Letter from the editors

Dear colleagues,

Welcome to the winter edition of our regular publicat

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It this issue the articles cover a breadth of topics some based on the rich exchanges that took place in our recent events; others are reflections sparked by contemporary discourses on good practice in the UK and abroad. This issue also includes some feedback on our recent successful September Residential Conference ‘from Diagnosis to Dialogue’ all of which we hope will stimulate reflection and promote further discussion.

In the newsletter you will also find information about future events and conferences as well as book discount offers for our members.

We would like to invite submissions to **ISPSUK Perspectives** and we welcome ideas of how to further develop the publication.

We hope you enjoy reading **ISPSUK Perspectives**!

With best wishes for the holiday season.

Vasilli Magalios, on behalf of the editorial team.
General Information

**ISPS UK Perspectives (formerly ISPS UK Newsletter)** is primarily a magazine for ideas, news and debate. It is for all members who come from many different backgrounds including professionals, services users and family members.

A contribution should therefore avoid jargon, be clear and readily understood and normally be around 500 words in length. Referencing is not required.

We welcome contributions from everyone and would encourage you to submit any articles to: Ali Haddock (admin@ispsuk.org).

**Deadline for the next issue is: 2nd March 2015.**

Don’t forget to follow ISPS UK through Twitter, Facebook and Linked in.

**Networking ISPS UK email group**

Don’t forget that you do not need to wait until the next Newsletter if you have something to say or want to hear what others have on their minds! The ISPS UK email discussion group is alive and lively - and for all members with email access. If you are not signed on contact our Administrator, Ali Haddock admin@ispsuk.org
Last week my four year old granddaughter had a painful leg. She was seen by the doctor in the urgent care centre, and came away 10 minutes later with a highly satisfactory explanation of her problem – her leg was painful because she had injured it fallen off a climbing frame the day before. This formulation fitted with her own and her family’s formulation, it didn’t involve uncertainty, complexity, blame, tricky combining of explanatory models, or even use of the peculiar term ‘formulation’. If that doctor had to write a letter to my grand-daughter’s GP, I don’t imagine he needed to hesitate much over the wording of his formulation.

A ‘formulation’ in psychiatry is an attempt to make sense of things. It is often an attempt to make sense of a problem for which someone is seeking help. As psychiatric diagnoses generally provide just a summary description and not an explanation of why the problem has occurred, something else – a formulation - is needed to explain why.

As a psychiatrist, I feel a little envious of those who like my grand-daughter’s doctor are able to make such totally satisfactory and uncontroversial offerings in the name of formulation. In psychiatry, almost always the situation is very different. The story and the explanation are likely to be complex. There are likely to be huge areas of uncertainty – about omissions in the story, about what aspects are most relevant, about what kind of formulation is likely to be acceptable and helpful for the person and their family. Some people want a formulation which casts their problems as a brain problem with a simple prescription. Many people want the exact opposite. And what if the person’s problem is a psychosis which seems to have developed in response to overwhelming emotional pain? Can it be helpful for the clinician to suggest that the problem seems to be the sadness and disappointment which the psychosis had served to obliterate? In addition, certain kinds of formulation may leave patient or family feeling they are somehow to blame. In a worst case scenario, practitioner and patient may find it difficult to find common ground. For my grand-daughter’s formulation the doctor may manage with technical skills – knowledge of anatomy, physiology and mechanics and so on. In psychiatry a whole set of other skills seem at least equally important.

I have been stirred to write this brief article by circumstances. I am involved with a small group of psychiatrists and experts by experience at the Royal College of Psychiatrists who, on behalf of a College committee, are drafting a briefing paper on good practice in the use of formulation in psychiatry. But what is good practice? Some aspects seem fairly straightforward – listening to the person’s story, starting the discussion with the person’s own explanation, being respectful of their
views, avoiding inappropriate certainty…. There are many inspiring first person accounts of the role of formulation - of how important it can feel to be asked what was happened and to be offered support in the process of making sense of things. There is some guidance around on how to go about it, for example guidance from The British Psychological Society, written by Lucy Johnstone, who spoke about these issues at our September ISPS conference *Diagnosis to Dialogue*.

However, in the meantime perhaps some of you reading this may have ideas of what best practice looks like - or doesn’t look like! I’d be delighted to hear from you if you have time to share these. (alison.summers@lancashirecare.nhs.uk)

Stanley Kubrick's '2001: A Space Odyssey'
Recovery Colleges: co-producing a new balance of power

By Sara Meddings (Consultant Psychologist) Jane McGregor (Education Researcher), Waldo Roeg (Peer Recovery Trainer)

Recovery Colleges are a relatively new and unique approach, becoming a key component of recovery oriented services for people with psychosis and other mental health challenges. Evolving from work in the United States, the first Recovery College at SouthWest London St. Geoge’s started in 2010. There are now a further 20 in England with Colleges along the same lines in Scotland, Eire, Italy, Canada and Australia.

The core features of Recovery Colleges are collaboration and co-production between people with personal and professional experience of mental health challenges; an educational, rather than therapeutic approach; recovery oriented, strengths-based and person-centred values; inclusivity for people with mental health challenges, their relatives / carers and staff; helping people identify and reach their own goals.

