with reference to the broader literature.

Strategies to minimise Restrictive Practices in Acute Inpatient Services: A qualitative study

Tessa-May ZIRNSAK[1], Lisa BROPHY[1], Kerryn RUBIN[2], Janine DAVIES[2], Catherine BRASIER[1], Richard GRAY[1]

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Introduction: Restrictive practices are interventions – typically physical and mechanical restraint and seclusion – applied in inpatient mental health services intended to regulate client's behaviour. People who use inpatient mental health services have reported that restrictive practices are traumatic and hinder recovery.

The aim of this study was to develop an understanding of how restrictive practices can be reduced. Consequently, this research projects investigates the approach being taken by an Australian service with some of the lowest rates of restrictive practices, to identify factors to support these efforts.

Methods: This qualitative study involved interviews with people that had been an inpatient within 3 months of recruitment, their supporters, and care staff. Fieldwork was conducted by a lived experience researcher in a single mental health service in Melbourne, Australia with 50 inpatient beds. Transcribed interviews were thematically analysed.

Results: Forty-two people participated in the study. The key theme is: "person centred care appeared to minimise the application of restrictive practices." Participants spoke of top-down leadership directives that discouraged the use of restrictive practices, instead championing prevention methods such as interpersonal connections between staff and clients and use of PRN (pro re nata).

Discussion: The key finding from this study was that staff responsiveness to the needs of clients supports reduction in the use of restrictive practices. Our results are consistent with previous studies that have examined factors impacting the application of restrictive practices reported over many decades. Despite a clear set of approaches already documented in the literature mental health practice, there seems to be little indication that front line practice reflects this decades long accumulation of knowledge.

Conclusion: Rigorous application of approaches that are demonstrated to be effective can substantially reduce the need for interventions that are both distressing and potentially traumatising.

The influence of self-esteem and quality of the therapeutic alliance on psychotic symptom severity

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Introduction. The therapeutic alliance (TA) is increasingly acknowledged as a fundamental quality of care indicator. Numerous guidelines advocate TA awareness in practice, but lack specifics on building a strong TR. Yet, previous studies have found independent associations between levels of self-esteem, the quality of TA and severity of clinical symptoms in people with psychotic disorders. It suggests that the TA possibly mediates the relationship between self-esteem and psychotic symptoms. The present study therefore examined the relationships between these three factors in people with psychotic disorders. **Methods.** The associations between the severity of self-esteem, psychotic symptoms and the TA were examined in a cross-sectional study (n=109). The short forms of the Self-Esteem Rating Scale and the Working Alliance Inventory, respectively, were used to assess self-esteem and TA. Psychotic symptoms were evaluated using the Positive and Negative Syndrome Scale. Linear regression models were applied, followed by a mediation-model when appropriate. **Results.** A higher self-esteem significantly predicted less severe psychotic symptoms (B = -.312; β = -.46, p <.001) and better TA (B = .123, β = .255, p = .009). There was no significant relation between TA and psychotic symptom severity (B = -.161; β = -0.109, p = .289), therefore no mediation-analysis was performed. **Discussion-conclusion.** We found no association between TA and psychotic symptoms, which may be explained by the mild psychotic symptoms and overall high satisfaction scores on TA in our chronic sample. Another factor might be that current measurements assume a one-on-one relationship between a client and a professional, while nowadays multiple professionals are involved. Therefore, we recommend re-evaluating the definition and assessment of the TA within chronic psychiatric populations. Our study results also offer practical guidelines for clinicians to improve their quality of care, such as the recommendation to focus on enhancing self-esteem in people with psychosis.

Experience Based Co-Design in Developing a Peer Support Model for Refugees.

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As a consequence of the increasing scale of prolonged conflicts and disasters, the global number of displaced people has risen sharply. In the UK refugees are significantly marginalised; they suffer from a range of adverse health outcomes and experience higher rates of mental distress when compared with majority groups. Emerging research suggests that peer support models may provide an effective way to support refugees, and co-designed interventions work best.

The Routes to Wellness Study used Experience Based Co-Design (EBCD) to create a peer support model for refugees. In Plymouth and Gloucester, 11 interviews with refugees and 4 focus groups with refugees and service providers were conducted. The data were thematically analysed to identify touch point. EBCD was implemented to develop a manual, training, and support tools using our synthesised narrative qualitative touch point data.

The EBCD series of 8 workshops with refugees, researchers, and service providers identified that a peer support worker should: i) be an active listener who connects people with social groups and services, manages boundaries and solves problems; ii) they should communicate face-to-face with refugees; iii) be provided with ongoing support, supervision and mentoring; iv) have some training prior to, and more training after recruitment; v) be embedded in communities and work alongside services; vi) be equipped with an app that allows them to record details of support provided and gives easy access to information for signposting. To evaluate the peer support work, face-to-face conversations with refugees that receive support were preferred and regular follow-ups with peer support workers recommended.

To facilitate an effective and meaningfull co-design process when working with refugees, trust must be built up, a common language between the various actors must be developed, and creative resources must be available to navigate the complex settings of concepts, diversity, and strcutureal issues.

Expressions of distress by refugees and the implications for current notions of cultural competency

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People who are forced to migrate grapple with traumatic experiences both in their home countries and within hostile political environments in host countries. This can often lead to psychological distress and mental health crises. In the UK context, there are multiple obstacles to seeking mental health support, including language barriers, problems with interpretation services, stigma around mental ill-health, dispersal and discontinuities of care. Cultural factors are highlighted as a main barrier for services to provide adequate mental health support. Debates exploring culturally specific idioms of psychosocial distress suggest the urgent need to be informed about diverse ways of expressing mental health distress (e.g. Jannesari et al., 2022). This paper reframes this urgency and questions whether culture is a useful lens to address barriers of mental health support for refugee populations.

Methods

The Routes to Wellness project uses Experienced-Based Co-Design (EBCD) to develop a peer-support model to improve refugees' mental wellbeing. This paper analysed the narratives of research participants based in two cities in England. Participants included people with lived experience of forced migration (n = 25) and service providers (n = 21). Their accounts covered stories about health access and contact with services.

Findings

Our findings suggest that there is a commonality in the drivers and expressions of mental distress in a diverse group of participants. These include sleeplessness, loneliness and alienation, anger and distress from experiences of racism and discrimination, stress and worries about the current asylum-seeking structure.

Based on a critique of the notion of cultural competency, this paper reflects on the desire to acquire and to know how forced migrants as people from different cultural backgrounds experience and express distress. It explores the balance between culturally sensitive approaches and the danger of generalised assumptions about specific ethnic/linguistic populations, with implications for clinical practice and community support interventions.

A Qualitative Synthesis of the Drivers and Expressions of Mental Distress in Refugees.

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Introduction

This review explored the ways in which refugees express mental distress, privileged the many voices of refugees from across the research and offered subsequent implications.

Methods

Five databases were searched; PsychInfo, SocINDEX, Scopus, Medline (EBSCO) and Web of Science between 20/09/2013 to 27/10/2023. Inclusion criteria: only qualitative research published within the last 10 years which represented the voices of refugees sufficiently enough for thematic analysis; participants aged 18 years or older who identified as being within any stage of the asylum-seeking process.

Results

A total of 10 papers were included, which accumulated the voices of 204 refugees. Samples of refugees from 6 different countries were included; Syria, Iraq, Burma, Sri Lanka, Eritrea and Bhutan. Three overarching themes were apparent: Drivers of Distress, Expressions of Distress and Coping with Distress. Expressions of Distress were inextricably linked to the Drivers of Distress and how people voiced Coping with Distress. Drivers of distress were commoly reoprted in the post migration period arising from cultural conflict, racism, issues with access to health services and most notably, experinces of hostile asylum systems.

Discussion

Limitations were noted in the reviewed studies, including: a lack of prioritization of the refugee's voice; lack of diversity in authorship; lack of researcher reflexivity and in-depth ethical considerations; and that the use of participants' mother tongue to convey expressions of mental distress was only observed in 1 of the studies.
Implications include a need to address post migration drivers of distress, through international governmental improvements to the asylum-seeking processes and social justice work.

Conclusions

An appreciation of the diversity of expressions of distress through humility and practitioner reflexivity is crucial, alongside taking a strengths focused and community-based approach when working with refugees.

Applicability of the NutriMental screener for the identification of nutrition-related risks

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Background: People with mental health conditions often face nutritional problems that promote the development of somatic comorbidities, which lead to a further reduction in their quality of life and life expectancy. To date, nutrition-related problems often are not adequately addressed in psychiatric and psychosomatic rehabilitation care. There is a lack of valid tools to identify individuals at risk of malnutrition, overeating and other nutritional problems.

Method: A screening tool (NutriMental screener) to identify nutrition-related problems of people with depression was developed in a participatory approach. To identify requirements for the NutriMental screener for use in inpatient psychosomatic rehabilitation, in a first step, qualitative individual interviews with physicians, dietitians and other staff members were conducted at eight psychosomatic rehabilitation clinics in Germany.

Results: We present the background and development of the NutriMental screener. Further, preliminary results of the qualitative interviews will be presented. Participants will elaborate on their experiences with the prescription and utilization of nutritional therapy services in psychosomatic rehabilitation and their subjective assessments of the potential added value of the NutriMental screener.

Discussion: The qualitative study will provide recommendations for the ensuing mixed-method feasibility test of the NutriMental screener with service users and service providers and for the sustainable integration of the NutriMental screener into everyday care in psychosomatic rehabilitation. Implementing the use of the NutriMental screener will lead to nutrition-related problems of service users being recognized at the beginning of inpatient rehabilitation and being addressed appropriately during the inpatient stay by selecting suitable rehabilitation measures, especially nutritional therapy services, thereby enhancing interdisciplinary care to promote recovery and well-being.

Epidemiological-Ecological Approach to Analyze the Effect of the pandemic on mental health services

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Introduction: The COVID-19 pandemic has introduced significant challenges in mental healthcare and has raised concerns about the impact of urban living, environmental stressors, and socioeconomic disparities on mental health. Our aim was to describe the effect of COVID-19-related restrictions alongside social and environmental factors on community mental health services' utilization

Methods: From January 2019 to June 2021, data on 13,475 patients and 294,801 contacts were obtained from an electronic clinical database. Solar radiation, PM2.5 and NO2 concentrations, % of trees, share of green areas, presence of water-courses and large public green areas were obtained for each census block. Contacts were categorized into outpatient care, social interventions, rehabilitations, multi-professional assessments, and daycare. Global and separate regressions for each type of service were performed and Incidence Rate Ratios (IRRs) were calculated for the number of contacts, while spatial and temporal analyses were employed for contact rate.

Results: In 2020, a significant reduction in the number of patients, except for young, foreign-born, and with schizophrenia. In 2020, contacts had a reduction of 33.9% with respect to 2019, notably affecting rehabilitations and day care. Additionally, regressions displayed a statistically significant effect of lockdown (IRR 0.673; p-value <0.001), but not of restrictions, in terms of reduction in the number of contacts expected for social interventions. Living in rented apartments, lower educational levels, higher tree cover, increased air pollution, and lower solar irradiance in the previous week were related to higher use of mental health services, but the COVID-19 attenuated these differences.

Discussion: Despite the access to mental health services during the pandemic was overall reduced, the mental health system was able to maintain support for more vulnerable patients. These findings can inform policies and practices at both national and international levels, to improve effective mental health care delivery during and beyond pandemics.

Exploring implementation factors for non-specialist mental health interventions in Sri Lanka.

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Introduction: Addressing the mental healthcare gap in low- and middle-income countries like Sri Lanka requires innovative solutions. This study investigates the perspectives of local mental healthcare workers and other community members on non-specialist mental health interventions. The primary goal is to identify anticipated barriers and facilitators to their implementation, with a secondary focus on exploring alternative strategies to reduce the mental healthcare gap in Sri Lanka.

Methods: Qualitative interviews were conducted with mental healthcare workers (n=9) and community members (n=11) from Colombo and Badulla in Sri Lanka, using convenience sampling until data saturation. Thematic analysis using an inductive approach was used to derive codes and themes from anonymized data.

Results: Anticipated barriers manifested as concerns (theme 1) regarding the effectiveness, acceptance, and feasibility of the general concept of non-specialist mental health interventions and specific intervention types. Anticipated facilitators were depicted through perceived values (theme 2) in these interventions, highlighting participants' trust in addressing the mental healthcare gap, increasing awareness, and reducing the overall mental illness burden. Other facilitators included suitable non-specialist characteristics (theme 3), such as social acceptance, specific occupational background, higher education, and personal attributes. Practical suggestions to facilitate implementation (theme 4) include community recruitment, engaging family members, collaborating with important societal groups, ensuring privacy protection, providing transportation and payment regulations, emphasizing positive psychology in school-based interventions, and considering cultural norms and resource availability differences. Ideas for reducing the mental healthcare gap centered on expanding mental health literacy and awareness programs.

Conclusion: This study offers valuable insights into essential contextual factors that may impact the implementation of non-specialist mental health interventions in Sri Lanka, providing crucial recommendations for researchers and policymakers. Acknowledging potential barriers in Sri Lanka, the study suggests counteracting these challenges through careful selection of non-specialists and adapting interventions to country-specific demands, norms, and availability of resources.

Walk the Talk Toolkit:A Knowledge Translation Tool to Implement Mental Health Recovery into Services

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Background: The prevailing way of implementing new interventions is for organisations to be told what needs to be implemented and how to do it. Our research project employed an alternative approach which built capacity in community-based organisations and shifted power. At the centre of the novel way of doing research is an implementation team made-up of service users, family members, knowledge users, service providers and managers. Implementation Teams followed a facilitated planning process and received coaching in order to implement a recovery-oriented intervention of their choice.

Methods: This implementation strategy of having Implementation Teams was tested in 7 organisations providing housing and mental health services across Canada. In all 55 implementation team members (12 managers, 19 service providers, 16 service users, 3 family members and 5 knowledge users) participated in eight 60-90 minute qualitative group interviews. Questions were open-ended and focused on the experience of participating on an implementation team. A thematic approach was used for analysis.

Findings: All seven organisations implemented one recovery-oriented intervention. Implementation team members, none of whom were previously trained in implementation science, learned how to apply implementation science frameworks and tools to their planning process. They reflected on how the process stood in contrast to usual approaches to research that they were accustomed to. For instance, rather than go fast, they could take time, rather than falling flat, they could follow through, and rather than top-down, it was bottom-up.

Conclusion: As a result of this innovative research a bilingual online toolkit -*Walk the talk/De la parole a l'action* was launched in February 2022. This toolkit builds capacity in implementing mental health recovery in non-academic settings. It offers organizations a concrete way to implement best practices into their services.This contributes to the social inclusion of people with mental health challenges.

Implementation and status of the Youth FACT model in Norway

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Introduction

Several national reports in recent years have described the fragmentation of services for adolescents with severe problems in several areas of life, including mental health, substance use, and social difficulties. The lack of collaboration between services provides major obstacles and many adolescents with complex needs do not receive adequate treatment and follow up. The implementation of the Youth FACT model in Norway was inspired by the positive results from the ACT and FACT models for adults with severe mental illness.

Method

A work group with young persons with lived experience, professionals from municipalities and specialist services, from government bodies and different resource centers on Youth mental health worked from August 2019 to May 2020 to investigate if and how Youth FACT should be implemented in Norway. These topics were investigated: 1) User involvement in FACT, 2) The composition and size of the target group, 3) Youth FACT and the child welfare system, 4) Methods for and elements in measuring the team fidelity, 5) How to educate the teams in the different aspects of working in a FACT team, 6) Implementation support required if Youth FACT was to be introduced on a large scale in Norway.

Results

Norwegian health authorities decided to invest in the Youth FACT model and established a national funding program and a national implementation strategy to support the teams.

Discussion

A summary of the implementation strategies, development, and status of the Youth FACT model in Norway will be discussed. Factors that promote or inhibit implementation, the development of the model in different service contexts, and thoughts on how to provide sustainability of the Youth FACT model in different settings will be shared.

SP-08 | Youth FACT in Norway - a national initiative, implementation, user involvement, and research ? - Hanne CLAUSEN, Norwegian National Advisory Unit on Concurrent Substance Misuse and Mental, Health Disorders / Akershus University Hospital

Training of Norwegian Youth FACT teams and Inclusion of the Youths' voices

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Introduction

The national program for the implementation of the Youth FACT teams in Norway is based on the involvement of the users' voices in all part of the implementation process. We will present our current Youth FACT education and training program for professionals in the Norwegian Youth FACT teams and the ideas behind it. All teams have peer specialists as a part of their multi-disciplinary team. Subsequently, the adolescent voice is an important part of the training. A panel of young persons with lived experience from mental health services has been established to include the youngsters voice in the implementation of the Youth FACT teams in Norway.

