Research Presentation Day 2016
-
Welcome

Stefan Priebe
Director of Research

Research in the last year (I)

- More complicated bureaucracy – Health Research Authority
- All performance criteria of research governance fully met
- 46 active studies on the NHS portfolio (≈)
- 1034 recruited patients (🡅)
- Ca. 100 peer-reviewed publications (≈)

Research in the last year (II)

- DIALOG research shortlisted nationally for best Clinical Research Impact by HSJ
- New link with QI
- Substantial new grants

Complaints about Robin Brook Centre

- Building noise
- Limited capacity
- Little space for stalls
- Poor access for disabled people
- Problem with break out rooms
- Alternatives?
  - easy to get to and in our patch,
  - sufficient capacity,
  - good facilities also for disabled people,
  - bookable in advance and not too expensive


MANSION HOUSE PLACE EC4
ROAD AHEAD CLOSED ACCESS ONLY


REUTERS


#POLITICS
BLAIR DOESN'T RULE OUT
SECOND REFERENDUM


2ND
REFERENDUM
Dynabox
www.testvalleypkg.co.uk

Referendum!

Remain in the Robin Brook Centre
or Robin Brexit?

Today

- Exploring break out rooms in pathology museum
- After break, ballot papers on Robin Brexit (Remain in the Robin Brook Centre or Robin Brexit?)
- Usual format with brief presentations
- Range of topics
- #ELFTResearch

Gender differences in effects of body psychotherapy (in schizophrenia)

Frank Röhricht

Previous studies of BPT in schizophrenia

- Body-ego-technique" vs. Music therapy: sign. Impr. emotional contact as well as motility (Goertzel et al. 1965)
- Movement & Drama therapy vs. SC in chronic sch. (RCT): sign. improvement of social behaviour and restlessness; other better in both groups (Nitsun et al. 1974)
- Body perception training: improved body size perception & social competencies, reduced anxiety (Seruya 1977)
- Concentrative Movement Psychotherapy (BPT): improvement in body perception (Jung 2002)
- RCT BPT vs. SC in chron. schiz: sign. reduction in negative symptoms (PANSS) (Röhricht & Priebe, 2006)

Two recent follow-up studies of BPT in chronic schizophrenia

- Multicentre RCT Germany BPT vs TAU (N=68): patients receiving BPT had significantly lower negative symptom scores (SANS total score, blunted affect)

  Martin et al. 2016

- NESS RCT study (N=275): BPT vs. Pilates for negative symptoms: no sign. reduction in negative symptoms (=primary outcome, PANSS); but improved expressive deficits on CAINS (and movement disorder symptoms) in favour of BPT

  Priebe et al. 2016

Secondary ('post-hoc') analysis of the NESS trial data

- Observation: far smaller proportion of women were recruited relative to earlier studies (72/203 vs. 50/50)
- Examining interaction between gender and treatment allocation as a predictor of outcomes
  - Negative symptoms were found to significantly reduce in women randomised to the body psychotherapy condition in comparison to Pilates
  - No such effect was detected in men
  - Consistent with the smaller trials, improvement was found to relate predominantly to expressive deficits

Savill et al., submitted for publication

Discussion

- BPT may be an effective treatment for deficits in expressive behaviour, not negative symptoms in general as one single construct
- BPT may be an effective treatment in women only
- Methodological issues: Definition of primary outcome; problems with patient selection / sample characteristics; therapists characteristics (in NESS ALL female, initially unnoticed), blinding …
- Maybe first gender specific treatment effect in Psychiatry?
- Other: e.g. „experienced therapist“ effect, ...???

Q&A

Who Considers Discontinuing with Antipsychotic Medication?

Ruth Cooper

'This article/paper/report presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.'