Students choose free courses from a prospectus. Personal tutors offer guidance, develop individual learning plans based on students’ hopes and aspirations, and identify learning support needs. Following course attendance, students graduate with certificates of success and are encouraged to seek opportunities in work, volunteering and further education beyond the College.

Some courses might be popular with most students such as ‘telling your story’, ‘Mindfulness’ and ‘work and wellbeing’ whilst others may be more specifically relevant to people with psychosis including ‘understanding psychosis’, ‘understanding medication’, ‘improving sleep’ and ‘coping with voices’.

Recovery Colleges may be a way of increasing access to social and psychological approaches for people with psychosis. In the UK, people with psychosis make up over half of people using mental health services yet only 10% of those using psychological interventions. Several recovery colleges have reported that about 40% people using their college are people with psychosis or their relatives / carers.
There is an emerging evidence base showing Recovery Colleges make a difference. Students want to attend and several colleges have reported over 95% students say they would recommend the course they did. After attending, students feel more hopeful about the future; more able to achieve their goals; have more friendships and work opportunities; and use mental health services less. They become experts in their own wellbeing and recovery. There are documented benefits to the whole service as staff work alongside peer trainers to co-produce and facilitate sessions. Thus the ‘balance of power’ is shifted - no longer ‘them’ and ‘us’.

Waldo Roeg of CNWL (http://www.cnwl.nhs.uk/recovery-college/) describes his experience of being a student and becoming a peer trainer.

My experience of working in a Recovery College started whilst working as a peer support worker in community day services. I had my first opportunity to discover what working in a truly co-productive way was when I helped develop the Trust’s Health and Wellbeing Plans. I went on to become a Peer Trainer in the Recovery College and I believe that Co-Production lies at the heart of everything we do. Seeing that traditional barrier between them and us that exists in services being broken down every day is inspiring. To see lived experience valued alongside clinical expertise in an equal and reciprocal way is very empowering for myself and all the students who attend. The college has made a huge impact on my own Recovery and Life - I have rediscovered many of the benefits of engaging as a constructive citizen. It is also the students’ narratives that come out of the courses that make it such a rich experience.

At Sussex Recovery College (https://www.sussexrecoverycollege.org.uk/), we found that students made significant progress towards their own personal recovery goals, course learning outcomes and, recovery, quality of life, wellbeing and mental health. Students say they especially value meeting and learning from ‘other people in the same boat’; experiencing the equality of peers’ lived experience and professionals; and learning new skills and knowledge. This reflects core aims of providing hope, control and opportunity.
A Recovery College Learning Network is being created through the Implementing Recovery through Organisational Change (ImROC) programme which also provides a series of readable briefing papers (http://www.imroc.org).

Waldo, Jane and Sara work at CNWL and Sussex Recovery Colleges respectively and work together as consultants with ImROC developing the Recovery College Learning Network.

Giorgos Paralis, 1908-1975
Hearing Young People’s Voice
By Sara Callarman

When I first became an advocate ten years ago, I had no knowledge or experience of voices or unusual beliefs.

Some of my work was in an adolescent inpatients unit. A young woman accepted my offer of advocacy and I was expecting her to tell me she didn’t feel she was being listened to or ask me to go to her review with her, but when she told me she thought she was in a parallel universe, I didn’t know what to say. Maybe I told her I didn’t think these beliefs were not true, or perhaps I asked her to tell me more about it (I hope so). My instinct was to reassure her that it wasn’t true, but I felt out of my depth. I started to hear about other young people who had unusual experiences –like hearing voices or seeing visions, and began my learning journey. For example Luke was a young person I met about 9 years ago through my advocacy work.

Luke had been a trainee car mechanic but when his employer found out he had been diagnosed with psychosis, he was asked to leave. He found out about ‘Experience in Mind’ - a group in which young people designed and delivered training to professionals, showing them how to respond to young people with mental health issues in a more positive way. He joined up and using his own mental health experiences, helped develop training materials to challenge the stigma surrounding mental health difficulties, and became a young trainer delivering training sessions to professionals. Through this group he was able to rebuild his self-confidence and learned new skills. Now he is employed by the Early Intervention in Psychosis Team in Brighton and Hove. He is a great worker because he can use his own experience of mental health difficulties and relate really well with the young people he works with.

Three years ago a colleague at work told me about the Hearing Voices Network and Soteria. I found out about the philosophy of these organizations - non-hierarchical groups which enable peer support for people who hear voices and have other mental health difficulties. The groups decrease isolation and stigma, giving people opportunities to socialize, talk and speak about different ways to cope with or accept their voices and visions. Group members can meet people from other areas, go to training meetings and conferences where they can listen to other people’s experiences and have the chance to tell their own stories.

I soon heard about a project called Voice Collective in London which worked with young people who hear, see or sense things that others don’t. I talked about it to a group of teenagers I was working with and several of them said that they heard voices or had other unusual experiences. They had not said anything about this to me before, but maybe because I had showed that I was interested, they felt comfortable telling me.
Voice Collective were offering free training days for teams of adults and young facilitators, to learn about running a Voice Collective group for young people. I asked if anyone would like to go with me and one young woman volunteered. Two of us headed up to London every Saturday on the early morning train for three weeks. At the training sessions we met other young people and adults, learned some games and activities and role-played some ways to encourage our future group to talk about their experiences and devise coping strategies. Voice Collective also organise support groups for parents to meet together and find out more about what their children are experiencing.