Method

Our training program has been using in-person meetings with traditional lectures and reflections in smaller group discussions, as well as digital webinars. The national youth panel meets digitally through the Teams platform every month.

Results

Three classes have completed the training by June 2024. The evaluation from the working teams holds promising potential. The national youth panel holds strong regards within the field of mental health and their opinions affect the decision making on many levels in the implementation process, including collaboration with national authorities.

Discussion

We will discuss the curriculum as well as the didactics of the training program, and how the seven C´s and the youth voice are consistent topics throughout the days the teams meet. A more detailed outline of the lived experiences and how they give advice on almost all parts of the implementation process will also be the focus in this presentation. National training and the inclusion of the youth voice ensures good quality in the services for the targeted population.

SP-08 | Youth FACT in Norway - a national initiative, implementation, user involvement, and research ? - Hanne CLAUSEN, Norwegian National Advisory Unit on Concurrent Substance Misuse and Mental, Health Disorders / Akershus University Hospital

Research-based evaluation of the three first Youth FACT teams in Norway

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Introduction

In the National Health and Hospital Plan for the 2020-2023, the Norwegian Directorate of Health was assigned to support the establishment, implementation, and evaluation of multidisciplinary outreach treatment teams for youth with severe and complex problems. These youth struggle with mental health problems, substance use, challenges in many life domains, and they often receive many different services including health, educational, and child welfare. The Directorate announced grant funds to implement a specific model, the Flexible Assertive Community Treatment (FACT) tailored for young people (Youth FACT). In 2020, three pilot teams were established in and around Oslo through a collaboration between hospital based and community based mental health services for youth.

Method

The Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders was assigned by the Directorate of Health to conduct a research-based evaluation of these three Youth FACT pilot teams. The evaluation focused on gathering feedback and experiences from the youth involved, their relatives, the team staff, and collaborative partners of the teams. This evaluation took place during the second year of operation for these teams. The ultimate goal of this assessment was to use the findings for the ongoing development and improvement of Youth FACT in Norway.

Results: The young people and their next of kin experienced the FACT team to be more flexible and a new way of giving services compared to the traditional services for children and youths. They experienced the team staff to be more oriented towards their needs and wishes. **Discussion:** the results provided direction for further developing the Youth FACT model in Norway. We will discuss the consequences for the FACT teams.

Children's Understanding of Mental Health - A Qualitative Study to Inform Mental Health Prevention

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Introduction: To counteract child and adolescent mental health issues, EU health priorities emphasize the importance of low-threshold, prevention programs on a population level. Increasing mental health literacy (MHL), i.e. the knowledge and attitudes of mental health, has been suggested as a promising prevention approach from the age of eight onwards. To develop an age-appropriate MHL program for primary schools, a comprehensive understanding of children's concepts of mental health and wellbeing is needed.

Methods: A participatory development approach was adopted, with a focus on exploring children's awareness and experiences concerning emotions, wellbeing, and mental health. Over the course of one academic year, iterative qualitative research workshops were conducted in six primary schools in Austria. Children aged nine to eleven participated in brainstorming, story-creation, and focus-group tasks, which were analyzed using thematic analysis.

Results: Children differentiated between small and big feelings. For this age group, big feelings could equally concern major challenges and events (death of a relative, school transition) and everyday situations that are momentarily overwhelming (sibling fights). Their understanding of wellbeing incorporated many momentary feelings and challenges, as this age groups' awareness of persistence over time and interference with everyday activities was still limited. Initially, only few children had a concept of mental health at this age. However, through their participation in repeated workshops, children gained a more nuanced understanding of the components of MHL as indicated in the child MHL model.

Discussion: Assessing children's baseline understanding of mental health is crucial to adapt mental health education to their knowledge levels, create examples relevant to their everyday experiences and develop age-appropriate ways to explain the components of MHL. Cultural differences and societal discourse are likely to shape children's baseline knowledge. Thus, combining participatory approaches and evidence-based intervention development is crucial to achieving effective mental health prevention.

Use of Participatory Methods in People with Intellectual Disability

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Background. When engaging people with intellectual disability (ID) in research, methods should remain accessible and inclusive, with reasonable adjustments made to match participant needs. Traditional methods such as interviews and focus groups have been limited to those whose communication abilities allow verbal communication and interaction. These methods discriminate against people with ID and those with severe impairments. Participatory research can ameliorate such barriers to allow understanding of their experiences and reality, and therefore their narratives.

Narratives of people with intellectual disability (ID) are underrepresented in research; in a population with additional health needs and poor outcomes in the context of health inequity, healthcare cannot be patient-centred, holistic or humanising if their voices are excluded. We therefore need to understand how different participatory methods have been used to elicit knowledge and understanding of experience beyond traditional methods of enquiry.

Method. A systematic review was conducted of empirical studies demonstrating the use of participatory methods in people with ID. The review developed knowledge on the range of intellectual disabilities that have been considered, and the range of participatory methods to develop knowledge and understanding of their experiences. A summary of review findings will be presented.

Findings. Our review found that people with ID are able to produce narratives with rich insights into their experiences and allow for inclusive research. Photovoices and digital story-telling are common art-based participatory methods to elicit and understand narratives.

Conclusions. Participatory research methods offer an opportunity to develop knowledge relevant to health services, through enabling the narratives of people with ID to be heard. Greater knowledge is needed of how the use of participatory methodology can be used in a range of ID severity, and how they can be used by health service to influence change.

Attitudes of French health professionals in child and adolescent psychiatry toward evidence-based practices

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Study Aims: Improving the implementation of evidence-based practices (EBP) must be at the heart of the health care system. The attitudes of practitioners toward EBP can impact the implementation of such practices. Our study aimed to validate the French version of the Evidence-Based Practice Attitudes Scale 36 (EBPAS-36F), to measure the level of attitude of professionals in child and adolescent psychiatry in France, and to study the factors that may be associated with the attitudes toward EBP in this context.

Methods: This is a cross-sectional observational study. Data were collected via an online survey distributed to medical, paramedical and educational professionals and students involved in diagnostic or care activities in child and adolescent psychiatry throughout France. We used a French language version of the EBPAS-36 scale, translated and back-translated for the study. Population and attitude characteristics were described and validation tests of the EBPAS-36F were performed. A multiple linear regression model was used to measure the association between attitudes and various individual and organizational factors.

Results: A total of 400 professionals answered at least one question and 211 respondents were included and completed all the items of the questionnaire. Validity and internal consistency of the EBPAS-36F were satisfactory. The mean attitude level in our population was 2.63 (95% CI = 2.57-2.69). Two factors were significantly associated with the attitude level: affiliation with a university center and employment in a tertiary care facility.

Conclusion: This study shows that attitude toward evidence-based practices in child and adolescent psychiatry in France is slightly lower to that of another European country. This first result and the validation in French of a scale to measure attitudes towards EBP will allow the development of protocols to improve health care professionals' attitudes and the use of evidence-based practices in child and adolescent psychiatry in France.

Mental health of Transgender people in prison: policy issues emerging from a systematic review

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Introduction: The Authors of this presentation have co-Authored a systematic review and meta-analysis exploring the condition of Transgender Inmates (TGI) in correctional facilities (CF), focusing on their mental health, and health service indicators of quality, such as TGI access to Gender-affirming Treatments (GAT) and their placement within the CF. This presentation will address in particular policy issues emerging from the narrative synthesis of the included studies.

Methods: Medline, Embase, Scopus, PsychInfo, and CINAHL were searched for studies on TGI in CF. Pooled Odds Ratios (ORs) with 95% confidence interval (95%CI) were estimated through inverse variance models with random-effects. A narrative synthesis of the studies was also performed.

Results: Thirteen studies were selected and four were considered in the meta-analysis, corresponding to 1255 TGI and 174314 controls. The meta-analysis showed that TGI have a higher risk of depression, post-traumatic stress disorder, and suicide attempts during detention than their controls (OR:3.07[95%CI:1.33;7.06]; OR:2.23[95%CI:1.46;3.43]; OR:2.25[95%CI:1.46;3.49], respectively). The following issues emerged from the narrative synthesis of the studies: an increased risk of harassment and victimization for TGI individuals especially when housing is based on sex assigned at birth rather than gender identity, predominantly affecting TGI women hosted in male sections (six out of thirteen studies), limited access to GAT worsening self-esteem and self-affirmation, and the negative impact of heteronormative and transphobic climates within CF on health disparities among TGI and other inmates, particularly concerning mental health needs and access to healthcare, including GAT (five studies).

Discussion: Collectively, these findings underscore the need for comprehensive transgender healthcare training for correctional staff. A comprehensive policy reform should be promoted to foster inclusive and supportive correctional environments and improve safety and health of TGI. Housing decisions should be made on a case-by-case basis, considering individuals' prior history of victimization and sense of safety as pivotal factors.

Increasing Physical Activity in Medium Secure Mental Health Services in England

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Introduction: The IMPACT study (Increasing Physical Activity in Medium Secure Services: The Development and Feasibility of a Physical ACTivity Intervention) aimed to understand the barriers and facilitators to increasing physical activity in a medium secure setting, to understand how to deliver an intervention and engage service users, to co-produce, develop and test the feasibility of the physical activity intervention.

Methods: There were four phases in the IMPACT study, using a mixed methods approach. Phase 1 obtained quantitative data via questionnaires on opinions of barriers and facilitators to increasing physical activity, with service users (n=69) residing in such settings and focus group with hospital staff (n=29).

Phase 2 (n=15) and Phase 3 (n=25) collected qualitative data through focus groups with service users, hospital staff and other key stakeholders to establish how to maintain engagement, deliver an intervention and to co-produce a physical activity intervention.

Phase 4 tested the feasibility of the physical activity intervention at two medium secure study sites in the NHS, UK. This involved service users (n=33) recruited onto the intervention and collecting data on their physical activity levels, clinical measurements and qualitative feedback. Hospital staff (n=36) were also recruited as facilitators and asked to provide feedback on the delivery and usability of the intervention.

Results/Discussions: The quantitative data from all four phases were statistically analysed and the qualitative data thematically analysed using Framework Analysis. Results suggest that it is feasible to co-produce, deliver and maintain a physical activity intervention in such settings. Further discussions and evaluations are required to refine and improve the intervention, such as technology used to deliver it and other contextual factors as part of a hospital setting.

This field of research is important for service users' quality of life and previously overlooked due to the complex nature of the environment in secure psychiatric settings.

Hidden Struggles: Exploring Institutional Microaggressions and Mental Health of LGBTQ+ Community

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Microaggressions against LGBTQ+ individuals are a common experience across educational and organizational spheres. The cis-normative culture of a society can extend to its institutions and become a source of discrimination and harassment for LGBTQ+ individuals. Due to policies and laws, overt forms of discrimination are limited, giving rise to subtle forms of microaggressions. Although microaggressions are considered " harmless and unnoticeable" ways of showing prejudice, studies have demonstrated that microaggressions have a detrimental influence on the mental health of the LGBTQ+ community. The current study aimed to shed light on the nature and forms of microaggressions across educational and professional institutions and its impact on the mental health of the Indian LGBTQ+ community. A qualitative approach with an exploratory design was employed, involving semi-structured interviews (N=33; students, N=18; employees). Thematic analysis revealed four overarching themes related to mental health; 1) Concealment of identity (involuntary outing, fear of social isolation, fear of hiring/ promotion discrimination, concerns about safety, cognitive dissonance) 2) Psychological distress (battle fatigue, negative emotions, hypervigilance, clinical symptoms), 3) Stigma consciousness (impact on self-perception and confidence, internalized stigma), 4) Coping strategies (problem-focused, emotion-focused, avoidance coping). Similarities and differences were observed in the experience of microaggressions across institutions, such as schools, universities, and workplaces. Microaggressions may cause more harm than discrimination, mental health services provided in educational and workplace settings should prioritize addressing these experiences. Suggestions for developing a queer- inclusive workspace and educational policies are also discussed.

Impact of exercise physiology and speech therapy in a forensic community mental health program

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Introduction: The Forensic Mental Health in Community Health (FMHiCH) Program at Monash Health is one of five in Victoria, Australia which provide mental health services to people on Community Corrections or Parole Orders. The program aims to improve the mental health of offenders with a moderate mental illness and assist them fulfil their Order. The program at Monash Health uniquely includes Exercise Physiology (EP) and Speech Therapy (ST) as a critical part of their multidisciplinary service model, including for client engagement. Although there is evidence that exercise can improve mental health, and ST can reduce offending through improved language skills, there is little research examining mental health treatment outcomes of EP and ST with adult offender populations. The aim of this project was to examine whether EP and ST were associated with treatment success in the Monash Health FMHiCH program.

Methods: Using service data from program inception late 2018 (n = 1111), mixed-effect univariate and multivariate logistic regression models were employed to examine the association of ST and EP with treatment outcomes (completed treatment versus failed to engage; treatment goal achieved versus not achieved). Sensitivity analyses used Multiple Imputation by Chained Equations to impute missing values in outcome variables and other covariates.

Results: EP and ST clients had significantly higher odds of attaining the service treatment goal than other clients (odds ratios: 7.3 and 3.8 respectively in fully adjusted models). Greater direct time and number of EP and ST service contacts increased the likelihood of achieving the treatment goal. EP and ST services also significantly increased the likelihood of completing treatment versus being discharged with failure to engage. Sensitivity analyses showed comparable findings.

Conclusion: Findings support the use of EP and ST services in forensic community mental health settings, noting the key limitation that this is an observational study only.

Benefits and experiences of a novel social coaching intervention for people with psychosis

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Introduction: People with psychosis tend to be socially isolated and have fewer social contacts than people in the general population, as well as others with long-term mental health conditions. This in turn, has been associated with poor health outcomes, including frequent hospitalisation, and low quality of life. There is evidence to suggest that coaching people to increase their social contacts, may help to harness this resource and improve outcomes for this group.

Method: A novel social coaching intervention called SCENE was developed based on the literature and through stakeholder involvement. The clinical and cost-effectiveness of SCENE is being assessed in a randomised controlled trial, compared with an active control condition, where participants are given a booklet with information about local social activities. The primary outcome is quality of life at the end of the intervention (EOI), and we also consider symptoms, loneliness, social situation and time spent in social activities at EOI, 6 months and one-year follow-up.

Results: The resulting intervention draws from principles of motivational interviewing, solution focused therapy and structured information giving, and can be delivered flexibly by a number of different health professionals. Overall, 577 participants with psychosis took part in the trial across urban, semi-urban and rural sites in England. The follow-up rate at EOI is 76% which will allow us to establish the clinical effectiveness of social coaching for this population.

Discussion: As well as the quantitative findings from the trial, we will present experiences of receiving and delivering the intervention gathered in the qualitative process evaluation. We will also reflect on the challenges of delivering a large multi-site trial to increase social contact in the period spanning the Covid-19 pandemic; a time when this was largely discouraged.

An RCT of a brief psychological intervention for young people who attend ED having self-harmed

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Intro: Suicide is a leading cause of death in children and young people (CYP) globally and the strongest predictor is self-harm, irrespective of suicidal intent. Visits to the Emergency Department (ED) are associated with repeat self-harm and suicide. Supporting CYP after presentation at ED offers a unique opportunity to intervene to prevent self-harm becoming an entrenched coping strategy. However, there are limited interventions to support CYP with self-harm. Therapeutic Assessment (TA) and Solution-focused (SF) follow-ups have shown promise in reducing self-harm and increasing engagement with care after ED attendance. Incorporating these approaches, we aimed to develop and evaluate a brief psychological intervention to address this gap.

Methods: We co-designed the SASH approach with CYP with lived experience. We have recruited 42 CYP crisis team and dedicated SASH practitioners who are delivering SASH across five teams, serving seven EDs in London, England. A randomised controlled trial with a target of 144 CYP is currently underway to evaluate its clinical and cost-effectiveness.

Results and Discussion: The SASH approach was designed and is a brief intervention including TA, enhanced safety planning, SF follow-ups and letters, delivered after young people present at the ED. TA involves the young person identifying their cycle of self-harm, with a SF approach used to identify ways to break the cycle and focus on the young person's strengths and broader hopes for their future. This presentation will discuss practitioner experiences of delivering the intervention and the challenges of delivering the trial in a post-pandemic public healthcare landscape in England, including recruiting and retaining practitioners and embedding new pathways of care in acute and CYP crisis settings.

Conclusion: Challenges and creative approaches to embedding and delivering the SASH approach in crisis settings in England have wider implications for interventional studies delivered in crisis care settings in public healthcare institutions.

Results from a cluster RCT testing DIALOG+ for people with chronic depression

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Introduction: DIALOG+ is a technology-assisted and solution-focused intervention that comprises the collaborative completion of a standardised quality of life outcome measure followed by a 4 step solution focused discussion. It has been previously established to be a clinically-effective and cost-saving approach for the care planning of people with psychosis in community care. However, service users with chronic depression often have lower levels of quality of life yet have fewer targeted treatments compared to those with psychotic disorders.