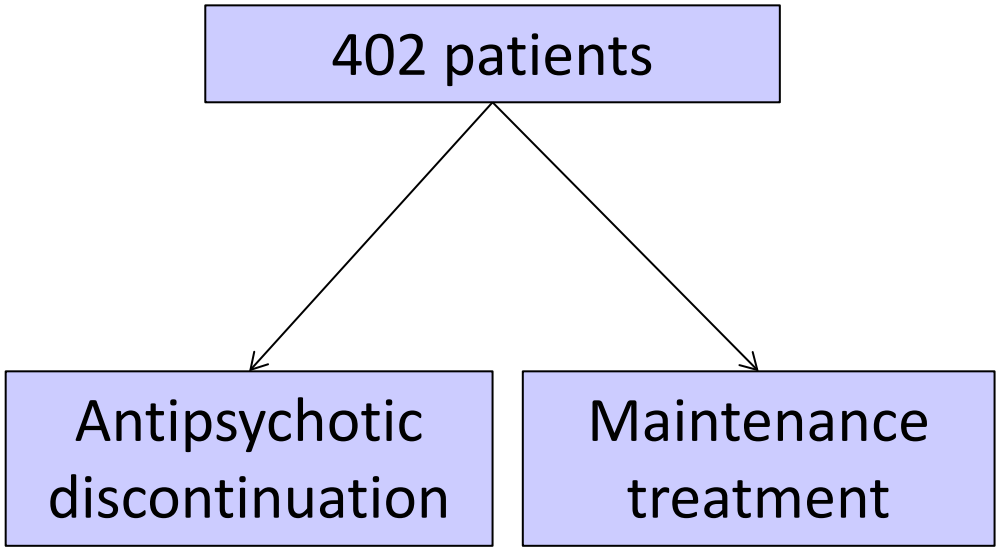
Background

- Anti-psychotic medication is often long-term
- No definite guideline for reducing
- Limited evidence on pros and cons
- Effective in relapse prevention
- Side effects and severe physical health risks
- Potentially negative effects on social function

RADAR: Research into Antipsychotic Discontinuation and Reduction

- **Stage 1**: Survey patient views on antipsychotic medication and potential interest to participate in a randomised controlled trial

- **Stage 2**: Trial of reducing/ discontinuing antipsychotic medication



How do you feel about taking antipsychotic medication on a long-term basis (N=78)?

Response	%
I am happy to take antipsychotic medication on a long-term basis	32%
I do not want to take antipsychotic medication on a long-term basis	26%
I am not happy about it, but I accept I will have to	14%
I do not want to take antipsychotic medication on a long-term basis but I am happy to take it now	24%
I am not sure how I feel about this	4%

Happy to take antipsychotic medication for the long-term:

“It stops me from hearing voices”, "If I wasn't on it, I'd be having a relapse”, "I do whatever the doctors tell me"

Do not want to take antipsychotic medication on a long-term basis:

“I get tired, can't do anything”, “Hard to function”, “I would like to go back to work”, “lazy, anxiety, weight gain, bad memory”,

“Forced upon you in hospital”, "Wouldn't if I had a choice"

Not happy to take it but accept that they will have to:

“On meds, symptoms disappeared, but …hard to get up in the morning…weight gain…not happy, but would be worse off without it”
“It's hard…you feel stigmatised…have to take it because it blacks out all the bad thoughts"

Would you consider participating in the RADAR trial?

	Yes	No	Maybe	Total N
%	73%	19%	8%	78
Mean age (years)	47	52	46	48
Gender (F/M)	15/42	4/11	1/5	20/58
Mean time taking antipsychotics (years)	18	20	12	18

Reasons for wanting to participate

To reduce side-effects and function better:

"Would like to get off the medication and lead a normal life"

"Want to work but always tired"

To provide an opportunity to stop medication:

"Hopefully I'd get chosen to reduce medication, and stop, only chance I've got."

To help other people/to learn:

"Benefit others…try and help others…a lot of people on meds who may not need them…confused about what might be better for me"

Reasons for not wanting to take part

Concern about randomisation:

“Might be unlucky, go into the group that stay on meds. Wouldn't be happy in medication maintenance group”

Concern about relapse:

“Only medications work”

"I don't want to take the chance…been down the road of psychosis and don't want to go anywhere near it again"