Groups for young people allow them to talk about their experiences in safety without stigma or worrying that they might get teased or bullied. They may find it hard to talk to family or friends in case they are shocked, frightened or dismissive. At the moment I help facilitate a group for adult voice hearers in Brighton. I aim to set up a group for young people from Brighton and Hove. I have applied for two local funding pots and am waiting to hear if we have been successful. Several young people have already told me they would like to join the group.

More recently another young woman told me that she had some unusual thoughts. Again I tried to reassure her that these beliefs were not true and she wasn’t in danger as she thought. I could see this wasn’t helpful to her, and so I asked for some advice from the paranoia network. They were really helpful and gave me lots of information and ideas. The result of this was that I asked her to tell me more about these experiences, and just listened.

I am constantly learning about people’s different experiences - of voices which could be their own or other peoples’ and sounds, in their heads or nearby; of glimpses of people, shapes or creatures.

I have worries in my own head that keep me awake at night and I can see that they are my version of voices and I can learn how to cope and use them instead of trying to drown them out.

On reflection I realise how hard must it be to not be able to tell people about things that frighten you in case they don’t believe what you say, or want to medicate or section you?

My experience of listening to young people who have different experiences or beliefs has given me the confidence to listen without judgment and without denying the experiences.

Sara Callarman works with the Mind in Brighton and Hove ‘Speak Your Mind’ Young People’s Advocacy Project
Reflections on my experience within the therapeutic space!

I was delighted to be invited to a collective way of thinking about psychosis in terms of the psychotherapeutic models and medical treatments that exist to treat schizophrenia. The aim of the conference was to pause and reflect on our knowledge and experience of psychosis, and reflect on the emerging transition of treatment coming into fruition. This conference did just that, and as a first timer I was thoroughly surprised with the safety and vulnerability of all persons in the room. To explore different ways of working within clinical practice, and working autonomously in everyday life, the workshops brought about emerging trends that are coming into being, and I hope to instil some of these by talking more freely about hearing voices, watch this space! However, I have always used myself as a resource in all situations and having experienced a drama workshop I will certainly use these techniques at home with my children - if a mere distraction from the occasional squabbling between them.

It really was a time to find that collective safe space, a place of safety which enabled me to feel the dynamics of another world that exists between the busy and the silent. The exploration of self initiated into the shadow of the complexities of emotive meaning in all situations of existing. In actual fact, a face that is shadowed on one side is completely different on the other, but is the true reflection of my personality. A safe space truly emerges where we are completely aware of sensations and thoughts and can see and feel more deeply than we do within the context of everyday life.

The conference brought home my very intense experience of working within a therapeutic community (of ten years ago) as a young lady finishing college and considering going on to train as a mental health nurse. It was a training ground and a firm foundation that was set to become part of my emerging involvement in supporting young adults towards deciphering the meaning in their experiences. However, this did not start until I initiated permission to explore self in terms of my strengths and limitations in my relationships with others. To begin to understand them, I consented to the doors becoming opened on myself. This then became the challenge, the challenge to experience emotive energies and sensations which I translated to enable me to work with their turmoil. It was here that I began to learn to understand myself, my emotions and relationship with others and separate
this from the clients experience.

In question, schizophrenia as a label within a social construct, I absolutely have no doubt that our entire population has experienced hearing voices, and felt sensations that give us clues within our own lives. However, some are more vulnerable than others and have not found the coping mechanisms to deal with this. The negative expression of hearing voices is no doubt a frightening experience but talking about this really helps to make sense, I believe. The relationship within our communities and families have proved to be the view of our personal mental health. A view that (Kennard 1998) discusses in 'Therapeutic Communities'. However, how has this changed when we have not experienced our own family? The disruption and fractured sense of self emerges with a vengeance, often we become the walking wounded, maybe hearing voices about traumatic events that have previously occurred, and or responding to harmful voices; causing harm to ourselves or others.

On a positive note however, hearing voices and experiencing sensations can feel very empowering at a time when guidance is needed to pursue or take a risk that involves coming out of a comfort zone; a way of being that has provided comfort over time. in dreaming about inner conflict with others within our relationships with them, however intimate, gives us guidance on how to approach a current situation. John Geekie expresses his experiences well in ' In Ten Tall Tales ' emphasised in his piece about his working in early intervention in psychosis in that, we never really reach our destination; it's a journey. So, life is experiential and the hum drum that moves with it. It is forever emerging, evolving and so are the initiatives shaping how we treat people who suffer with enduring psychosis.

I consider the shift of psychotherapeutic models used within practice enabling, not disabling. The tension between psychotropics medication and therapy is limiting as it doesn't appear to work collaboratively together. The system too readily gives medication to suppress the distress and disables the persons inner belief that recovery is possible through exploration of the self. To paralyse the person hearing voices, can leave them in a place of inertia, unable to explore what and why? However, in a safe environment where exploration and a freedom to express this, we can begin to understand, to make sense.