Methods: After a period of feasibility testing to see how appropriate DIALOG+ was for a population with chronic depression, a multi-site cluster randomised controlled trial was conducted across 9 National Health Service (NHS) sites in the UK.

Results: The trial team recruited 366 eligible participants, and 128 clinicians delivered DIALOG+ for between 6 and 12 months as part of routine care. Analysis showed that receiving DIALOG+ marginally improved individual's quality of life compared to people in the active control group (DIALOG scale + treatment as usual). Further, the health costs for the intervention were minimal and economic analysis showed the added clinical benefits were worth the slightly increased costs. Process measures also indicated that the experiences of service users and clinicians using DIALOG+ were largely positive.

Discussion: Taken together this shows that DIALOG+ is a worthwhile approach to use for people with chronic depression in community care. Further its generic nature and low costs indicate the potential for it to be implemented widely across different mental health care contexts.

ASSURED: A brief psychological intervention for people who attend ED for self-harm/suicidal thoughts

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Introduction: Self-harm is a key risk factor for suicide. Annually, 200,000 presentations of self-harm are treated in hospital Emergency Departments (ED) in England. Risk for suicide is highest shortly after hospital presentation for self-harm. Interventions after this critical period represents an important opportunity for suicide prevention. However, there are limited services available for this group. To address this problem, the ASSURED programme aims to develop and test a psychological intervention for people shortly after presenting to ED for self-harm and/or suicidal thoughts in England.

Method: To develop the intervention, we systematically reviewed literature on brief interventions for people who self-harm; conducted focus groups and interviews with staff and people who have lived experience of attending ED for self-harm and/or suicidal thoughts; and consulted experts in the field of suicide prevention and experts by lived experience. ASSURED is currently testing the clinical and cost-effectiveness of the intervention in 10 hospitals across England through a pragmatic randomised controlled trial (RCT) with a sample of 620 patients. The primary outcome is reduced re-attendance to ED and secondary outcomes include improved suicidality, psychological wellbeing, social outcomes, experiences of attending ED, and suicide.

Results: A rapid intervention following presentation to ED was developed. The intervention consists of therapeutic assessment and enhanced safety planning, three solution-focused sessions, and three letters. Currently, 290 participants across 10 hospitals in England have been recruited and recruitment is ongoing. Preliminary findings from interviews with staff delivering the intervention and people receiving the intervention will be discussed in this presentation.

Conclusion: Conducting an RCT in ED context in England has led to several pragmatic challenges. The study team have adapted the trial methodology and study procedures to ensure the viability of this project. Early feedback from staff and patient participants suggests positive reception of delivering and receiving the intervention.

SP-22 | Contribution of network analysis to personal recovery and integrated mental health care organisation - Pablo NICAISE, Institute of Health and Society (IRSS), UCLouvain

Care integration and recovery-orientation in Belgian mental health and addiction service networks

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Introduction

Mental health comorbidity is widespread in people with substance use disorders. However, generic mental health and specialized addiction care services are not necessarily integrated despite organisational mechanisms that aim to support such integration. Personal recovery is an evidence-based approach to care in both fields that could favour more integration. Therefore, we assessed the structure of relationships existing between mental health and addiction services within five Belgian mental healthcare networks and explored the orientation towards personal recovery of network key services in terms of linkage and coordination.

Methods

An online survey was used with 194 services in five mental healthcare networks in Belgium. Data on referrals between services was collected. In addition, the survey included the Recovery Self-Assessment Scale for providers to measure the recovery orientation of services, as well as information on organisation characteristics. Social Network Analysis was applied to identify network structural and composition properties and assess the structural position of recovery-oriented services.

Results

The five networks differed in terms of size, linkage, and centrality. Both service types, i.e. mental healthcare and addiction, tended to have homophilous relationships, i.e. favouring relations with services from their own sector. The global level of service recovery orientation remained low, but was higher in specialized addiction than in generic mental healthcare services. Recovery orientation was also lower in inpatient services, especially regarding long-term facilities. These services, however, had higher centrality, indicating a favourable position for coordination.

Conclusion

All mental healthcare service networks may not be well adapted for care to people using substances within a personal recovery approach due to their structural differences. In particular, whilst there is a need for more collaboration between generic mental health and specialized addiction services, services in a coordination position are less oriented towards personal recovery.

The structure of personal networks of people with severe mental illness and mental health outcomes

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Introduction: The personal social support network of individuals with severe mental illness (SMI) is a key feature in recovery-oriented therapeutic models. While it is known that networks of people with SMI are smaller, less diversified, and more fragile than those of the general population, little is known about network structural characteristics and their association with mental health outcomes. In this study, personal support network data was collected during intervention sessions involving clinicians and users. A typology of networks based on network structural characteristics was applied and we analysed how network types were associated with psychosocial functioning and social integration.

Methods: 620 personal support networks of SMI users of Belgian out- and inpatient mental healthcare services were collected. We applied Vacca's strategy, originally developed for classifying personal networks in the general population, to identify network types with similar characteristics in terms of sub-communities, centralisation, and cohesion. Poisson regression was applied to test the association of network types with measurements of psychosocial functioning (HoNOS) and social integration (SIX).

Results: Five network types were identified. The level of fragmentation in networks was high across types and determined membership. Network types having less components were associated with higher psychosocial functioning (β=2.78, p<0.01), although more cohesive networks were associated with lower social integration (β=-0.57, p<0.01).

Discussion: Overall, the typology was reliable and allowed classifying personal support networks of people with SMI based on their structural characteristics. In addition, network types were associated with significant differences in terms of psychosocial functioning and social integration. However, SMI personal support networks were highly fragmented, making the typology inaccurate. The strategy might need to be further refined. There is an avenue, however, for more research on personal support networks of people with SMI and their association with health and social outcomes.

SP-22 | Contribution of network analysis to personal recovery and integrated mental health care organisation - Pablo NICAISE, Institute of Health and Society (IRSS), UCLouvain

Mental healthcare service networking solutions: a multi-layred network approach

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When it comes to creating positive change, relevant mental healthcare services should call for better coordinated actions to create holistic plans of care and incorporate patients' social and environmental contexts. The healthcare system has a multilevel nature because clinical, community, organisational, and policy levels are interdependent in promoting mental wellness and creating a well-connected support system. However, creating synergies towards healthcare integrated solutions among different set of players in healthcare is complex. Medical doctors, health, and lay health professionals, working in community health centres, pro-bono clinics, private foundations, hospitals, not-for-profit organisations, etc., have different needs, capabilities, and priorities that non necessarily converge when assisting their patients. All these actors create a complex web of multilevel relationships that, in turn, generate complex governance structures that regulate the health sector. What can facilitate partnerships among different mental health services to build an integrated care system for mental health? Which factors nurture trustworthy relationships and which network structures sustain systemic collaborations? These questions have been insufficiently examined because the analysis of multilevel collaborative processes (i.e., referrals, interventions, and campaigns, as well as resource sharing between public and private service providers, trust relationships among key personnels, patients and their families), has yet to be undertaken. Using past and current case studies, the present presentation discusses the theoretical and practical implications of applying a multilevel perspective, rooted in social networks research, for analysing the layered interpersonal patterns of relationships within and across different healthcare professionals and their networking performance, with a view to also map patient´s larger social system to understand how better support people´s mental health.

SP-22 | Contribution of network analysis to personal recovery and integrated mental health care organisation - Pablo NICAISE, Institute of Health and Society (IRSS), UCLouvain

Visualisation of personal network maps : the experience of people with severe mental illness

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Introduction: Visual mapping refers to the collaborative construction of a sociogram by both the researcher and the participant, resulting in a visual representation of the respondent's social network. This exercise is generally well-received by participants. However, mapping one's personal network and visualizing it requires respondents to expose and share their social identity. While this approach is gaining momentum as a data collection technique, little attention has been focused on its use for intervention purposes. Moreover, for vulnerable respondents, mapping and visualizing their social network can give rise to more significant concerns that remain unexplored. There is limited research describing the experiences of vulnerable respondents with regard to visual mapping. The aim of this study is to investigate the experience of vulnerable individuals when mapping and visualizing their personal network, assessing the appropriateness of this exercise, highlighting the social identities being emphasized, and exploring whether this approach induce a potential identity threat.

Methods: Individuals with severe mental disorders (SMI) were recruited as participants for an intervention focused on exploring and mapping their social support network in order to personalise care. The intervention was computer-based, using Network Canvas Interviewer. A deductive thematic analysis was conducted based on recorded and transcribed interviews.

Results: Seventeen SMI individuals were interviewed. Five central themes emerged from the data: the appropriateness and feasibility of the intervention both in terms of its nature and the digital tools employed, the patient identity presented before and throughout the interview, loyalty conflicts towards network members experienced at different stages of the mapping exercise, the network mindset, and the perceived identity threat occurring with visualization when there is a discrepancy between the sociogram and sense of self.

Discussion: Effect of visualisation requires researchers to adopt a reflexive approach during research encounters. Network visualisation is a relevant intervention for recovery practices.

A Space to Speak Your Mind: The Potential for Coproduced Community Radio to Improve Mental Wellbeing

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Introduction

Community Radio has existed in a government-regulated way in the United Kingdom since 2004. There are now over 300 stations across the country serving a variety of communities, based on location, ethnicity and faith. Community Radio has proven health benefits for both listeners and practitioners (broadcasters, studio staff and management) in terms of mental health, social and community wellbeing. The Practice Research project "A Space to Speak Your Mind" (ASTSYM) sought to use innovative methods to coproduce a lived experience radio show and podcast about mental health. It then interviewed participants to establish whether CR practice can generate mental wellbeing benefits.

Methods

A lived experience radio show and podcast was coproduced at Source FM, a CR station in Cornwall, Southwest UK. Participants were recruited through the mental health charity Mind, who also provided safeguarding and mental health support for participants. The content and format of the show were codesigned by the participants. Shows were recorded, written, edited and presented by people with lived experience of poor mental health. After a year, participants and stakeholders were interviewed for their perceived mental wellbeing benefits.

Results

All participants in the practice reported an improvement in mental wellbeing in four of the Five Ways to Wellbeing developed by the New Economics Foundation (Connect, Take Notice, Learn, Give). The radio show continues three years later and is now broadcast on five CR stations n Cornwall. The show has won 7 awards at the UK Community Radio Awards including Gold for Specialist Content Show in 2023.

Discussion-conclusion

The method used for ASTSYM shows the potential for lived experience coproduced radio shows to be developed at CR stations across the UK, discussing the mental health concerns of the communities they serve, as well as improving the wellbeing of the participants.

Developing a recovery narrative intervention for service users: Outcomes from our focus groups

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Introduction

People with a severe mental illness (SMI) often experience difficulties in all aspects of life. Experiencing (self)stigmatization and prolonged symptoms can make recovery seem unattainable. Offering lived experience narratives to service users could potentially lead to hope, a sense of recognition and potential other benefits. We set up focus groups with different stakeholders to gather input for the development of a recovery narrative intervention.

Methods

We included focus groups with SMI service users (n=6), autism service users (n=3), peer support workers (n=4) and other health care professionals (n=4). Focus groups followed a semi-structured format with open questions. Topics included among others the potential of recovery narratives as an intervention concept, which kind of narratives to use, timing and platform to offer narratives and considerations regarding people who share their recovery story. The sessions were audio recorded and transcribed verbatim for qualitative thematic analysis. Consensus on themes was reached between four coders and a member check was performed.

Results

All focus groups were positive about the potential of recovery narratives to promote recovery through offering practical and emotional support, being destigmatizing, and inducing hope. Positive effects of narratives might depend on the recipients' recovery phase. An option for contact to discuss narrative content was deemed important, for example with a therapist or peer support worker. Narratives should be offered via an independent website in different lengths (i.e. short/longer versions) and modalities (i.e. written, video, audio) to account for personal preferences. Possibility to remain anonymous and restricted access of the narratives were reported as factors influencing the willingness to share recovery stories.

Discussion-conclusion

Recovery narratives may be able to provide hope and emotional support to mental health service users according to the focus group members. Their concrete suggestions are currently used to develop an innovative recovery narrative intervention.

Roadmap to recovery stories-? A novel technological model for social change in people with SMI

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Narrative therapy approaches suggest that people can re-narrate their life and personal stories, and through this feel empowered and their well-being may also improve (Zilber et al., 2008). “Amitim for rights” program by the Israeli MOH and The Israeli association of community centers (IACC) aims to promote social change and fulfillment of rights in mental health.The program has developed a technological tool that promotes recovery in people with SMI through telling their personal recovery story. The purpose of the process is to support the recovery process and reduce self and social stigma. At the peak of the aforesaid process, people will narrate their recovery story to their close and far environments, thus promoting social change (Shteinman & Adler-Ben Dor, 2022).Indeed, research suggests that telling one’s story can be extremely meaningful in one’s recovery journey (Nurser et al.,2018).

The road map model for recovery story building, is a novel technological tool that is already implemented and includes seven stages: (1) ‘The compass’- basic questions that lead the process of writing and story rebuilding such as: who is the audience, goal and message to convey through the recovery story;(2) Choosing and in-depth describing significant life events in the recovery process;(3) Writing and re-writing the story and allows the story to be externalized, thus allowing audience the listen and accept the story (Carlson & Erickson, 2001);(5) The promotion of social change in the audience;(5) Re-building a new identity and mediate their recovery story to themselves and their surroundings (Roe et al., 2014);(6) Renewed relationships and mental health oriented social change (Corrigan, 2020).

The development and implementation of the recovery promoting technological tool led to new recovery narratives in the employees at ‘Amitim for rights’ program. Thus, positively effecting their personal well-being in general and specifically their recovery, as well as audiences’ perspectives.

Poster sessions

A personal recovery approach to physical activity for community mental health service-users.

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Introduction

Traditionally, mental health services and policy are guided by a clinical recovery approach, but there is an increasing appreciation of adopting person-centred approaches to support positive mental health, often known as personal recovery. Physical activity (PA) is one approach suggested to contribute to personal recovery. However, PA remains scarcely adopted as routine practice and engagement levels remain low. Research is limited in understanding precise mechanisms underlying processes of PA engagement, and how, why, and who can benefit from PA.

Methods

This realist evaluation focused on a PA project for service-users within two community mental health teams. Data was collected using repertory grids and semi-structured interviews, involving 24 service-users and 12 staff members. Interpretative Phenomenological Analysis was used to analyse the data, within the broader realist evaluation framework.

Results

Findings are best understood as four stages of the participants' journey through the project. Firstly, it was found that mental health professionals were vital gatekeepers to the PA sessions, either enabling or prohibiting service-user involvement. Secondly, service-users required their priority needs to be met before they could be interested and involved in PA sessions. Thirdly, service-users needed to be both physically and mentally able to access sessions, including considerations of practicalities, emotional support, culture of the sessions, and expectations being managed and met. Finally, once participants were able to access sessions, it was found that PA was beneficial in facilitating service-users' personal recovery in a positive manner.

Discussion

Exploring and valuing the lived experiences of the service-users was vital to understand underlying mechanisms that contributed to the accessibility and outcomes of PA for personal recovery. Key recommendations include considering how PA is offered within services, especially in terms of facilitating access and support before, during and after sessions for service-users to participate and aid their personal recovery.

A novel method for obtaining service users' perspectives on community mental health services in order to influence design of systems.

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Introduction

Despite the recommendation and likely benefits, service user involvement in decision making about how services are delivered remains limited. Often individual service users are asked to advise rather than obtaining experiences systematically from diverse groups.

When support is provided across multiple community organisations (voluntary, social and health sectors), a number of challenges hinder routine acquisition of service user experiences. These include building trust, as well as obtaining formal permissions in an increasingly bureaucratic world.

This presentation describes how we have created a system to obtain the perspectives of a diverse range of services users about their experiences of services aiming to reduce health inequalities.

Methods

Initially two researchers were embedded into a system in order to understand initial access and flow between teams. We worked with service user groups and practitioners to understand both a focus for the evaluation and ideas about how to obtain data about experience of care. We worked with ethics and governance experts to design a legal, flexible and person centred approach to obtaining relevant data. We will use realist analysis to understand mechanisms influencing patient journeys.

Results

Service users advocated for depth understanding of patient journeys through case studies and for a simplified single page Information sheet. We will approach those early in the path as well as those engaged in therapy. We will recruit more vulnerable individuals by building trust during observation of care and inviting them to 'go-along' interviews. We have started interviewing and observing care, creating detailed case studies by "following" 20-30 service users over 3–8-month period to create rich narratives of journeys.