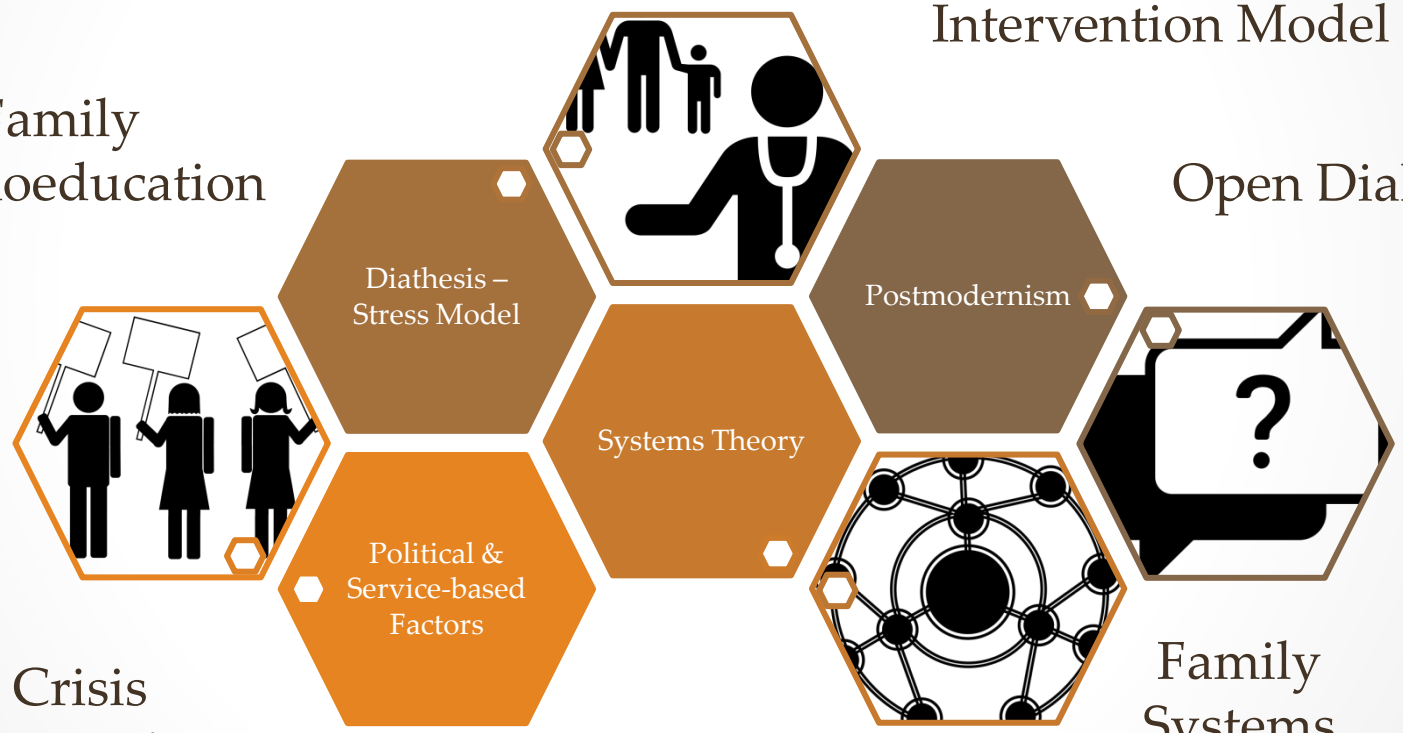
Conclusions

- ~25% of patients want to discontinue
- Relapse prevention vs side effects
- 73% interested in the RADAR trial
- Taking antipsychotics for ~18 years
- No clear differences between patients who do and do not want to participate