The residential conference provided a safe environment where all was permissible to express and discover meaningful ways of working with psychosis. The social space promoted flexibility to enable this to happen, and some individuals felt the need to express and challenge unanswered questions they felt prompted them.
The space felt completely safe and brought about a confidence to engage well beyond our comfort zone and utilise our inner resources of safety and security to seek answers and gain knowledge. I particularly enjoyed the drama workshop where the audience heard a narrative on a young woman's struggle to overcome her distress to which she is now moving towards recovery. It was encouraging to hear how psychotherapeutic interventions had empowered her to move on. The use of drama and engaging with another was a distraction from the the high energy in the room and provided an opportunity to physically express emotions in another form.

I felt lost initially within the boundaries of the room at times, which was a reflection of the dynamics present in the space. I'm confident that the dynamics in the room were a reflection of how I was feeling at the time. All persons within the room were vulnerable because there was an exposure to their inner being. Some acted out a need to be listened to and were seeking answers, however there wasn’t a definitive answer or combination to their queries. It did anger me at times that there was no definitive closure to the suffering other than a medicalised view including a change in medication therapy, with limited access to therapy. Some were seeking knowledge and clarity, though I was seeking an understanding to the distressed experience in the troubled world.

I was overwhelmed by the amount of people who are in recovery and have moved on in the way that they have. They live within their own world which is sometimes challenging, and are constantly finding new ways to cope throughout their journey and seeking answers. Perhaps those who seek to help and empower, can seek to understand the individuals experience through truly listening and allowing themselves to feel vulnerable in the permissible space presented at the time. The nature of hearing voices, truly listening can allow us to travel to places we thought not possible, a confidence to express our repressed feelings inherent within us, and to create and grow as a person. The conference consolidated closure through music which was the heart and soul of the workshop as it prompted the sense of not knowing what was next. The rhythm remained in the heart of the player, which is the same for all of us, the ownership of our own personal dynamic.

I sincerely look forward to the next ISPS UK Residential Conference challenge and developing my role in supporting others. A reflection of my own coping strategies used in life is a tool to impart knowledge on to others when needed, and a feeling of family togetherness where all is permissible within the social space.
I have recently returned from attending the first module of the Foundation Diploma in Peer-Supported Open Dialogue, Social Network and Relationship Skills (POD) at the Quaker Centre in Birmingham an ideal setting for the training which fits well with the Quaker ethos. This is the first NHS organised training and is the essential prerequisite for a pilot project that will research the adoption of peer supported open dialogue in four NHS Trusts, North East London, Kent and Medway, North Essex and Nottingham. The catalyst behind this exciting new development is Russell Razzaque a psychiatrist and clinical director from North East London who organised a conference earlier in the year which drove this project forward. Russell has in a short period of time organised a training delivered by himself, Val Jackson and Mark Hopfenbeck that will result in an award from Gjovik University College in Norway with a retrospective accreditation at foundation level from the Association of Family Therapists.

The teams from the four trusts are multi disciplinary, nurses, psychological practitioners, peer support workers, carers, psychiatrists, social workers etc and they will be forming separate teams within their workplaces to provide a model of open dialogue within their localities. This will be the first NHS trial of the approach and the work will take place over the course of three years. There has been considerable interest displayed in this project and the first module was filmed by a television company who intend to make a 3 part documentary following the year long training through to the implementation of the pilots in their individual settings, interest has already been displayed by the major channels.

The 5 days in Birmingham were long, and thought provoking, starting with yoga or mindfulness as it became apparent that greater levels of self awareness would be necessary for this approach and we finished at 9.30 in the evening exhausted. Emotions were raw as the group were away from home and families and the material involved personal disclosure, the level of support and care that we displayed to one another will aid us in developing a supportive learning community. We were sustained by excellent food and the consensus was that we would all return heavier. The majority of us left this training with an almost evangelical zeal for the prospect of change for mental health services within the NHS.
Feedback from Stavanger, Norway—how to involve nurses more effectively?
By Neil Thomas

Following discussions from within the ISPS committees, and in recognition of the low participation rate of mental health nurses within the membership of the ISPS Internationally relative to the wider Mental Health multi-disciplinary workforce, concern was expressed about the low numbers of nurses within the membership of ISPS in comparison to the majority voice that nurses have within the field of practice. As a result of this in the UK, a declaration of interest was requested from Alison Summers (UK Chair) for any current nursing members of the ISPS UK to offer themselves as the ISPS UK representative for this exciting opportunity to attend a two day meeting which was held in Stavanger, Norway on the 1st and 2nd of September. I attended on behalf of the ISPS UK nursing membership to discuss how ISPS may move forward to encourage more nurses to join and participate in the work of the organisation.

On Sunday 31st August 2014 I arrived early evening in Stavanger. A meal and brief discussion followed with Jan Olav Johannssen (Professor of Psychiatry, Stavanger), Jan Erik Nilsen (Director of Nursing, Stavanger), Debra Lampshire (ISPS chair NZ, and Teaching Fellow University of Auckland) and Jane Barrington (Teaching Fellow, University of Auckland) who had both previously arrived on the Friday.