Conclusions

We will report on our initial findings showing how accessibility and flow are influenced by team culture, facilitators and gatekeepers and voice of service users. And report on how findings are influencing service design.

Personal Recovery Self-Report Outcome Measures in Serious Mental Illness: A Systematic Review

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Background. The transformation of mental health services towards both person and recovery-centered care has been defined as a priority by the World Health Organization (WHO, 2021). Yet, it has proven difficult to create recovery-oriented health services that consider users subjectivity and perspectives: there is a need to shift from traditional clinical outcome measures to assess specific personal recovery processes (Slade et al., 2014). Validated self-report outcome measures (Patient Reported Outcome Measures, PROMs) are therefore needed to facilitate the transformation towards recovery-oriented practices and services. Objectives were to identify published measures and analyze their measurement properties using a standardized methodology.

Method. Following the COSMIN guidelines (Prinsen et al., 2018, Mokkink et al., 2017), we conducted a systematic review of personal recovery PROMs in serious mental illness. The MEDLINE, PMC, PsycINFO, PsycARTICLES, PBSC and Scopus electronic databases were searched for articles published between May 2012 and October 2023. Full-text articles from a previous systematic review were also examined. A broad spectrum of psychometric properties was reported and analyzed using standardized criteria. A supplementary content validity analysis was conducted.

Results. 118 studies were included in the review, describing 25 PROMs. Ten of them had not been identified in previous reviews. Quality of evidence was globally poor for most PROM measurement properties. Very little evidence was found for cross-cultural validity, measurement invariance, measurement error and criterion validity. The Recovery Assessment Scale and Questionnaire about the Process of Recovery showed the strongest evidence for sufficient psychometric data on a wide range of measurement properties.

Discussion. Several personal recovery measures are now available. While research is still needed to enhance their validity on some psychometric properties, the current tools appear sufficient to cover most research and clinical needs.

Experiences of Trauma Among Older Adults with Lived Experiences of Homelessness: A Systematic Review

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Introduction: The prevalence of homelessness among older adults in middle- to high-income countries is growing. Concurrently, there is increasing recognition that individuals who are precariously housed often have experiences of trauma, leading to increasing calls for trauma-and-violence-informed care in practice and research. It is unclear, however, to what extent researchers have focused on the lived experience of older adults who are or have previously been unhoused. We conducted this review to consolidate existing literature exploring experiences of trauma among older adults who have experienced homelessness.

Methods: We conducted a systematic review of qualitative evidence and meta-aggregation following the Joanna Briggs Institute methodology, in adherence with PRISMA guidelines.

Results: Our search yielded 22 studies. Through a process of meta-aggregation, we generated five synthesized findings: 1) Being let down by society and systems; 2) The world is not a safe place; 3) Survivor not victim; 4) Living in the long shadow of trauma; and 5) Homelessness as a deeply personal trauma.

Discussion and Conclusion: Our findings underscore the reality that older adults without housing face multiple experiences of trauma, including the trauma of homelessness itself. Considering these findings, research, practice, and policies need to focus on ways to better support older adults, both in preventing trauma and assisting those who have already experienced trauma. Our findings indicate the necessity of: 1) implementing trauma-and-violence-informed care across all sectors who work with older adults; 2) supporting older adults to age in place in safe, affordable, accessible housing; and 3) creating shelter environments more suitable for older adults, and especially those who have experienced trauma.

Use of Mental Health Services by Survivors of Psychological Intimate Partner Violence in Lithuania

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Introduction: Lithuania has one of the highest averages in the European Union of psychological and economic intimate partner violence (PE-IPV). Intimate partner violence (IPV) is a major public mental health issue and its survivors are several times more likely to have mental health conditions than those without IPV experiences. This presentation aims to highlight the prevalence, characteristics and attitudes of PE-IPV survivors in Lithuania, and the predictors of them accessing mental health services.

Methods: A cross-sectional study based on a 2021 national survey representative of the adult population (n=1001). The survey was implemented by a third-party independent market research company employing an online survey panel. Chi-square or Fisher exact tests and logistic regression models were employed in the analysis. Estimated odds ratios and corresponding 95% confidence intervals were obtained; their statistical significance was assessed by likelihood ratio tests.

Results: Almost 50% of women in Lithuania experience PE-IPV. Females are significantly more likely to experience it than males. The vast majority of women find PE-IPV unacceptable; however, only one-third of survivors seek any type of help. Only one-tenth approach mental health services, with divorcees and those living with more than four persons in the household being at higher odds of doing so.

Discussion-Conclusions: The study highlights an unexpected and alarming result that even though the prevalence of experiencing PE-IPV among women in Lithuania is high and so is the expected rate of mental health conditions among these women, only a small fraction of them seek help at all or use mental health services. Further research is warranted to explore predictors and contextual factors of why IPV survivors seek mental healthcare, or not. Policy implications include the need to eliminate IPV and mental health stigma; and develop accessible mental health services and effective treatment approaches for this specific population.

Facilitators and obstacles in recovery: Converging perspectives of professionals and users

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For decades, mental health research has been predominantly guided by professionals, often overlooking the voices of users. In contemporary practice, the first-person approach is essential in understanding recovery and enhancing services. Recovery-oriented practices emphasize the significance of user participation in their own recovery process, utilizing available facilitators and confronting obstacles. This study aims to identify the convergences between the perspectives of professionals and users regarding facilitators and barriers in the recovery process.

This study was structured based on two prior e-Delphi studies, involving 101 users and 78 professionals. In the first round, participants were asked two open-ended questions about the facilitators and barriers of the recovery process. The research team formulated statements derived from the qualitative analysis of their responses. In the second round, participants rated the relevance of each statement using a Likert-type scale. In the third round, reassessment was requested for statements that did not meet the cut-off point for agreement. The statements that reached a consensus among professionals, and those among users, were compared and matched.

In total, 18 statements describing facilitators and 22 statements describing barriers were analysed. The study found a convergence in 31.3% of the facilitator statements and 45.5% of the barrier statements. This convergence between the perspectives of professionals and users underscores the importance of support, financial security, and a holistic approach to treatment. It also highlights the potential negative impacts of stigma, self-stigma, coercion, and social exclusion. The results contribute to the discussion on the necessity of integrating the first-person perspective in mental health, aiming to reach new research frontiers through the enrichment of this integration.

Exploring lived experience expertise: A mixed methods study

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Introduction

McPin Foundation, employ and collaborate with people who actively work with lived experiences of mental health issues. Roles range from patient involvement to peer research roles embedded in trials. McPin undertook an internal evaluation to understand how staff recognise, mobilise, and value their lived experience expertise.

Methods

A mixed approach was taken. A workshop (n=8) and a survey (n=30) with McPin employees whom actively work with their lived experiences of mental health issues explored: peer identity, experiential knowledge, methods, methodology and personal philosophies. Survey questions were informed by a rapid review of academic, grey literature and oral histories. A reflexive thematic analysis approach was taken to data analysis.

Results

Results highlight experiential skills associated with peer research at McPin. Thes are skills gained from experience rather than theory or reading. These included: selective disclosure of one's own lived experiences, resilience and adaptability to stigma and discrimination, an empathic approach to fieldwork and a reflexive approach to data analysis.

Peer research at McPin holds a similar value base to the survivor research movement. A pragmatic approach is taken with institutional collaborations. Peer research seeks to redress power imbalances in research practices, incrementally over time. Challenges of having to embody both an 'insider', and an 'outsider' position when actively working with one's own lived experiences of mental health issues can lead to a sense of imposter syndrome.

Discussion and Conclusion

McPin's approach to working with lived experience is integrated into its values base as an organisation. To work collaboratively, compassionately and with courage. These values were evident at the individual, interpersonal and organisational level.

Do people experiencing schizophrenia or bipolar disorder have different web and social media usage ?

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Background

People experiencing severe mental illness such as schizophrenia or bipolar disorders are becoming frequent Internet and social media users. Studies have raised concerns about potential risks of misuse in this population, and at the same time unexploited social connection opportunities. In this context, our study aims to explore and compare the Internet and social media use of French persons experiencing schizophrenia or bipolar disorders, as well as their perception of benefits and risks.

Methods

20 persons experiencing schizophrenia or schizophrenia spectrum disorders (peS), and 20 persons experiencing bipolar disorders (peBP) were recruited on a voluntary basis through patients and family associations (UNAFAM, Argos 2001) or in healthcare settings. All were mental health services users and had received their diagnosis by a psychiatrist.

We used a semi-structured interview collecting information about their experience of the Internet and social media (frequency of usage, type of content and information accessed, benefits and risks perceived), as well as sociodemographic questions. Methodology and instruments were discussed with a user – researcher.

Results

After controlling for age and education level, which were different between samples, it remains that less peS used the Internet multiple times a day. Yet, the researched content concerned information about diagnosis, new treatments, secondary effects and testimonies in both populations. While benefits were reported by each group, peS appeared more worried about specific risks, like fake news, over-stimulation, addiction, viruses, dangerous encounters or a risk of disconnecting from reality.

Conclusions

Although peS have a comparable qualitative usage of the Internet than peBP, they still use the Internet less times a day, and seem to be more preoccupied by potential risks. Developing adapted e-mental health tools and approaches, as well as enhancing digital skills learning is key to address this population’s need for safety and to help closing the digital gap.

Is personal recovery a transdiagnostic concept ? A study using narrative experiences

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Introduction

Personal recovery concerns rediscovering one's identity, renewed meaning in life, and coping with difficulties and trauma. The concept of personal recovery has its origin in psychosis-related recovery narratives, but it is unclear whether personal recovery themes are transferable to other mental disorders. The aim of this study was to test the transdiagnostic fit of personal recovery as a concept, by analyzing lived experience narratives from service users with psychosis, depression, anxiety and autism.

Methods

Thirty recovery narratives were retrieved from the Dutch Storybank Psychiatry. These were coded sentence-by-sentence by three independent coders, using the codebook of the CHIME framework for personal recovery (i.e. Connectedness, Hope, Identity, Meaning, Empowerment). We assigned new codes to narrative content that was related to recovery, but that did not fit within the CHIME (sub)categories. Content related to the illness but not recovery was coded with 'Difficulties and Trauma'.

Results

All five CHIME dimensions were richly reported in the narratives, independent of diagnosis. Most (n=17) of the narratives contained all five dimensions, and the remaining narratives contained four (n=12) or three (n=1) of the CHIME dimensions. A total of seven new codes were assigned to recovery related content, such as 'recognition by diagnosis' and 'support from a pet or assistance dog'. A member check was performed, after which consensus was reached that all newly assigned codes fit within the CHIME framework.

Discussion-conclusion

In this study we found that personal recovery is transdiagnostic, as the five themes of CHIME were richly reported in all narratives, independent of diagnosis. All newly assigned codes seem to fit well within the CHIME model. They provide nuances for different diagnoses, and appear to increase the overall inclusivity of the CHIME model. Mental health care professionals might consider incorporating personal recovery goals in treatments of service users regardless of diagnosis.

People are complicated, why choosing simplicity helps

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Humans are adaptive, complex creatures that move in vibrant networks. When they get stuck and develop psychological problems, our current concepts of disease and linear treatments often fall short and is it necessary to respond with more flexibility. In my lecture I will discuss the properties of living systems, ways to reduce complexity with their advantages and disadvantages, levels of management of care processes and consequences of the choices therein. I will describe other forms of dealing with complexity and what can help to connect to various and changing networks. I will show why organizational principles, in which simplicity, trust and self- management are leading, help to connect open and curious to people in psychological distress and their environment.

A Realist theory of how voluntary sector programmes improve community support for underseved groups

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Introduction

In England there is pressure for mental health support to include community/voluntary sector provision. Such provision may be lower for some locations/groups, creating concern that this further disadvantages people belonging to disadvantaged, minoritized, or stigmatized groups. Two statutory providers in England set up voluntary sector run projects to tackle this. It is unknown how, why and under what circumstances these projects work.

Methods

We have created and are refining Realist programme theories of change: to what extent is change created, how it is created and what are the barriers/enablers to change. Data includes interviews, observations, internal documents and workshops. During analysis we noted convergences in ways of working and mechanisms and contexts of change, allowing for importing of programme theory between the two programmes. Here we compare the two programme theories and discuss a possible overarching theory.

Results

The projects differ in funding sources, initial aims, length, ways of working, and type of employee. One project deploys an Asset Based Community Development approach, the other has no formal framework. However, mechanisms converge: needing to build trust with the groups, utilising existing key persons within the community, creating an understanding of what it was like to be a member of that group and how they thought and talked about mental health. Enablers were similar: employees who belonged to groups enhanced ability to understand the group; employees with a varied career history were more resilient in this challenging, undefined, role. Disablers diverged: limited time scale in one project, distrust between different community providers in the other location.

Conclusion

Inequalities of access to community mental health support may be tackled by voluntary sector projects. Utilising formal theories of community development may not impact changes created in these projects. Understanding how to build trust with groups is key to creating change.

Dutch Validation of the Self-Evaluation of Negative Symptoms scale (SNS)

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Background

Negative symptoms are related to impaired social functioning and lower quality of life, making accurate assessment important. To date, most tools for assessing negative symptoms are observational, which can be influenced by the raters' experience and opinion. Self-rating scales could complement objective ratings by adding information from the patient's perspective. To this end, Dollfus and colleagues developed a self-assessment scale for negative symptoms that can be completed in 5 minutes: The Self-Evaluation of Negative Symptoms (SNS). Here, we aim to evaluate 1) the psychometric properties of the Dutch translation of the SNS and 2) the relationship between the SNS and functional outcomes.

Methods

The SNS was added to the Pharmacotherapy Monitoring Outcome Survey (PHAMOUS)-protocol for adult individuals with a DSM-5 diagnosis of a psychotic disorder. Internal consistency was assessed by Cronbach's alpha. Confirmatory factor analysis was used to evaluate the construct validity of the five subscales. The relationship between self-reported negative symptoms and interview based negative symptoms, social functioning, global functioning, functional remission and quality of life was investigated through correlational analyses of the SNS with the Positive and Negative Syndrome Scale (PANSS), the Health of Nation Outcomes Scales (HoNOS), the Global Assessment of Functioning (GAF), functional remission and the Manchester Short Assessment of Quality of Life (ManSA).

Results

340 patients participated in this study. Internal consistency was good (α=0.88). CFA confirmed the five factor structure of the SNS. Correlational analyses showed that the SNS is significantly correlated with the HoNOS ($r = 0.32$, $p < .001$) and the ManSA ($r = -0.43$, $p < .001$).

Discussion

Here, we showed that the Dutch SNS shows good psychometric properties and can be used to self-assess negative symptoms.

"Stepping Through": Participatory Interactive Storytelling for Shared Experiences in Mental Health

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The poster proposed illustrates how non-linear storytelling (characterised by multiple viewpoints and perspectives coexisting within the same stories), typical of interactive media, can be co-created with people who have lived experience of mental illness to allow them to shape personalised accounts of their experiences, especially when those experiences are complex and nuanced, and can be only superficially tackled by traditional linear storytelling. Non-linear storytelling can also support participants in creating modalities of audience involvement that favour self-reflection and empathy.

These creative possibilities will be illustrated through the case study of an interactive poetic documentary called Stepping Through, which was written, directed, and produced by five men who experienced mental illnesses. The film explores multiple perspectives on recovery where viewers can choose resonant feelings to explore participants' experiences of mental illness while also reflecting on their own wellbeing. Stepping Through was evaluated by audiences with varying levels of mental health awareness and showed potential for this type of storytelling to be applied to support and therapy, to training of mental health professionals and service evaluation, and to campaign for stigma reduction to general audiences.

This research was carried out at the Digital Creativity Labs, University of York, in collaboration with community partner Converge, a provider of educational and creative courses for people with mental health problems. The research outcomes are currently being disseminated through a follow-up yearlong project at the Institute of Mental Health Research, University of York.

The poster will illustrate the main research phases and outcomes, and to mirror the non-linearity of Stepping Through the poster itself will contain paper-based interactive elements, in the form of paper envelopes, windows, and layers which the conference audience will be able to interact with.

Exploring gender impact on collaborative care planning: a community case study

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Introduction Personal recovery is associated with socio-demographic and clinical factors, and gender seems to influence the recovery process. This study aimed to investigate: i) differences in the recovery goals of men and women users of a community mental health service in Italy; ii) any differences by gender in recovery over six months using the Mental Health Recovery Star (MHRS).

Methods At the South Verona community mental health service in 2017-2018, service users and staff completed the MHRS together at recruitment and six months later to agree the recovery goals they wished to focus on. Socio-demographic and clinical characteristics and ratings of symptoms (BPRS), needs (CAN), functioning (FPS), and functional autonomy (MPR) were collected at recruitment and six months follow-up. Comparisons between men and women were made using t-tests.

Results Ten women and 15 men completed the MHRS with 19 mental health professionals. Other than gender, men and women had similar socio-demographic, and clinical, characteristics at recruitment. Women tended to choose recovery goals that focused on relationships whereas men tended to focus on work related goals. At follow-up, both men and women showed improvement in their recovery (MHRS) and women were less likely to focus on relationship related goals. There were also gains for both men and women in engagement with work related activities. Ratings of functional autonomy (MPR) improved for both men and women, and men also showed improvement in symptoms (BPRS) and functioning (FPS).

Conclusions Our findings suggest that collaborative care planning tools such as the MHRS can assist in identifying individualized recovery goals for men and women with severe mental health problems as part of their rehabilitation

Supported accommodations for people with serious mental disorders: experiences during COVID-19

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Introduction: The coronavirus disease 2019 (COVID-19) pandemic affected mental health and mental health care worldwide. However, not much is known about its impact specifically regarding supported accommodations (SA). This study intended to explore the experiences of residents and professionals of SAs for people with serious mental disorders during the pandemic.

Methods: A purposive sample of 11 residents and 11 professionals from 11 different organisations responsible for SAs in Portugal was included. Data was collected through semi-structured interviews. The interview guide included questions regarding changes in the functioning of SAs and implemented measures during COVID-19, and the impact of the pandemic on the well-being of residents and professionals. Thematic analysis was used.

Findings: Some SAs had to close or relocate, and several procedures were changed. Residents felt that the most impactful changes included not being able to go outside or see loved ones. Despite some residents reporting anxiety or sadness, almost none relapsed. However, some professionals noted an impact on the autonomy and cognition of residents. Despite reporting a negative impact of the pandemic on their own well-being, professionals struggled to maintain the functioning of SAs and the well-being of residents. Residents recognised the effort done by professionals and felt supported by them during COVID-19.

Conclusions: The COVID-19 pandemic significantly impacted the functioning of SAs. In line with our findings, some actions seem fundamental to improve SAs' resilience in the future. These relate to human resources, training, structural conditions, new technologies, and professionals' well-being.

Reducing the impact of epistemic injustices in shared decision-making processes

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Shared decision-making (SDM) has emerged as an essential concept in community mental health services, emphasizing collaboration between service providers and service users to make informed choices that impact their lives. However, this framework is not immune to the insidious influence of epistemic injustice, hindering a fair and equitable distribution of knowledge and the recognition of service users as valuable carriers of experience-based knowledge. This presentation delves into the intersection of SDM and epistemic injustice in the field of community mental health, highlighting the crucial need to address epistemic injustices to ensure more just, inclusive, and ethical decision-making processes within social work practices. Drawing upon the theoretical frameworks of epistemic injustice, the presentation will examine real-world examples from an intervention study where SDM is implemented in care planning situations with service users with complex needs. Strategies and interventions that can be employed by staff and organizations to mitigate the impact of epistemic injustices on SDM in these care planning situations. By acknowledging the presence of injustices and actively working to rectify them, mental health staff can foster a more inclusive, equitable, and empathetic approach to decision-making that respects the diverse perspectives and experiences of all individuals involved in the process. This research contributes to the ongoing discourse on social justice and ethics in mental health practice.

Navigating Compassion: Stigma & Barriers to Compassionate Acts in Borderline Personality Disorder

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Compassion, the desire to alleviate another person's distress, has positive effects on both giver and receiver. Recent research highlights that engaging in compassionate acts benefits the recipient, and also enhances the well-being of the compassionate individual. However, individuals with mental disorders, such as Borderline Personality Disorder (BPD), face challenges in such compassionate engagement due to perceived stigma associated with their condition.

This study investigates the impact of stigma on acts of compassion among individuals aged 18-25 with BPD. The research underscores the psychological benefits of generative acts, like peer support and mentoring, for mental health service users. Despite the emphasis on compassionate care in mental health services, limited research exists on how stigma affects engagement in compassionate acts.

BPD, characterised by emotional instability and distorted self-perception, affects 1%-2.5% of the UK population, typically diagnosed between ages 18-35. The study's focus on the 18-26 age group aligns with early intervention strategies for improved long-term outcomes. Stigma, encompassing public, structural, and self-stigma, significantly impacts individuals with BPD, considered one of the most stigmatised mental disorders.

Common barriers to compassionate acts for the general population, such as a lack of opportunity and heightened fears of misunderstanding, are pronounced for individuals with BPD. Stigma exacerbates these barriers, leading to exclusionary behaviours and diminished community connections. Despite the known benefits of compassion for mental health, little research explores factors influencing individuals with mental disorders, like BPD, to engage in compassionate acts.

This study aims to fill this gap by examining how stigma serves as a barrier and contributing to interventions promoting compassion and well-being. The methodology involves a knowledge synthesis through a scoping review and a mixed-methods approach with qualitative life narrative interviews. The study aims to shed light on the nuanced relationship between stigma and compassionate acts, contributing to interventions supporting individuals with BPD.

Recovery College in Krakow

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The Patients' Association "Open the Doors" from Kraków, Poland gathers individuals who want to share their recovery experience and counteract stigma placed on the mentally ill.

Educational activities on recovery cover various social groups. The course „Assistant in Recovery" is a new profession for persons with mental health crisis. The Cogito Academy of Leaders is a movement of experts through experience who are acting for the mentally ill in Poland. Participation in psychiatry events and cooperation with the city's cultural institutions play an important part. Together with professionals we investigate the quality of psychiatric care. Apart from the magazine of communities acting for the mentally ill „Dla Nas" (For Us) the organization publishes books and is often present in media. Moreover our experience is shared in international cooperation. Finally, our participation in internal political structures is meant for the implementation of community psychiatry in Poland.

We have carried out about 500 educational meetings for over five thousand participants, especially medicine students. The "Assistant in Recovery" course has been led since 2020 and more than 60 % of 110 graduates found the relevant employment. The Cogito Academy of Leaders has held regular meetings since 2016 and we participate in annual Days of Solidarity, psychiatry conferences or art exhibitions. Our research covered the topic of barriers to work and employment and the needs of the mentally ill in our region like inclusion and support. The "Dla Nas" magazine has issued 60 editions so far. We also published "Empowerment and Recovery" books. With our German or Norwegian partners we exchange experience and get inspiration. Our members are engaged in the Ministry of Health Committee for Psychiatry System Reform or the Commissioner for Human Rights.

The Recovery College in Kraków is an example of good practice and support for people with mental health problems.

Barriers to the utilization of mental health services among the Bedouin Arab community

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Previous studies indicated indicators of high psychological distress among different ethnic minorities including the Bedouin Arab community in Israel. Despite the large need for mental health services, studies have revealed the underuse of mental health services among this minority. This research examines the barriers to the utilization of mental health services to cope with the psychological distress among this minority. In this research, we addressed five different barriers: 1) barriers related to stigma 2) barriers related to people's attitudes 3) instrumental barriers 4) exposure to microaggressive in health services, and 5) Low mental health literacy.

Six hundred and fifty-one participants in this study. Women comprise 60% of the participants. They completed a questionnaire that included a demographic questionnaire, questions about past experiences of psychological distress, a questionnaire on barriers to accessing care (BACE v3), the General Health Questionnaire (GHQ-12), the Mental Health Literacy Scale (MHLS), and a questionnaire on the Use of mental health services.

The results indicated a high prevalence of stigma-related barriers (48.5%), those related to attitudes (58%), and instrumental barriers (49%). The vast majority reported a lack of knowledge about mental health (96%) and exposure to microaggressive experiences (91%). The statistical analysis indicated the prominent role of barriers related to attitudes, instrumental barriers, and barriers related to MHLS in predicting the utilization of mental health services. In other words, the higher the levels of attitudinal, instrumental barriers, and lack of knowledge of mental health issues, the less likely they are to seek mental health services.

This study underscores the need to tackle barriers to the utilization of mental health among the Bedouin Arab community and other ethnic-collectivistic minorities by increasing awareness and knowledge about mental health issues and providing the required resources for linguistically and culturally competent mental services within the local communities.

The Mental Health Research Associates Programme: building capacity from the inside out.

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Introduction

Despite ongoing emphasis on the importance of mental healthcare staff using and doing research, there are significant barriers that prevent progress. These barriers include having time, resources and academic mentors who understand the local context. A University based mental health research capacity building initiative in the South West of England developed several approaches to addressing these problems and this presentation reports on what happened.

Methods

Between 2021 and 2023, four health and care staff were recruited as Research Associates at the Peninsula Mental Health Research Initiative, a capacity building initiative between the Universities of Plymouth and Exeter, and local health and care services. They worked with academic staff from PenARC to design a research project that was meaningful to their local work context.

Results

Research Associates learnt skills in research design, data collection and analysis and built connections to the wider academy as well as presented their work at conferences. Research outputs were written up and published in academic journals, as well as being used to drive local service improvement. Two of the Research Associates are now involved in applying for research grant funding: one as a fellowship candidate, one as a co-applicant.

Discussion

In this session, we share our experiences as academics of working with the Research Associates. We explain how we recruited them, negotiated their time and designed projects with them. We also provide some insights into what worked well to support research capacity building as well as what we learnt and would do differently.

Participatory research with carers: a systematic review and narrative synthesis

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Introduction: As Patient and Public Involvement (PPI) in research has become increasingly common, and research-based recommendations on its principles and impacts have been established. The specifics of these are likely to differ when involving different groups. Family/ carers for those with health conditions or disabilities have a lot to contribute to research, but instances of their involvement have not yet been reviewed. We aimed to systematically review and synthesize studies where family/ carers were involved in the research process, to develop an understanding of the benefits, barriers and facilitating factors.

Methods: A search of five electronic databases and grey literature was conducted using a combination of terms relating to carers, involvement, and research. Expert consultation and hand-searching were also used. Following screening, data extraction, and quality assessment, a narrative synthesis incorporating thematic analysis was conducted. The initial findings and themes were presented to a group of carers who had been involved in research, whose reflections informed the final synthesis.

Results: 55 studies met the inclusion criteria, with diverse designs and participatory approaches. Four themes were identified, relating to the outcomes, challenges, and practicalities of involving carers: (re) building relationships with carers; carers as equals not afterthoughts; carers have unique experiences; carers create change. Full involvement throughout the research was not always possible, due to barriers from the research world and responsibilities of the caring role. The literature demonstrated how carers can contribute in ways that suit them, maximizing their impact, whilst attending to relationships and power imbalances.

Conclusion: This review synthesises different examples of how successful research partnerships can be built with carers, despite various challenges. Carers are a heterogeneous group, and participatory approaches should be tailored to specific situations. Wider understanding of the challenges of conducting empowering research with carers, and the resources required to address these, are needed.

The Recovery Mentor Intervention - Evaluation of peer support in a mental health service (REMIND)

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Introduction:

Peer support has found its way into the mental health services in Denmark. In the mental health service in the Capital Region, Recovery mentors (peer support workers) have been employed since 2023. The mental health services plan to hire recovery mentors across the entire organization and needs a higher degree of coordination and alignment of the peer support delivered across services. Therefore, an evaluation of the current evaluation is needed to qualify the peer support delivered. The aim of the evaluation of the Recovery mentor intervention is to develop a program theory for the intervention, investigate mechanisms of change, and potentially improve the intervention if needed.

Methods:

The evaluation is designed using the Medical Research Council framework, a realistic evaluation underpinned by critical realism, and is carried out as a PhD study. Phase one of the evaluation will describe and gather information about the current intervention in addition to existing knowledge about peer support. Furthermore, a systematic review and qualitative evidence synthesis about mechanisms of change will be conducted. This will create a basis for developing an initial program theory. Phase two of the evaluation, will test the program theory and evaluate the intervention through a qualitative study using realistic interviews with patients and Recovery mentors. They will be used to identify the mechanisms of change in the respective contexts to investigate what works for whom and under what circumstances.

Results:

The results from phases one and two will be used to revisit and refine the program theory. The refined program theory will make up the basis for refining the Recovery mentor intervention and making recommendations.

Perspectives:

The evaluation will add to the existing knowledge of peer support internationally and potentially increase the quality of peer support provided in the mental health service in the Capital Region of Denmark.

Improving long-term clinical psychiatric care: implementation of a method for renewed diagnosis and treatment (DITSMI)

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Background

The DITSMI method (Diagnose, Indicate and Treat Severe Mental Illness) involves diagnosis or re-diagnosis and appropriate treatment for persons with severe mental illness (SMI) in need of longer term clinical psychiatric care. In the current project, we aim to implement the DITSMI method in four organizations providing long-term care for persons with SMI throughout the Netherlands.

Methods

The DITSMI method is based on providing a holistic diagnosis including psychiatric, somatic and social functioning for each participating individual. Subsequently, a multidisciplinary treatment proposal according to treatment guidelines is formulated and adhered to. In the current implementation study, we will measure potential adaptations in diagnosis, treatment indications, medication use, and use of psychiatric care services, as well as potential changes in somatic and psychosocial functioning.

Results

In the original study (Veereschild et al., 2020) 83 persons with SMI (mean age 49±11.8y; 31% female; mean duration of care history 21±8.9y; 53% DSM-IV classification Schizophrenia) were evaluated over a three-year period. After DITSMI, 49% of the DSM-IV classifications changed; 67% of the treatment proposals changed; medication prescriptions changed for 67% of patients; time spent by professionals in face-to-face contact as well as administrative time lowered with 20-29%; bed utilization lowered with 44%. Preliminary results from the implementation study will be presented at the conference.

Discussion

The DITSMI method was previously found to lead to changes in diagnosis and treatment indication, resulting in improved medication use and psychosocial functioning and less utilization of psychiatric care services in persons with SMI within a long-term clinical psychiatric facility. While the clinical validity of DITSMI is considered high, factors complicating daily health care for persons with SMI on a provider and organizational level will need to be carefully investigated for a successful implementation of DITSMI on a larger scale.

Prescription of antidepressants and anxiolytics in France 2012-2022 and changes with covid19.

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Depression and anxiety have their prevalence increased during the COVID-19 pandemic. We aimed to describe the consumption of antidepressants and anxiolytics since 2012 in France and evaluate the potential effect of the COVID-19 pandemic until the end of 2022.

We conducted an interrupted time series analysis of routine drug sales data (Medic'AM) from French outpatient pharmacies from 2012-2022 covering the full population by health insurance. We investigated defined daily doses of antidepressants and anxiolytics sold per 1,000 inhabitants (DDD/TID) and health system expenditures in amounts reimbursed by health insurances, before and after COVID-19 pandemic onset and in relation with stringency of pandemic mitigation measures. Analyses were performed descriptively and based on segmented linear regression models and Auto-Regressive Integrated Moving Average (ARIMA) models.

From 2012 to 2019, overall antidepressants sales increased (+0.02 DDD/TID each month) and overall anxiolytics sales decreased (-0.07 DDD/TID each month, 95% CI -0.09 to -0.06) in France. Expenditures for both drug classes relevantly decreased in 2012-2016, as generics increasingly became available. With pandemic onset, there was a relevant and persisting trend increase (+0.20 DDD/TID per month) of antidepressants sales overall, with an estimated excess of 120 DDD/TID (95% prediction interval [PI] 93.9 to 146.4) sold from May 2020 until December 2022. Patterns similar to the overall trend were observed for recommended first-line antidepressants. Anxiolytics sales were elevated from February 2020 throughout the pandemic and returned to expected levels by December 2022, with an estimated excess of 32 DDD/TID (95% PI 8.7 to 55.7). There was no evident association between stringency and antidepressants or anxiolytics sales.

This study showed a protracted increase in the trend in antidepressants consumption since onset of the COVID-19 pandemic. Pandemic's impact on anxiolytics consumption was temporary, while it may have had long-lasting consequences for the management of depression.

Socioeconomic vulnerabilities of individuals living with a mental disorder

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Introduction

Social inequalities in mental health are wide and scientific discussion on causal pathways between socioeconomic status (SES) and mental disorders is ongoing. A recent linkage of the main longitudinal population sample representative of the population living in France with the national health data system offers new research opportunities on the topic. Our objective was to increase the evidence base on socio-economic disparities of incidence and prevalence of mental disorders.

Methods

Individuals with mental disorders were identified in the 2016-2017 period using data on causes of hospitalizations, conditions leading to entry in the long-term illness scheme and drug deliveries over the past five years. Considered SES indicators included the standard of living, household composition, socio-professional category, level of education, marital and migratory status, and residency in a deprived priority neighborhood or in social housing. Sub-analyses were carried out by gender, age, and type of mental disorders.