Monday 1st September:

I was warmly invited to the grand opening of a new state of the art Psychiatric Hospital and Psychological/Family Therapies building on the site of the main hospital in Stavanger. This was opened by the Minister of Health for Norway, who himself was from Stavanger and appeared to be playing an active and positive role in engaging Mental Health services within the wider community. This was reinforced by the very clear media presence.

Apart from the thoughtful art and interior design that greeted you on entering this new building (a significant difference to some hospitals in the UK which I have both worked on and visited) was the open layout to engage the local community. For example, one of the main lounge areas of the hospital had huge clear open windows and French doors that opened up to the outside area leading on to a local school sports amenities area and a park built for public use. This invited a real sense of normalising, integration, de-stigmatising and engagement of the individuals using the hospital and the local community.

This was followed by a tour of the current hospital in use and an introduction to some of the teams which subsequently ended with an informative user survivor
Feedback from Stavanger, Norway—(cont.)

how to involve nurses more effectively?

By Neil Thomas

presentation "Living With Voices" by Debra Lampshire. An incredible story of therapeutic interventions and guidance from someone living with 13 voices for most of her life.

We then had meetings for the remainder of the day with the following recommendations recorded by Jan Olav Johanssen:

Present: - Jan Olav Johanssen, Jan Erik Nilsen, Debra Lampshire, Jane Barrington and Neil Thomas.

1. We will recommend that the Executive Committee (EC) establish an ISPS-Milieu therapeutic network (ISPS-MN). We discussed whether it should be an ISPS-Nurses Network (ISPS-NN), but the majority felt that that could have the effect of excluding nurses form the general society in ISPS

2. We recommend that the ISPS EC establish a task-force dedicated to the above, with 7 members: 2 from Western Europe, 1 from Eastern Europe, 2 from NZ/Australia and 2 from US

3. We recommend that the EC organises a separate meeting in New York 2015 for milieu therapists/nurses

4. We recommend that the EC take the initiative to design a brochure directed at Milieu therapist, relational treatment and the importance of psychosocial approaches in the daily milieu therapeutic work.

5. We recommend that ISPS write a special letter to all members with a milieu therapeutic background.

6. We recommend that ISPS is represented with a stand and information material at some international and national conferences for nurses/milieu therapists.

7. We recommend that all ISPS conferences (national and international) always have as a part-theme (at least) and focus on nurses/milieu therapists.

We hope that this can be a basis for further discussions in the EC.
Feedback from Stavanger, Norway— (cont.)
how to involve nurses more effectively?
By Neil Thomas

Tuesday 2\textsuperscript{nd} September:

Due to my interest and work in an Early Intervention service in Somerset, England (Somerset Team for Early Psychosis or STEP), Jan Olav Johannsen kindly invited me to spend some time with his Early Intervention team in Stavanger, known well as TIPS (Early Detection and Treatment of Psychosis).

A full discussion and handover of cases with the whole team took place in the morning and was kindly translated to English for my benefit. Specific differences noted to EI services in England were the POPS research groups that the TIPS team are currently exploring. This is a group of clients specifically with Prodromal elements of Psychosis being treated with intensive CBT and Omega 3 Oils. I believe they are currently 2-3 years in to a 5 year study and it will be exciting to see the final results.

The day ended with a tour to a local Psychiatric Book shop in the centre of Stavanger called Psykops. Originally set up as a charity by carers of individuals with Psychosis or Schizophrenia due to the frustratingly limited availability of information for families and carers. This has now grown to gain support from the government who also back Schizofrenidagene which is the world’s only and largest 3-day festival of workshops dedicated completely to Schizophrenia and Psychosis between November 3\textsuperscript{rd}-7\textsuperscript{th}. This event is supported by International speakers from around the world who have a wealth of experience and evidence of the subject, this will be an event I shall certainly be placing in my diary for the following years.

Neil Thomas

STEP Senior Assessment Worker (Community Psychiatric Nurse)

Somerset Team for Early Psychosis (STEP)

Somerset Partnership NHS Foundation Trust
GETTING REAL ABOUT WHY WE USE COERCION
By Neil Caton

The report in February 2013 by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment by Juan E. Méndez recommends that mental health systems should:

Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. (UNHRC, 2013, para. 89)

This represents the UN recommending a marked shift away from using mental disorder as grounds for detention within psychiatric hospitals and challenges legislatures to think again about what grounds it uses to detain its citizens.

As someone who has been admitted to a psychiatric hospital and told that if I left I would be detained, I give this recommendation a warm welcome. Although at the time I did not question the actions of the nurses on the ward nor do I feel it particularly hindered my recovery but I am someone who has learnt to stop talking about his distress using diagnostic labels as a means of recovery. I have heard too many narratives of people on similar paths that have found themselves at conflict with the staff in psychiatric hospitals that cannot fathom thinking of extreme distress in any other way than mental disorder and inflict their ways forward on their detainees. The concept is so entrenched in the way we train mental health professionals that I sometimes get blank looks from professionals when I suggest that the way we talk about language is instrumental for a user’s recovery. You can’t just do the right thing you have to say the right thing as well, using a language that is tangible to the user.