Results

Findings underscored a marked socio-economic gradient for both prevalence and incidence of psychotic, bipolar and other mood disorders. Prevalence were two to seven times higher for individuals in the quintile of the lowest standard of living compared to those in the highest quintile. These differences grew with age, revealing an increasing impoverishment of individuals with mental disorders over time. Furthermore, in comparison to the general population, they had increased odds of not completing their secondary education, of living alone, in a priority neighborhood and in social housing.

Discussion

A better understanding of the socio-economic vulnerabilities faced by people with mental disorders offers avenues for future research, including on inequities in their care pathways after adjustment on these vulnerabilities and the implementation of longitudinal studies focused on causal links between mental illnesses and SES.

Effects of the day ward on the negative symptoms in patients with schizophrenia spectrum disorders

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Introduction

Negative symptoms in schizophrenia are still difficult to treat, even with adequate pharmacotherapy and psychosocial interventions. Relatively little is known about the effectiveness of complex treatment programs. The purpose of the present study was to test the effectiveness of the day care clinic on psychotic symptoms in patients with schizophrenia spectrum disorders and to explore possible predictors of therapeutic response.

Methods

The study involved 59 patients with diagnosis of schizophrenia spectrum disorder, 41 of whom had complete data. Participants were examined using the Brief Negative Symptoms Scale (BNSS), Positive and Negative Syndrome Scale (PANSS) and Calgary Depression Scale (CDS). After completing treatment in the unit, patients were reexamined with the same measures.

Results

Participants experienced a significant reduction in the severity of negative and depressive symptoms. The improvement in negative symptoms was explained in part by a decrease in depressive symptoms. No predictors of treatment response were found for negative symptoms.

Discussion-Conclusion

The study found that a three-months treatment can lead to a clinically significant reduction of the severity of negative symptoms. The improvement was observed in all five domains, which is likely due to the inclusion of various therapeutic interventions - such as psychotherapy, art therapy, social skills training and others. Although caution is needed because of the naturalistic nature of the study, it appears that a day ward may be beneficial for patients with schizophrenia-spectrum disorders experiencing negative symptoms.

Psychological distress, anxiety and depression among French students

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Introduction: Young people attending university often do so during a developmentally critical period that is highly vulnerable to the onset of mental health problems. The impact of mental health problems can be profound, including reduced academic performance and relationship breakdown (Osborn et al., 2022). Distress tolerance and depression play a mediating role in the relationship between anxiety-related symptoms and stress among both dropout and non-dropout college students (Abbas et al., 2023).

Background: Derived from a broader study of mental health and addictive behaviors among 917 students, this study focuses on the effects of gender on psychological distress and correlations between psychological distress with anxiety and depression.

Methodology: A quantitative methodology was used, using the MIH-7 scale along with the GAD and PHQ9 scales to measure anxiety and depression, respectively.

Results: A significant gender difference was observed on most MIH-7 items. The scale demonstrated good reliability (Cronbach's alpha = 0.782, McDonald's omega = 0.787). Positive correlations were also found between mental health (MIH-7), anxiety (GAD), and depression (PHQ-9).

Conclusions: This study highlights the gender differences in psychologicall distress among university students and the strong association between psychological distress and symptoms of anxiety and depression. The results highlight the need for integrated approaches to the assessment and support of students' mental health, taking into account gender factors and related psychological symptoms. The reliability of the MIH-7 scale further supports its utility as an preventive assessment tool in university settings.

Dissociative processes and symptoms of schizophrenia spectrum disorders

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Introduction

In recent years, it has been recognized that dissociative processes are an important factor in the etiology and treatment of this type of disorder. These processes can be further divided into two types: fragmentation and detachment. The primary objective of our study is to analyze the relationships between the severity of dissociative symptoms and the symptomatology of schizophrenia spectrum disorders, cognitive functioning and mindful awareness.

Materials and methods

The study involved 70 patients with a diagnosis of schizophrenia spectrum disorder . Participants were examined with the Positive and Negative Syndrome Scale (PANSS), The Addenbrooke's Cognitive Examination-III (ACE-III), Audit-C, Anxiety and Depression Scale (DASS-14), Mindful Attention Awareness Scale (MAAS), Dissociative Experiences Scale Revised (DES-R), Somatoform Dissociation Questionnaire (SDQ 20), Detachment and Compartmentalization Inventory (DCI), Dissociative Symptoms Scale (DSS).

Results

The participants showed various intensity of dissociative processes, with 18.6% reaching the cut-off of 28 points for dissociation in SDQ-20 and 32.9% the cut-off of 72 points in DES-R. The strongest correlations were found for dissociative symptoms and symptoms of depression, anxiety and emotional distress. Weaker correlations emerged between some positive symptoms and dissociative symptoms. The strongest inverse correlation was found for mindful awareness and dissociative symptoms. A linear regression model including number of stationary hospitalizations, anxiety and depression symptoms, duration of illness (years), cognitive functioning (ACE=III) as covariates (all non-significant) and dissociation symptoms (DSS; significant) explained 24% of variance in psychopathological symptoms (PANSS).

Conclusion

The study showed that a significant portion of patients experiencing schizophrenic symptoms also experience marked dissociative symptoms, which indicates potential direction for further research and the design of therapeutic approaches to effectively help people experiencing psychotic symptoms. The study also showed that mindfulness techniques could facilitate the therapeutic process as regards dissociative as well as depressive, anxiety and emotional withdrawal symptoms.

Artificial intelligence for reducing involuntary admissions: Opportunities and challenges

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Artificial intelligence (AI) has garnered significant attention in various fields, and its potential to revolutionize mental health care is undeniable. One area where AI shows promise is in improving the quality of care by reducing involuntary admissions in mental health care. Involuntary admissions refer to situations where individuals are admitted to psychiatric facilities against their will, often due to concerns about their safety or the safety of others. These admissions are typically guided by mental health professionals who assess the risk and make decisions based on their expertise. AI algorithms can be used to analyze large amounts of data from various sources, such as electronic health records and social media, to identify potential indicators of a mental health crisis. This can enable early intervention and preventive measures, reducing the likelihood of involuntary admissions. Moreover, the utilization of advanced predictive models in healthcare analysis can allow hospitals to forecast increased demand for emergency care and plan accordingly. This is crucial, as an excessively high patient-to-staff ratio can contribute to involuntary admissions.

However, the use of AI to reduce involuntary admissions also presents significant challenges. AI systems are only as good as the data they are trained on, and if the datasets used to develop AI algorithms are biased, the resulting system may perpetuate inequalities in mental health care. Another main concern is the ethical implications associated with relying on AI systems in such critical decision-making processes. The complexity of mental health conditions and the subjective nature of certain symptoms make it challenging for AI algorithms to accurately capture the nuances of individual experiences. Human oversight and clinical judgment should, therefore, continue to play a crucial role in the decision-making process, with AI serving as a supportive tool rather than a replacement for human expertise.

Recovery Colleges and Universities: an obvious partnership with enormous potential

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Introduction: Recovery Colleges are a rapidly expanding international innovation, promoting personal recovery whilst transforming mental health services and communities. Whilst Recovery Colleges vary their funding, operation and characteristics, a uniting feature is their educational approach; all involved become 'students' learning from one another, and many Colleges adopt practices such as prospectuses and semesters to instil this philosophy. In Australia, complex commissioning contexts challenge the resourcing and sustainability of Recovery Colleges. Our aim was to understand models of Recovery Colleges formed through tertiary educational institutions and community organisations/ health providers partnerships, and to explore feasibility and potential benefits of this in an Australian context.

Methods: We conducted a brief scoping exercise, connecting internationally with researchers and communities of practice to identify existing Recovery Colleges with university partnerships. We then held discussions with these Recovery Colleges about their contexts, benefits and challenges. These models were then discussed with staff from an Australian University and local community organizations to explore their perspectives on the potential benefits and challenges of these models in their context.

Results: 32 partnerships were identified (with likelihood of many more undocumented instances). Models varied in their funding structures, management, course codesign, delivery and attendance, with tertiary education institutions involved in different ways and extents. Numerous anecdotal benefits were reported, regarding additional opportunities for Recovery College students and wider community impact and cultural transformation. Further potential advantages were identified for the specific Australian context, where joining of Universities and Recovery Colleges was seen as a potential solution to current challenges.

Conclusion: Community organisations and tertiary education can collaborate to deliver Recovery Colleges in different mutually advantageous ways. Universities could play a role in supporting implementation of Recovery Colleges as a systemic and sustainable element of Australian mental healthcare innovation, but further research is required to evidence this model.

How is trauma-informed care currently conceptualised? A scoping review.

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Introduction

In the UK, the Health Innovation team in Northeast and North Cumbria, have created a platform to help promote and advocate for trauma-informed approaches to mental health treatment, to support the development of a national trauma-informed community of practice. The current scoping review explored how trauma-informed care (TIC) is currently conceptualised, from the perspective of healthcare providers and professionals. This will foster its acceptance in the English healthcare workforce and internationally.

Methods

3 databases were used to identify relevant journal articles. Web-searches were used to identify policy handbooks and national guidelines relevant to healthcare settings. The included documents were published in the last 15 years.

Results

An initial set of 14 documents were identified from 2008 to 2023, consisting of clinical trial reports, books, policy documents, and practice handbooks. Different interpretations of TIC were described. This included networking activities with a shared national vision of integrating the TIC principles at a systemic level. A few expressed that facilitating its implementation by tailoring it contextually to the organisation is significant. Many highlighted re-occurring implementation challenges such as safety, transparency, cultural sensitivity, trustworthiness, collaboration, empowerment, and choice. Barriers to the implementation of TIC at an organisational level were identified. These included having no dedicated strategy, agreed terminology, or framework, and only modest levels of evidence-based findings from the UK healthcare system. This worryingly creates a cohort of professionals lacking the skill to respond with confidence when a patient discloses assault, violence, or abuse within an organisation.

Conclusion

Future research should continuously document and evaluate robust trauma-informed practices across healthcare systems internationally. There are differing views on the future implementation of TIC; some believe it has gained critical momentum, but others are pessimistic, due to insufficient political support, creating a potential barrier to meaningful reforms to healthcare practice.

Top 12 facilitators and obstacles in supporting mental health recovery: Insights from families

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Mental health services have transitioned towards a recovery-oriented approach, prioritizing human rights and the self-determination of users. Central to this approach is the concept of connection, highlighting the significant impact of positive support. In many instances, families constitute the primary support system for mental health service users, introducing unique challenges in the process of supporting persons with mental health problems. Recognizing the facilitators and obstacles faced by families and caregivers in supporting their loved ones is crucial. This study aims to establish an international consensus on the key facilitators and barriers in supporting the recovery process, as seen from the perspectives of families and caregivers of mental health service users.

To achieve this, family member and caregiver associations were invited to participate in a three-round global e-Delphi study. Fifty-three family members and caregivers worldwide consented to participate. The first round involved two open-ended questions concerning the facilitators and barriers in supporting mental health recovery. The second round focused on evaluating the relevance of each statement derived from the qualitative analysis of the initial responses. The third round entailed re-evaluating those statements that did not meet the predetermined relevance threshold, defined as 70% - 80% of participants rating them as "relevant" or "very relevant".

This study presents the 12 most significant facilitators and 12 principal obstacles in supporting recovery, as agreed upon by consensus among family members and caregivers of mental health service users. The statements with the highest agreement underscore the importance of being present, trusting users, and being willing to learn. These findings contribute to elucidating new avenues for families supporting their relatives in the mental health recovery process.

Findings contribute to elucidating new frontiers to care for families supporting their relatives in the mental health process from a recovery-oriented approach.

Standard Description of Adicction Services in Andalusia (Spain) to inform service planning

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Andalusia's social and health administration is developing a new Strategic Plan for Mental Health and Addictions. The diagnosis of the current service provision faced challenges related to defining meaningful study units (commensurability issue) and addressing the diversity of care within the same administrative typologies (terminological issue). This communication aims to describe and classify addiction services, analysing their provision in Andalusia (2023) while overcoming both methodological issues.

The Description and Evaluation of Human Services and Directories (DESDE) system was applied to describe and classify addiction services based on their main activities. The study included public access and specialised services, encompassing both general and specific diagnoses, from the social, health, and justice sectors. Service managers completed a questionnaire with key information. The analyses included calculating availability, capacity, and workforce rates per inhabitant.

Andalusia held 181 main types of care delivered across 179 care units provided by 96 providers, including public agencies and not-for-profit organisations. When considering mental health services, addiction services comprised approximately 25% of the total. Nine different types of care were used to describe these services. Services were targeted to any addiction (n=170), offenders (n=11), and specific diagnoses such as alcohol and gambling. The services delivered outpatient care (69%), residential/hospital care (24%), daycare (4%), and accessibility to care (3%). The placement capacity was 607 beds and 430 daycare places. The services employed over 900 professionals, predominantly including social workers, instructors, clinical psychologists, and physicians.

While most services were described with only one type of care, indicating precise functions, some services within the same administrative typology delivered different care. Thus, administrative typologies should be defined more clearly to prevent care inequities. Furthermore, the availability of community residential care should be increased. The service classification provided an accurate and helpful picture of the provision to inform and support the new plan.

Bridging the Gap in Mental Health: Developing Specific tools for Advanced Care Planning Assessment

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Advanced Care Planning (ACP) is increasingly recognized as a critical component in healthcare, underscoring the autonomy and dignity of individuals across various health conditions. Its significance is especially pertinent in mental health, where ACP empowers adults with mental illnesses to express their future healthcare preferences and directives, thereby ensuring that their choices are respected during crises when they may lack decision-making capacity. Despite its importance, there is an absence of instruments specifically designed for ACP assessment in the realm of mental health. Our study outlines the methodology approach employed in the development of specific instruments for evaluating ACP-related dimensions in mental health. The initial phase of our research involved a systematic review of existing literature on the development or adaptation of ACP assessment tools in diverse health conditions. This systematic review spanned across five databases: PsycNET, PubMED, Web of Science, Scopus, and CINAHL, aiming to pinpoint studies focused on the creation, adaptation, and validation of ACP assessment instruments. Following this, we pinpointed key aspects measured by these tools and identified items to integrated into a novel instrument tailored for ACP in mental health.

Out of 1,222 studies, 54 met our inclusion criteria, contributing to a total of 57 instruments. Predominantly, these instruments assessed knowledge of ACP procedures (36%), attitudes towards ACP (17%), participation in ACP activities (16%), and self-efficacy regarding ACP (12%). We reviewed and adapted items, particularly those related to knowledge and attitudes, for application in the mental health context. This led to the creation of two novel instruments specifically designed to evaluate attitudes and knowledge about ACP in mental health. These measurement instruments address aspects previously overlooked in ACP for mental health, potentially fostering a culture of empowerment and enhancing the overall quality of care delivered.

Development of an Advanced Care Planning Training Program in Mental Health

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Advanced Care Planning (ACP) in mental health involves written documents that allow adults with mental illness to express future preferences and decisions, ensuring their choices are respected during crises when decision-making capacity may be compromised. Although ACP is legally supported in various countries, its clinical integration is limited, potentially due to insufficient knowledge, negative attitudes, and barriers among professionals, service users, and their support networks.

This study presents the development of a comprehensive ACP training program for Catalonia's mental health services, conducted in two phases. The first phase, a two-round Delphi study, involved national and international ACP experts, including mental health professionals, service users, and their support networks. In the first round, experts assessed the relevance of the training content (initially based on WHO's QualityRights materials and other ACP training programs), as well as suggested the ideal trainers (either peers or health professionals), and estimated the required training duration. In the second round, experts received results from the initial round, enabling them to re-evaluate and refine their opinions based on collective feedback. Contents included in the training program were those considered essential by at least 75% of the participants.

The second phase focused on creating training materials, guided by the Delphi study outcomes. A consensus conference with 30 experts reviewed these materials to ensure they aligned with Catalonia's mental health care structure. Participants individually examined the materials before the conference, then collectively discussed their feedback.

This ACP training program represents a significant step in mental health care, offering a user-centered approach to ACP. Its collaborative and iterative development process promotes practical applicability, addressing the diverse needs of mental health service users and caregivers. This program holds the potential to transform mental health care practices, fostering an environment of empowerment and improved care outcomes.

Utilization of Psychiatric Rehabilitation Services among People Coping with Severe Mental Illnesses

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Introduction

People coping with severe mental illness (SMI) experience serious debilitation, decrease in quality of life and a significant decline in daily life functioning. The Israeli health system provides psychiatric rehabilitation services, named Sal Shikum services (SSS), aimed at integrating people with SMI into the community, with the goal of enhancing their quality of life and functioning. Yet only 30% of eligible individuals utilize these services. This study examined factors contributing to the utilization of SSS.

methods

In this cross-sectional study 227 people with SMI who were entitled to SSS filled out an online survey distributed through social media and within a psychiatric department. The survey included questionnaires assessing utilization of SSS, level of knowledge regarding rehabilitation services, attitudes toward seeking mental health treatment, quality of mental health provider-client relationship and degree of provider-client shared decision-making.

Results

Users of SSS exhibited a higher level of knowledge and more positive attitudes towards seeking mental health treatment compared to non-users. In the path analysis, quality of provider-client relationship and attitudes significantly explained the likelihood of using SSS. Furthermore, attitudes mediated the relationship between quality of provider-client relationship and utilization of SSS.

Discussion-conclusion

Quality of provider-client relationship and attitudes towards seeking mental health treatment seem to be the most important factors in explaining the likelihood of SSS utilization. Programs aimed at reducing negative attitudes towards seeking mental health treatment and at improving provider-client relationship should be developed. Improving provider-client relationship can be achieved by promoting professional development of mental health providers through targeted training and by increasing manpower within health systems in order to enhance service availability and reduce staff workload. Additionally, campaigns and programs to reduce stigma towards mental health services can contribute to more positive attitudes towards such services and to the utilization of mental health rehabilitation services.

Common mental disorder in Basque Country

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Background/Objectives

One of the public health problems of our time is the prevalence of mental disorders. In Spain, it is estimated that 2.5 million people suffer from depression and 2 million from anxiety. The literature has highlighted the link between social and economic determinants and physical and mental health. Several studies have claimed that the positive correlation between socioeconomic status and health varies between European countries and welfare states. This may indicate that geographical location is a factor that needs to be considered. Spatial epidemiology describes, quantifies, and explains geographical and geo-temporal variations in disease and assesses the relationship between disease incidence and possible social, economic, and environmental risk factors. Understanding, handling, and analysing this information requires specific techniques. Among these techniques, spatial autocorrelation analysis attempts to show a pattern in the variable's behaviour according to the variable's geographical location. This research aims to identify the hot/cold spots of incidence and prevalence of common mental disorders and the use of specialised services in the Basque Country in 2019.

Methods.

This research examined the minimum dataset corresponding to community mental health centres by the smallest available spatial unit (basic health areas/municipality) in the Basque Country in 2019. The variables considered in the study included prevalence and incidence of attendance and visits per inhabitant. Bayesian empirical standardisation was applied to smooth the data to avoid overestimation, and then global and local autocorrelation indices were used to identify statistically significant clusters.

Results.

Spatial clusters were identified at both global and local levels for both variables, identifying points that need special attention within the Basque Country.

Conclusion

The results provide helpful information for planners and decision-makers searching for efficiency, quality, and equity in mental health care. The next step of this research will be identifying risk factors that explain these spatial patterns.

Effects of COVID-19 pandemic on psychiatric and psychological consultation-liaison services

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Introduction. The COVID-19 pandemic has prompted significant changes in healthcare, particularly affecting psychiatric and psychological Consultation-Liaison (CL) services in general hospital settings. This study investigates the impact of pandemic-related restrictions on these services in a General Hospital in Northeast Italy.

The aim of the study is to assess the effects of COVID-19-related restrictions on use of psychiatric and psychological CL services during 2020, and to compare it to the one in the previous year (2019).

Methods. The study collected data on psychiatric and psychological consultations in 2019 and 2020 from a hospital database. It categorizes consultations by type of patient (inpatient or outpatient) and referral source (hospital wards, general practitioners, other specialists). Pandemic-related restrictions were classified as "lockdown," "intermediate restrictions," and "no or reduced restrictions" based on the Covid Stringency Index (CSI). Poisson regression models were employed to analyze the data.

Results. The findings reveal a significant 28% increase in the number of psychiatric and psychological consultations in 2020. Notably, consultations for outpatients increased by 51%, while those for inpatients decreased by 11%. However, the lockdown and intermediate restriction phases were deemed responsible of a decrease of 42.9% and 19.5% in consultations, respectively, which could be attributed to patient reluctance to seek in-person care and healthcare providers' caution in admitting vulnerable patients.

Discussion. The study underscores the need to incorporate telemedicine options in psychiatric and psychological consultation services to address patient demands, especially during periods of heightened restrictions. These insights can inform policies and practices at both local and international levels, ensuring effective mental health care delivery during and beyond the pandemic. Future research should explore the impact of pandemic-related restrictions on mental health care across different settings and consider various clinical factors influencing access to services.

Feasibility of a benzodiazepine deprescribing program to reduce side effects and carbon emissions

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While many health systems are trying to develop an actionable roadmap towards a net-zero health system, medications have been identified as one of the largest contributors to carbon emissions. The idea of “sober” prescribing patterns is thus emerging, yet remains as an umbrella term without concrete evidence or programs on the policy agenda.

At the same time, this idea has a natural link to a well-identified public health problem: polypharmacy, or the prescription of 5 or more drugs. This problem is increasingly prevalent and poses serious threats in terms of side effects via drug interactions. It has become a particular public and mental health concern with the recent surge of psychotropic prescriptions since the Covid-19 pandemic, related to the rising prevalence of anxiety and depression. Indeed, health professionals are generally trained at prescribing, but not at de-prescribing. The latter has now emerged as a dedicated field of study.

Our study, addressing two of the four main topics of focus in this year’s conference (health system and interdisciplinary approaches to quality; new frontiers for research and policy), will combine these two streams and addresses the following questions:

- What does the literature say about deprescribing programs that work?
- What is the estimated impact (clinical, economic and carbon) of deprescribing benzodiazepines?
- What are barriers and facilitators, with providers and patients, for a benzodiazepine deprescribing pilot program in France?
- Would including carbon footprint as a rationale have an effect on the acceptability of such a program?

To this end, we will collect data via internet databases and conduct semi-structured interviews with stakeholders, practitioners and patients. After analysis of the evidence, we will assess feasibility and attempt the design of an actionable pilot program.

Are the Assertive Outreach Community Teams an efficient type of care? In search for meaning

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Introduction: Assertive community treatment (ACT) is an alternative care to hospitalization to avoid the revolving door in cases of patients suffering from severe mental disorders. The implementation and care provision by ACT teams evidence significant variance in the fidelity to the original model. The lack of a general framework and standardization of care provision could compromise the replicability and comparability of these studies, showing controverse results worldwide. In Europe, hybrid versions of ACT teams, or Assertive Outreach Community Teams (AOCTs), are being implemented without standardization. Many of those mental health systems have failed to provide adequate care, compromising the efficiency of AOCTs. This research aims to assess the of AOCTs in the mental health system of Bizkaia (Basque Country, Spain). **Methods:** The sample consisted of 19 catchment areas in Bizkaia (Basque Country, Spain). This mental health system is a community care-based model that integrates hospital and community care services. It has 5 AOCTs, which provided care to 317 AOCTs users. Input variables included services, places, psychiatrists, nurses and psychologist in AOCTs. Outputs were the number of visits, prevalence, length of stay, discharges and readmissions. The EDeS-MH decision support system was used to assess the AOCTs performance. **Results:** Findings showed that the AOCTs were performing efficiently in terms of decreasing readmissions and length of stay at inpatient care. On average, the relative technical efficiency oscillated from 0.91 to 0.90, which evidenced that there was a good management of the available resources, avoiding the revolving door phenomenon and proving aftercare when users are discharged from hospital. **Discussion:** AOCTs in Bizkaia are performing in an efficient way by decreasing number of admissions, length of stay and readmissions at inpatient care. In addition, this type of care plays an essential role to avoid overloading on acute day hospital care and non-acute hospital care services.

The cost-utility of a community mental health care intervention over 24 months in Germany

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During the last two decades the several evaluation studies on the effectiveness of community mental health care interventions (CMHC) have been conducted. However, in spite of the important role of economic outcomes for decision makers, the cost-utility of CMHC has been rarely investigated so far.

In this study the cost-utility of a community mental health care intervention for people with severe mental disorders in addition to routine care over 24 months will be investigated on the background of the German health and social care system.

In a randomized controlled trial 927 persons were assigned to the GBV intervention (n = 470) or to care as usual CAU (n = 457). Assessments were made at baseline and four follow-ups over 24 months. Quality adjusted life years were estimated on the basis of health states defined by the EuroQol EQ-5D-5L and the German value set. Comprehensive costs of illness (COI) were estimated by means of the Client Sociodemographic and Service Receipt Inventory (CSSRI) adjusted to the German health and social care system. An incremental cost-utility analysis (ICUA) from the societal perspective was conducted by means of the net-benefit approach. Stochastic uncertainty of the incremental cost-utility ratio (ICUR) was estimated by means of nonparametric bootstrapping with 10.000 replications. Results were interpreted on the basis of the cost-effectiveness acceptability curve(CEAC) and the net monetary benefit regression curve using a maximum willingness to pay (MWtP) threshold range between 0 and € 125.000.

Results of the CUA reveal an increase of QALYs by 0.038 at increased costs of € 286,13 resulting in an ICUR of € 7,529.75 for the 24 month period. The CEAC indicates that a 95% probability of cost-effectiveness would be reached at a MWTP > € 125.000 which would not be appraised as cost-effective on the background of suggestions for national MWtP thresholds.

A liaison-somatic team: Exploring meetings between medical specialists and patients in Psychiatry

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The increasing numbers of people with multimorbidity has been a concern in international context for years. The population of people with two or more treatment requiring illnesses is pressuring our healthcare system, which, in most Western countries, is organised to provide specialised and effective treatments. This presents a challenge in managing people with multiple and complex health issues. Furthermore, it is well-known that people with severe mental illness face a substantially shortened life expectancy compared to the general population and that up to 70% of early deaths are caused by physical ill health. Based on this knowledge and the wishes of a local mental health peer board, patients with physical health needs in the mental health services of the North Denmark Region are currently offered consultations and follow-up with medical specialists from the university hospital. This liaison-somatic team is built on collaboration between staff from different medical specialities and the mental health departments. The study aimed to explore the meetings that take place between members of the liaison-somatic team and patients in the mental health services. The objective is to gain insight into what characterises these meetings and the experiences of both patients and members of the liaison-somatic team. The study is designed as a focused ethnographic study and generates data through participant observations of meetings and interviews with those participation in the meetings. Data will be analysed using conversation and thematic analysis. The study is ongoing, and preliminary findings will be available at the conference.

How can we improve mental health care accessibility for people with substance use disorders?

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According to a government report from 2022, healthcare provision for people with mental health and addiction problems is considered to be too high-threshold. To address this issue, the Substance Use and Mental Healthcare InTegration (SUMHIT) project was initiated to study the accessibility of regional mental health networks for people with substance-related disorders. The research group selected relevant barriers to seeking professional help based on the output of previous quantitative and qualitative research. The selection criteria of these barriers were the possibility to have impact by field workers and relevance for the working field. These barriers were presented to 5 panels of professionals and experts by experience in the Belgian regions where the previous surveys were conducted. As a result, professionals and peer workers were encouraged to explore possibilities to lower the threshold to professional mental health and specialised addiction care. Through a three-hour GPS methodology, a brainstorming session was initiated to ceate some concrete solutions.

The brainstorm session focused on formulating solutions to the negative effects of waiting lists, how intake criteria can be used as a means of alignment, and how caregivers can respect the choices clients make, even if it would not be the appropriate way to go according to them. The brainstorm session further explored how to build a real working network with and around a client, as well as ways to work more trauma-sensitive. The suggestions focus on adapting and refining methodologies that are already used, as well as on a more radical commitment to network-based care for people with substance use disorders.

What are the impacts of implementing recovery innovations into services? A new conceptual framework

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Introduction: Outcome studies in mental health recovery have focused primarily on personal-level recovery outcomes. Evaluating the broader impact of implementing recovery innovations on organizations is lacking. In the context of a 5-year Canadian study to implement recovery guidelines and transform services towards a recovery-orientation, we developed the IMpacts of Recovery Innovations (IMRI).

Methods: Seven organisations providing mental health services participated. Each site created an implementation team that selected and implemented a recovery innovation that met their organisational needs. Four types of recovery innovations were implemented including: peer support, staff training on recovery, WRAP and a family support group. Ninety participants from diverse stakeholder groups including service users, service providers, family members and managers participated in 41 qualitative interviews after the implementation of their recovery innovation. We applied a collaborative qualitative content analysis approach using NVivo12 to code and interpret the data.

Results: The IMpacts of Recovery Innovations (IMRI) conceptual framework includes: 18 impacts of implementing recovery innovations organised around four overall categories: *Ways of being, Ways of interacting, Ways of thinking, and Ways of operating and doing business.*

Discussion/Conclusion: This new conceptual framework is unique because it goes beyond evaluating the impact on the person and includes the impact of implementing recovery innovations on systems and services targeted by the innovations. IMRI may help to advance evaluation efforts because too often impact is narrowly defined as patient outcomes. When implementing recovery innovations aimed at system-transformation, we need a broader view of impact that includes, but is not limited to, individual-level impacts. The IMRI conceptual framework fills this gap by encompassing service and organisational impacts.

Comprehensive evaluation of MH care provision in Andalusia (Spain) for effective service planning

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Andalusia has developed a public mental health (MH) care system with a community perspective since the constitution of its autonomy. Great strides have been made in the approach to MH from primary care and the creation of a network of specialised second and third level facilities. However, there is still room for progress. This study is included in the new regional Strategic Plan for MH and Addictions and is aimed at analysing MH service provision in Andalusia.

MH services were described and classified based on their main activity (Main Type of Care, MTC). The tool used was the Description and Evaluation of Human Services and Directories, (DESDE) system. The research encompassed a comprehensive evaluation of public MH services from the health, social and Justice sectors. Analyses quantified and compared accessibility, capability and workforce considering both general and specific diagnoses.

The analysis of MH services provided 518 main DESDE codes and 25 secondary codes. These codes were part of the main activity found in 486 MH Basic Stable Unit of Care (BSIC)(the main unit of analysis comparable to service). Providers included 30 different agencies like MH clinical Management Units (UCG SM), FAISEM for social and dependency services, among others. Most services were classified as residential (47%) according to DESDE, secondly as outpatient (31%), and then as day care (26%). Fifteen different DESDE codes were used to describe services.

The study offered a precise overview of the MH care provision of Andalusia, useful for strategic decision-making and planning. The analyses showed a diverse and well-balanced health-social system. The analysis of BSICs and MTCs revealed problems of terminology in some resources that required more than one DESDE code to describe them. Additionally, the geographical location of codes made it possible to detect regional differences in access to some of the services.

Exploring the sustainability determinants of recovery-oriented interventions for adults.

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Introduction:

The transformation of mental health services to recovery-orientation is a policy priority for countries worldwide. Over the past two decades, there has been increased research on the conceptualization, effectiveness, and operationalization of mental health recovery into services. However, less attention has been given to the sustainability of recovery-oriented interventions and practices over time even though international literature consistently reports that not all health interventions can fully sustain their activities beyond the initial implementation phase. Unsustainable health programs represent a significant public health concern due to the lack of long-term health outcomes for service users, the expenditure of resources in an era of scarcity and the demoralization of involved stakeholders, etc.

Methods:

Building on a pan-Canadian study on facilitating and evaluating the implementation of mental health recovery-oriented guidelines, this study assessed the capacity of three organizations to sustain peer support and staff recovery training two years after their initial implementation and identify the facilitators and barriers for sustaining these interventions. Between 2022 and 2023, 37 people involved in implementing recovery-oriented interventions participated in this research. In order to understand the factors that most determined sustainability qualitative and quantitative data from 37 interviews were mapped to three well-established implementation science frameworks.

Results:

Results will report on the factors that determine the sustainment of peer support.

Discussion:

Sustainability is a significant concern for all involved actors in healthcare. Researchers have not yet explored the concept of sustainability in great depth in mental health and recovery oriented interventions. This study will help to fill this gap in our knowledge, and findings could pave the way for more focused research.

Conclusion:

At its core, understanding the sustainability of recovery interventions may result in increased social inclusion of people with a mental illness, a marginalized group experiencing high poverty rates, homelessness, and low life expectancy.

Integrating mental health care into primary care for adolescentsand young adults: systematic review

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General practitioners, as primary care specialists, often play a key role in the prevention, early detection and treatment of mental health (MH) disorders. Early detection and care are especially important for adolescents and young adults, as the majority of mental disorders start before the age of 25. However, the specific aspects of the physician-young patient relationship poses challenges to the integration of MH issues in general practice with young adults. As a result, emerging MH disorders are often underdiagnosed in this population, preventing or delaying care that may improve MH, prevent complications, and limit evolution toward chronic condition.

In the past decades, the concept of integrated care has been promoted as a lever for improving primary health care, with objectives that can be broken down into: 1) clinical integration (aiming at continuity of care, i.e. “seamless service” or “continuous caring relationship”); 2) professional integration; 3) organizational integration; and 4) system integration.