Having spent many years looking at myself and blaming myself for the distress I experienced more recently a narrative has emerged about my experiences that make my distress legitimate. Whilst I found mental health services helpful in this time I did not feel that by talking about my diagnosis and what I could do differently they fully acknowledged this narrative and how truly difficult life is and that it can debilitate us at times in ways we find insufferable. It seemed to me that I was hit by so many bad experiences that followed each other that I didn’t get chance to take a breath and reflect and give myself a break. On the brink on my thirtieth birthday I find myself after twenty years of misery and madness finally starting to take that breath and feel safe. I guess mental health services were more of a help than a hindrance to me but I found myself having to define my experiences in a way that they did not, which, particularly towards the end elicited some degree of
Indeed I am glad that I was detained by someone at a time when I could have been a risk to myself; quite simply I am glad I am alive today!! I have come across arguments that we should not use coercion at all or more often find that people seem to imply it. We do need to detain people who are a risk to themselves or others as we know of countless narratives including my own where people have decided that this was a choice they are glad they were stopped making. Whilst I agree that suicide at times can be a rational choice and agree with the right to die, I think that there is something about the human spirit wants to give life a second chance in most cases. We can re invent ourselves, discover awareness and insights that are beyond what our previous best efforts produced. Why this is possible is a debate that will go on. The reality that it is possible, is for me beyond any reasonable doubt.

INTAR Conference Feedback

By Judith Varley

This Conference, organised through the International Network Toward Alternatives and Recovery, was entitled ‘Power to Communities, Healing through Social Justice’. Social Justice is not commonly overtly addressed in mental health meetings. Including it so conspicuously ensured it attracted contributions from a much wider range of people than usual, many of them survivors of mental health ‘diagnoses’ and (often multiple) periods in psychiatric wards; they were on the committee and in the groups selecting the presentations. So, it had a very different feeling to other conferences, and the whole content was essentially NOT academic but addressing the very practical problems in developing a much fairer society based on greater democracy and social justice. The presentations by internationally respected academics were done differently to reflect the purpose. There were interactive theatrical presentations; for instance it was not unusual to come out of a lecture theatre (a talk / discussion) and walk into and participate in an apparently ‘ad hoc’ performance happening just outside; it made you think, it made you reconsider your views quite fundamentally, and it was great fun as well as informative. I have never laughed so much at a mental health conference, despite the topic being essentially so serious.

There were many more offers of presentations than the conference could accommodate, even with the usual multiplicity of choice in the non-plenary sessions. It illustrates how important this approach is, and how neglected
Currently, and it is not possible to do justice to a 3 day event in this short review of course.

Trying to summarise the content, it was clear that the more interpersonal justice anyone has, the greater is his personal well-being. Fairness in all systems (relations, individual, organization, communal, environmental . . . ) is essential. Clearly, we are far from that with inequalities escalating in every aspect of society currently. None of that equates to good mental health / well being. One quote ‘I’ve had no training about the impact of trauma on health in my training as a doctor.’ Learning how to integrate difficult experiences, those which overwhelm the spirit, is essential. All ‘models’ need to be questioned and the providers of support need as much help as those traumatised by life events. Much is to be shared and learned from those who have been through the mental health mill, developing countries and Scandinavia enabling people to return to mainstream lives much more successfully, than the standard approach here.

A further difference was although it had a local organizing committee, and especially a co-coordinator who did an absolutely outstanding job from scratch, there was no larger umbrella oversight or funding. It was the third INTAR conference and it will be the last unless someone, some key figure volunteers to take the baton and it sprouts around this individual elsewhere; Richard Bentall was the person in Liverpool. An Indian contributor was the most likely contender in June.

Merseyside has 5 times the national average of mental health problems, so it was a very relevant and appropriate home for this conference and Liverpool CCG supported the event, by making a significant and crucial financial contribution from the start.

As is commonly said and is so true for this event, you had to be there to really understand this exceptional conference and its impact. I can say that if there is another in India, I’ll be there, and that was the overwhelming commitment of most people who enjoyed and participated.

https://twitter.com/cpsynetwork/status/377169673600520192

For those who access Twitter, the above should give some further comments

Judith Varley
We are delighted to be able to announce that the Open Dialogue UK training programme will be commencing in London in April 2015. We have received sufficient applications to proceed with the training, including applications from 8 NHS Trusts, clinicians and peers working internationally in public services, and independent practitioners. This training programme is the first outside of Finland to be modelled on the full Open Dialogue training at Keropudas Hospital in Western Lapland where the approach was developed, and we are honoured to be developing it in conjunction with senior members of the Open Dialogue team and leading international trainers. The programme will help us to establish the approach in the UK as well as those developing the approach internationally. We are working on a variety of initiatives to support this process further, and hope to have news of these soon.

At the request of some NHS Trusts we have decided to extend the deadline for applications to the training until 16th January 2015. We will not be able to extend the deadline beyond this, so if you would like to be considered for the training, please ensure that your applications are submitted by then. We are still taking applications from teams working in NHS mental health settings, independent practitioners and peers interested in working in teams at a centre in London, and teams working internationally in public services. We are particularly keen to hear from NHS Trusts who would like to be a part of a pilot project to evaluate the approach.