To investigate the potential of this concept to improve mental health primary care, we performed a systematic review of the PubMed, PsycInfo and PubPsych databases, following the PRISMA recommendations, to identify and compare interventions integrating MH services into primary care for 12-25 year-old patients. A specific focus was given to continuity of service and professional integration between primary care and MH professionals.

The strategies implemented to integrate MH care into primary care for young patients were heterogeneous, and depended on local resources and health system. Preliminary analysis identified four main organizational types: “collaborative co-locations”, “collaborations without co-location”, “one stop shops”, and “MH care resources for primary care”. Few interventions were evaluated. Professional integration ranged from simple referral to regular interactions between professionals.

The diversity of approaches identified call for detailed investigations and report of the contextual factors and constraints that led to the design of each intervention.

An evaluation of the Danish headspace initiative to improve youth mental health and well-being

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Introduction: Since 2013, headspace Denmark has been provided to young people between 12 and 25 years. The initiative is based on the Australian headspace model, but local adoptions have been made. In Denmark, headspace aims to promote youth mental health and well-being through free counselling and support, primarily provided by trained volunteers in the headspace centers, and a national chat center. Moreover, there is an aim of building bridges to other services, for instance in the mental health sector, and the headspace centers provide information and awareness about youth mental health through community engagement. Until now, few independent evaluations of the Danish headspace centers have been conducted.

Methods: The evaluation consists of 1) an effectiveness evaluation with a matched cohort study, where the exposed person (n=1500) in this case the young person receiving counselling sessions at headspace will be matched by using propensity scores to five unexposed individuals, using propensity score matching. 2) a cost-effectiveness evaluation with an economic analysis of the same cohort as in the effectiveness evaluation. 3) A process evaluation with predominantly qualitative methods to investigate the implementation of key activities of headspace, their mechanisms of change, and interactions with contextual factors.

Results: The results from the evaluation will contribute to scientific knowledge about the Danish headspace centers` effectiveness, cost-effectiveness, implementation, and mechanisms of impact. Preliminary results are expected in Ultimo 2024.

Discussion: Because headspace centers have achieved national endorsement and are fully implemented in 30 municipalities in Denmark, there is an urgent need for research that supports the document of the effectiveness of the services. Results from the evaluation can also add new knowledge targeted at international youth mental health promotion initiatives.

Mapping the care pathway to multidisciplinary assessment of 12-25 year olds with somatoform disorder

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Introduction

Somatoform disorders (SD) are known to challenge healthcare professionals and systems, as those common conditions reducing quality of life often lead to excessive referrals and investigations before adequate diagnosis and management. Although studies have proved multiple interventions to be effective and cost-effective in various clinical settings, little is known about the accurate healthcare utilization associated with SD. Two major limitations are SD detection and correct SD labelling, which are challenged by heterogenous clinical presentations and disputed cross-disciplinary classifications. Additionally, usual healthcare data do not systematically identify the triggering events leading to healthcare services use, nor the expectations and perceived help, even though healthcare is known to be a core theme of patient experience of SD. The aim of this study is to trace back the pathway of care that individuals follow before they eventually undergo a specialised multidisciplinary assessment.

Methods

This monocentric descriptive study relies on data retrospectively collected from participants and their parents during face-to-face interviews assisted by a biographical grid. Inclusion criteria are to be aged 12 to 25 years old and to be diagnosed with SD by a specialised multidisciplinary team. Variables measured to describe the healthcare pathway are chosen according to professional experience and literature review. They are collected alongside concomitant life events both to reduce memory bias and to explore determinants and effects of healthcare consumption as a secondary outcome.

Results & Discussion

We will present the data describing the pathway of care of all patients enrolled so far and underline the emerging patterns and variations among the population. We intend to question our findings and discuss the method chosen to map the healthcare pathway. Perspectives of larger studies allowing more data analysis will also be discussed.

Addressing Intergenerational Injustice's Impact on Youth Mental Health

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Introduction: Today's young people face unique challenges, such as high debt, precarious employment, unaffordable housing, and environmental crises, while facing reduced government support compared to older generations. This disparity, known as intergenerational injustice, may affect young people's mental health, yet the subjective impact of this injustice on young people's mental health remains unexplored. This study investigates how young people experience intergenerational injustice and its mental health implications. **Methods**: We used a qualitative descriptive approach, focusing closely on the participants' experiences while also facilitating a comprehensive interpretation of the findings. Participants (n = 8) included young people between the ages of 18 and 30 living in the UK and were recruited using snowball sampling and social media. Interviews were conducted digitally, transcribed verbatim, and analysed using thematic analysis to generate themes. **Results**: Participants described how various forms of insecurity impacted their mental health. Of note, participants highlighted the combined and cumulative toll of financial, employment and housing insecurity gave rise to feelings of anxiety, depression. These insecurities not only delayed but also negatively impacted key life decisions (e.g., pursuing education, starting a family), which in turn further affected participants' mental health. Participants described a sense of hopelessness and feeling abandoned by the government considering these overlapping crises. **Discussion**: Issues related to intergenerational injustice may be exerting a negative impact on the lives of young people which may have important implications for their mental health. Policy and decision makers should take note of and develop concrete solutions to address these challenges.

Nature-Based Approaches in Child & Adolescent Mental Health a qualitative study of staff experiences

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Introduction

There is a growing evidence base that spending time with or in nature can be beneficial, perhaps essential for health and wellbeing. Many different mechanisms may mediate change including parasympathetic and immunological response, attention restoration, sensory integration, increased physical activity and exposure to daylight. Nature-based approaches (NBA) within mental health care can increase nature contact and utilise pathways to increase nature connectedness to improve outcomes for patients. Although traditionally NBA have been more the domain of social prescribing, a local project to embed NBA in a Child and Adolescent Mental Health Service (CAMHS) in the UK provided an opportunity to understand staff experiences of implementation and outcomes.

Methods

CAMHS Practitioners from one NHS Trust in the South of England were invited to take part in interviews on the use of nature-based approaches in their work. Semi-structured interviews were carried out online, transcribed and analysed inductively using thematic analysis.

Results

14 people participated in the interviews. The analysis covered: how organisational culture affected NBA take up and influenced how risk was perceived and managed; the practical implications of implementing NBAs; and NBA benefitted staff and patients in different ways and led to increased staff satisfaction.

Discussion

The findings show that whilst CAMHS staff are interested in and motivated to use Nature-Based Approaches in their work, there remain some challenges to making this happen in practice. Understanding of the evidence of NBAs was variable, and previous experience and utilisation of nature in practice were important factors in staff confidence to use NBA. Further research needs to consider how organisational culture is an important factor in NBA implementation.

Child & Adolescent Mental Health workers' reported levels of wellbeing job satisfaction & burn-out

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Introduction

In the UK we have seen a rapid increase in the number of referrals being made to specialist children's mental health services and this, combined with a decreasing workforce, has led to concern around the level of occupational stress being experienced by staff in this sector. In this poster we present survey data from 97 staff working in one Child and Adolescent Mental Health Service (CAMHS) in the UK during Spring 2023, reporting on their wellbeing, job satisfaction and burnout.

Methods

All Clinical and non-clinical staff working at a single UK CAMHS unit were invited to participate in a an online survey through Qualtrics. The survey covered respondent demographics and administered the following instruments Copenhagen Burnout Inventory, Short Warwick Edinburgh Mental Wellbeing Scale and Short Index of Job Satisfaction. The data were collected between February and March 2023.

Results

Our results indicate that only 2% of staff reported high levels of wellbeing, 32% reported moderate or high levels of work-related burnout and 39% reported moderate or high levels of personal-related burnout. When considering client-related burnout, the number reporting moderate or high levels was much lower at 13% of the sample and the average level of job satisfaction reported was 19.9%.

Discussion

Whilst these results are from a small sample in one area of the UK, they present an important snapshot of staff wellbeing and are discussed alongside data from other studies that report similar findings. In response to the CBI questions about whether respondents found it difficult to work with clients (children and young people), the data suggest this was not the case for most CAMHS workers. Instead, factors such as working conditions, workload, staffing issues and funding may be more closely linked to occupational stress.

Psychosocial difficulties of children aged 3 to 17 years, a representative cross-sectionnal survey

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The aftermath of the health crisis has been pronounced by worrying observations about the mental health of children, adolescents and young adults. French psychiatric epidemiology lacks data to document it regularly. Social and territorial inequalities in children's mental health are poorly understood. The aim of this study is to document the social inequalities affecting psychosocial problems and recourse to care for psychological reasons among of minors in the general population.

It is a study based on the data of a cross-sectional survey.

The study population is made up of minors aged 3 to 17 and their parent. Psychosocial difficulties were assessed using the Strengths and Difficulties Questionnaire completed by a parent or parent's spouse or a foster parent. These difficulties, as well as the child's recourse to care for psychological reasons are described using bivariate and multivariate statistics to identify the socio-economic and individual factors associated with them.

Data from the EpiCov panel survey were used. Specific weightings are applied to the respondents and children concerned by the data collection which took place in July 2021 using telephone and online questionnaires.

The EpiCov survey collected weighted data on 20,127 children representative of children aged 3 to 17 living in France. 9% of children had an abnormally high level of psychosocial difficulties. Significant socio-economic disparities in psychosocial difficulties and use of healthcare have been identified, but they are not symmetrical according to the sex of the child. Other factors, such as parent's mental health and social support, as well as the child's exposure to screens, physical activity and reading. Children from foster care had important difficulties in comparison to general population.

EpiCov's data on the psychosocial difficulties of minors will enable to give a reference for futur monitoring of children mental in general or specific populations.

Parent and care-giver support following a young person's suicide attempt A qualitative evaluation

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Introduction

Parents and care-givers of young people who attempt suicide or experience persistent suicidal ideation are at high risk themselves of experiencing stress, distress and trauma. Support services, however, tend to focus on the child or young person themselves, and parents may feel disempowered or sidelined, despite playing an important role in the ongoing care of the young person. This paper reports on the qualitative findings from a research project which was undertaken as a component of the larger Child and Youth Hope (CY Hope) service evaluation at a mental health service in Melbourne, Australia. The service is a new initiative introduced to tackle the increase in youth suicide rates and at the time of data collection had been in operation for 12 months. An overview of the service will be provided.

Method

Five mothers, one father and one partner participated in one-on-one interviews at 3-months post-discharge of the young person from the CY Hope service. The interviews sought to gain views around their experiences and their perspectives on the care their young person received.

Results

Participant distress was eased by the CY Hope service in two ways. Firstly, direct support for them such as access to a family peer worker and ability to contact clinical staff. Secondly, indirect support such as a reduction in stress knowing that their child/partner was receiving support and strategies, improved parent/carer-giver communication with the young person communication and providing connections, for example, to other mental health services.

Discussion

Although this is a small-scale study, the findings highlight the importance of supporting parents and care-givers when they are caring for a young person following a suicide attempt. When support is provided the parent or care-giver can feel heard and can process their own distress knowing their young person is ‘held’ by a team of professionals.

Non-pharmacological management of overweight and obesity in adolescents with psychiatric disorders

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Introduction: Adolescents with mental illness (AMI) are a particularly vulnerable group at elevated risk of developing obesity, with the prevalence of overweight and obesity among AMI markedly exceeding that of the general pediatric population. However, this issue is often not addressed in child and adolescent mental health services. This study aims to map and synthesize existing evidence regarding non-pharmacological management of overweight and obesity in AMI.

Method: The study followed the guidelines from the Joanna Briggs Institute's review manual and PRISMA-ScR guidelines. The protocol was preregistered on the Open Science Framework (OSF). The literature search was conducted in collaboration with an information specialist and performed in the following databases: PubMed, CINAHL, EMBASE, PsycINFO. The Covidence tool was employed for removing duplicates, as well as managing and screening abstracts. Two reviewers independently conducted the initial screening of titles and abstracts in line with the eligibility criteria. Three reviewers read the full-text versions of the identified articles to assess their final inclusion. In instances of discrepancies, consensus was reached through discussion.

Results: A total of 10 published, peer-reviewed studies were included in the review, including four qualitative studies, three cross-sectional studies, two cohort studies, and one secondary analysis. The work is still ongoing, and the results are expected to be available by the end of February. The findings will be presented in figures and tables, providing a comprehensive overview of the available literature in this field.

Conclusion: By summarizing available evidence on the management of overweight in a psychiatric context, this study offers a comprehensive description of available interventions, their effectiveness, and challenges. The results of this study will serve as a valuable resource to inform evidence-based clinical practice, guide the development of tailored interventions specifically adapted to the psychiatric environment, and encourage further research in this critically important area.

Mindfulness training in a virtual reality environment for people with schizophrenia.

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Aim. Virtual Reality (VR) is an increasingly popular tool in the treatment of various psychiatric disorders, including psychotic disorders. However, to date, no studies have been published on mindfulness interventions supported by VR in psychotic patients.

Method. Twenty-five participants diagnosed with either schizophrenia or schizoaffective disorder underwent three assessments with 4-week intervals, using the six-item Positive and Negative Syndrome Scale (PANSS–6), Quick Inventory of Depressive Symptomatology (QIDS), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), State-Trait Anxiety Inventory (STAI), Perceived Stress Scale (PSS-10) and the Addenbrooke's Cognitive Examination III (ACE-III). Additionally, the participants' emotional intensity was measured through a Visual Analogue Scale (VAS) before and after each training session.

The findings indicate a substantial decrease in symptom severity following the completion of mindfulness training. This was demonstrated by the PANSS-6 total score, as well as the subscales for negative and positive symptoms. In addition, there was a considerable enhancement in cognitive functioning, as evidenced by the ACE-III scores. No significant alterations in these measures were observed when solely implementing the standard intervention.

Conclusions. Our study suggests that the developed mindfulness intervention in VR for schizophrenic patients is highly feasible. The findings indicate potential benefits in reducing symptoms and improving cognitive function.

Effects of physical development on children's trait perception, empathy, and prosocial behaviour

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Introduction: Puberty, a universal event that begins in late childhood, entails critical physical and psychosocial changes. Relevant for the definition of the self, pubertal development, especially if manifesting earlier, may have consequences on how developing children are perceived and treated. There is little research on how physical changes during puberty influence peer trait perceptions, as well as state empathy, and prosocial behaviour. This study aims to fill this gap. Method: The sample consisted of 133 children (59 females, 74 males; M age= 11.77). In an online survey, children were asked to rate traits (i.e. how nice, intelligent, popular, attractive, and athletic) of drawn stimuli of physically more and less developed girls and boys. Following this, they viewed a comic, where a physical and relational victimisation of the stimulus was observed. Participants then reported their state empathy, prosocial behaviour, as well as available strategy knowledge. Data were analysed using a mixed model ANOVA, with within subject factor (physically more vs less developed) and between subject factors (gender stimuli; gender participants). Results: Male participants rated the more developed female as smarter than the more developed male stimulus, while female participants perceived the less developed female as smarter than the male stimuli. The physically more developed male was seen as significantly less intelligent by male participants compared to less developed male stimulus. Female and male participants expressed higher concern, and a greater sense of responsibility to help their own respective gender. Female participants felt more knowledgeable about strategies to help females. Empathic responses were not modulated by level of physical development. Discussion: This study assessed children's trait perception, empathy and prosocial behaviour towards differently developed peers. The data revealed significant gender-based variations in perceptions and empathic responses, of which only trait attribution was associated with differences in physical development.

" VIA FAMILY VERSION 2.0" - Peer Support in a family-based intervention

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Introduction

Can peer-support in a family-based intervention promote recovery and well-being and support the prevention of mental illness in the family? The overall aims of the study were to: 1) Develop three co-created co-led peer support interventions targeting: a) Parents with mental illness; b) Their children (aged 15-20 years); and c) The co-parent or other close caregivers – based on existing literature and co-creation processes with the three target groups. 2) Examine the active ingredients of how, when, and under what circumstances the co-led peer support groups can promote personal recovery among parents with mental illness, as well as promote well-being and prevention of mental illness among their children and caregivers.

Method:

1) Development of co-created intervention manuals followed the British MRC guidance for developing and evaluating complex interventions. Co-creation processes with parents with mental illness, their children, and caregivers were facilitated based on existing knowledge from literature searches and practice experiences.

2) The VIA Family Version 2.0 intervention is evaluated in an RCT. This process evaluation covers a qualitative evaluation of the co-led peer support interventions targeting the parents with mental illness, their children, and caregivers investigating mechanisms of change and context among the recipients and the providers with a focus on the peer support element.

Results:

Three co-created peer support intervention manuals are completed in Dec. 2023 to be used in the VIA FAMILY VERSION 2.0 trial in January 2024.

We obtained funding for the qualitative evaluation of peer support intervention targeting the children (15-20 years). The data collection, i.e., focus group interviews with recipients and providers is expected to start in 2024.

Discussion:

The perspectives of this project is to contribute to further implementation of evidence-based peer support in family-based mental health practices.