For full details of the training, including the dates for 2015, and to apply, please visit this page on our website: http://opendialogueapproach.co.uk/training-programme/
TRIANGLE MODEL: A Truly Integrated Approach in Complex Case Management
By Nanda Palanichamy, Consultant Psychiatrist and Consuelo Farina, Adult Psychotherapist (Northumberland Tyne & Wear NHS)

INTRODUCTION
The authors are developing in the NHS secondary care setting, a model of treatment for patients who are chronically symptomatic and functionally highly disabled and have a background of complex psychological difficulties, including childhood attachment difficulties.

This model is centred on the presence of both clinicians (psychiatrist-psychotherapist) in the room which allows developing a robust integration between biological and psychological treatment models. The “Triangle” model is implemented in steps, starting with the reconstruction of an emotional timeline in the patient’s story that helps to identify the “Psychic Retreat” - a clear expression of the patient’s difficulties. This type of work is delivered by the authors providing a secure/safe therapeutic environment which will help the patients to recover faster and move forward with their lives.

BACKGROUND
The authors had an opportunity to work together in a much more integrated fashion than the usual Psychiatry and Psychotherapy Joint working, which was the key in the patient achieving remission in his mood and psychotic symptoms. The patient, having grown up witnessing a disharmonious relationship between his parents, presented with depression and psychotic symptoms after he had significant relationship difficulties with his wife and his level of distress was so high that he rapidly lost capacity to function in his daily life. The authors, working in close co-operation created a supportive and secure environment where the patient was able to heal and restore his capacity to function in the family, work and social environment.

PRINCIPLES
The authors argue that patients with complex needs- having chronic and unrelenting or recurring mental health difficulties, and are in the services for a number of years without making much of a meaningful progress, because they hide in a “Psychic Retreat” - described by John Steiner as “a pathological organisation into which the patient can retreat to avoid contact both with the analyst and reality”.

“A Psychic retreat provides the patient with an area of relative peace and protection from strain when meaningful contact with the analyst is experienced as threatening. It is not difficult to understand the need for transient withdrawal of this kind, but serious technical problems arise in patients who turn to a psychic retreat habitually, excessively and discriminately”. (John Steiner- psychic Retreats, 1993)

The “Triangle Model” based on the presence of both clinicians in the room, is drawn from attachment theory and has been adapted to the treatment of adult patients with complex presentations, including Psychosis and Personality disorder.
"I want also to emphasize that, despite voices to the contrary, looking after babies and young children is no job for a single person. If the job is to be well done and the child’s principal caregiver is not to be too exhausted, the caregiver herself (or himself) needs a great deal of assistance". (Bowlby- Secure Base, 1989)

**METHODOLOGY**

The triangle model is delivered in steps. The first step consists of both the Clinicians and the Patient trying and identifying the “Psychic Retreat”. The length of this process will depend upon the patient’s capacity to co-operate (in psychological terms) in the room. At this stage of the process, whilst one clinician works with the patient to establish an “emotional timeline”, the other clinician actively listens to the material brought to light during the session. The authors discovered that a good enough timeline of the patient’s distress will explain the reasons for the patient to go into a psychic retreat in the first place. Once the psychic retreat has been identified, both the Clinicians and the patient collaboratively reflect on the possible meaning of it (i.e. thinking aloud). The clinicians do not judge the patient for hiding in the psychic retreat but instead they show an understanding and discuss with the patient whether he/she would be interested to replace the psychic retreat with an alternative space which might enhance a more healthy adaptation to reality (may include practical solutions and problem solving techniques). If and when the patient shows an interest to consider an alternative option to the psychic retreat, it is crucial to support the patient every time he/she emerges from it, in order contain the patient’s anxiety that is provoked by contact with reality.

**DISCUSSION**

The authors believe that the “active listening” (includes eliciting a detailed emotional timeline, clarification and reflection) process, from their different (Psychiatrist and Psychotherapist) perspectives, helps the patient to not only feel that they have been taken seriously but also helps them to make some important “connections” themselves between their past and current emotional states. It will also create an opening for the clinicians to work on the psychic retreat. When patients feel actively “listened” to (as evidenced by the use of Outcome Rating Scales (ORS) and Session Rating Scales (SRS) in our pilot study), it helps the patient-psychiatrist-psychotherapist to make sense of what until then has been a “mental disorder”. The authors argue that the presence of both clinicians in the room is particularly helpful for patients with a background of childhood abuse and neglect. The scope of the Triangle model is to encourage the development of mind in individuals whose capacity to have healthy thoughts and emotions have not developed properly in developmental stages in their life.
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Posters on a wide range of subjects will also be presented.

The program we are presenting is rich in substance. The audience and the presenters are varied with a wide range of expertise.

If you go to only one meeting in 2015, this is THE one to go to. Don’t be left out.

A warm welcome to ISPS in New York!
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**Straight Talking Introduction to Psychiatric Diagnosis**

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Eleanor Longden, Psychosis Research Group, University of Liverpool

**Straight Talking Introduction to the Causes of Mental Health Problems**

This brilliantly engaging, understandable and thoughtful book describes current opinion about the causes of mental health problems and will equip service users, carers and professionals alike with empowering knowledge.

Tony Morrison, Professor of Clinical Psychology, University of Manchester

**Psychiatry in Context: Experience, meaning and communities**

This book describes, with incisive clarity, the multiple crises facing psychiatry and mental health services. Using a powerful mix of historical and scientific evidence, together with illuminating stories, Philip Thomas starkly describes the darkness that has befallen the world of mental health, before showing us some ways back out to the light.

John Read, Professor of Clinical Psychology, University of Liverpool

**Living with Voices: 50 stories of recovery**

This book is a breakthrough because for the first time we hear about and can make sense of ‘hearing voices’ through the direct voice of fifty service users themselves.

Peter Beesford BBE, Professor of Social Policy and Director of the Centre for Citizen Participation at Brunel University

**Young People Hearing Voices: What you need to know and what you can do**

[This book] re-frame[s] voice hearing as ‘a human characteristic and an indication of problems that need to be solved, instead of a psycho pathological problem’. For anybody who supports children who hear voices, this is the book to read.

Caroline Rosta, Counsellor and psychotherapist
Local Groups

ISPS UK has local networks in many parts of the UK – we are aiming to have them in all parts. Local networks operate in different ways, but usually they arrange meetings where members can get together, either with an invited speaker or to share members’ own experiences. Most meetings are open to professionals, service users and carers, and welcome non-members as well. A few are more specialised – e.g. reflective practice, research planning. This page shows the contact persons/convenors for the local ISPS UK networks, and announcements of meetings or other events that have been arranged. (Convenors should send info on forthcoming events to Ali Haddock at admin@ispsuk.org.) As the website develops, local networks will be able to use it to let members know what they are doing, and members will be able to use it to find out what’s going on locally. If in doubt, please make contact with your local contact person, who will be greatly encouraged to hear from you.

NORTH WEST  Neil Caton. neilcatonisps@outlook.com
NORTH EAST  Angela Kennedy, Newcastle. angela.kennedy6@nhs.net
SCOTLAND  Alf Gillham, Glasgow. alfredgillham@yahoo.com
SOUTH EAST/SOUTH COAST  Bill McGowan, Brighton. B.McGowan@bton.ac.uk
WEST MIDLANDS  Grainne Fadden, Birmingham. Grainne.Fadden@bsmhft.nhs.uk
YORKSHIRE AND HUMBERSIDE  Vacant

Other Networks

Psychodynamics and Psychosis Network (North West)
Alison Summers. Alison.Summers@lancashirecare.nhs.uk

ISPS Membership

A new membership year is about to begin—do invite friends and colleagues to join.
Membership Fees range from £10 to £50, with the £25 special offer membership remaining for a further year for those who work NHS Band 7 and under.

ADDED membership benefit for 2015: Unable to attend one of our conferences? Conference material will now be made available on-line for members as well as conference delegates (in the form of PowerPoints, audio recordings and videos where available and permission granted).

A reminder of other membership benefits:
• The chance to support an organization that actively promotes improvements in psychological care
• Subscription to Psychosis, the highly respected international journal for psychological, social and integrative approaches (normally £36 pa to individual subscribers)
• 20% off all books in the ISPS series published by Routledge
• Reduced rates at ISPS regional, national and international conferences
• Our regular e-newsletters “ISPS UK Perspectives” with articles, book reviews & conference reviews and monthly e-bulletins giving regular updates
• Local & national networking opportunities, including membership of our on-line Google discussion forum.
• All membership details are available on our website: http://www.ispsuk.org/?page_id=10)
ISPS Conferences (cont.)

WATCH THIS SPACE FOR DETAILS TO BE ANNOUNCED ON OTHER FORTHCOMING CONFERENCES for 2015 and beyond:

We are working towards four potential conferences in 2015 covering
(1) Open Dialogue;
(2) the tensions and opportunities of working together when people have the different perspectives of expertise from personal experience, and expertise from training and practice;
(3) Mental Health Nursing and
(4) a psychodynamic theme (for our Annual Psychodynamics & Psychosis Conference.)

We will also soon begin to plan our 2016 National Residential Conference, and have already begun preparation for hosting the 2017 International Conference in the UK. as well as hosting the 2017 International Conference in the UK.

Non-ISPS Conferences

· The Donald Meltzer Development Fund—3rd international conference “A mind of one’s own—Exploring the work of Donald Meltzer”, 20 February 2015 to 22 February 2015, Tavistock Centre. The conference is now full but an overflow room may be made available. Please contact the administrator for further details.

· 16th Annual Mental Health Conference, Greynore Hall, University of Brighton, University of Brighton, Darley Road Site, Eastbourne, East Sussex, 18th March 2015. Promoting positive mental health and wellbeing through a group-based literature reading approach.” Incorporating the Marion Beeforth Memorial Lecture to be given by Jane Davis, Founder and Director of the Reader Organisation. www.thereader.org.uk For information contact Mahess Jeeawock on m.jeeawock@brighton.ac.uk. (Jane Davis has pioneered a new approach to both literature and mental wellbeing through the creation of 'shared reading', which draws on longstanding traditions of reading aloud and therapeutic groups. Jane started with the intention of extending literacy, introducing non-readers to the pleasures of great writers such as Shakespeare, Tolstoy, and George Eliot, but members of her early groups soon began to tell her of unexpected mental health benefits they were deriving from their attendance at the weekly read aloud sessions. Jane will tell the story of the development of shared reading and offer some thoughts on why it has been met with such enthusiasm.)