“Family Involvement” In Acute Mental Health Care

Aysegul Dirik

Influences & Approaches



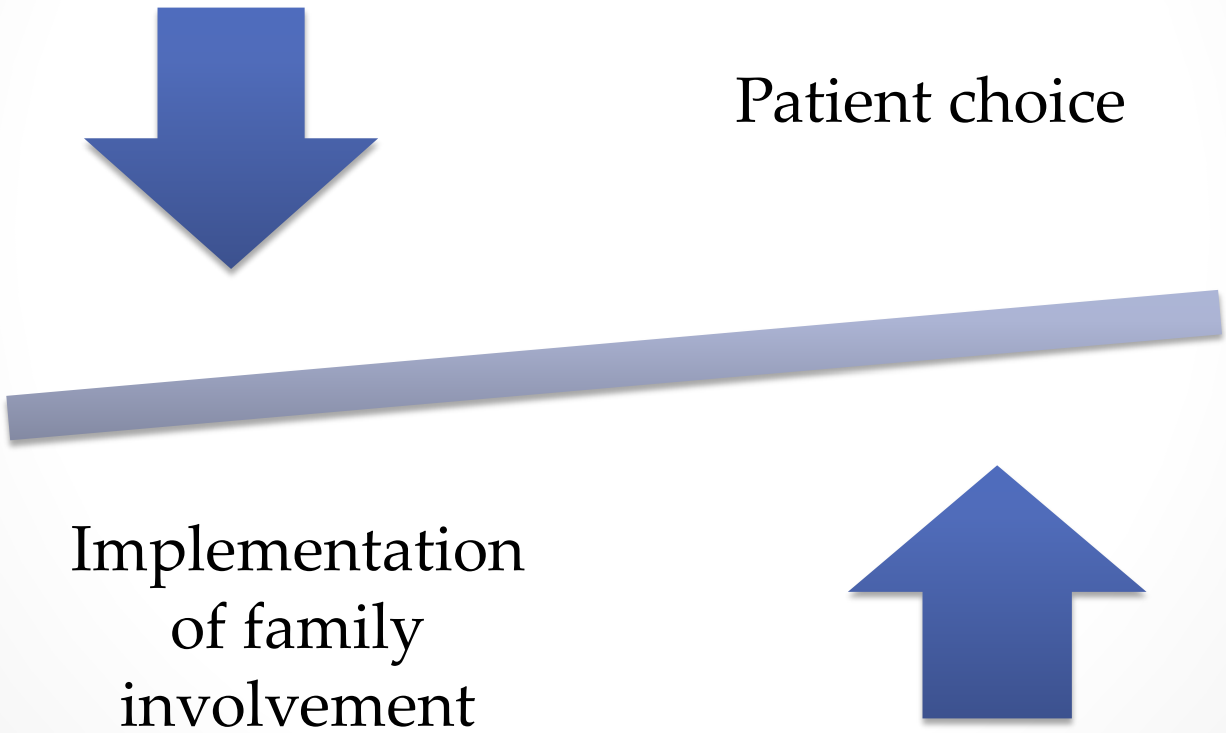
Similarities

- Communication focus
- Families are a resource
- Linear “patient - carer” relationships

Differences

- Theoretical orientation
- Who to involve
- Whole system or specialist teams

Service organisation: tough decisions?



Preventing premature mortality in people with severe mental illness

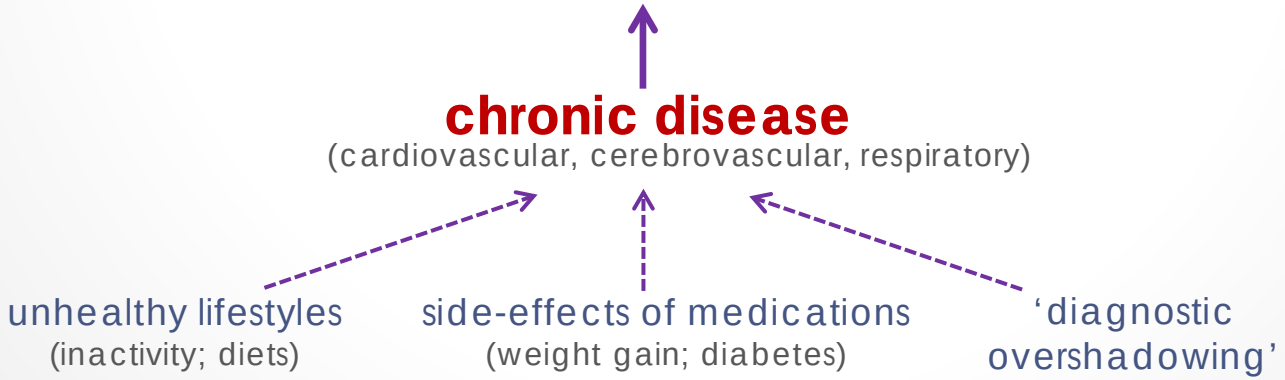
Dr Heidrun Bien

Severe Mental Illness (SMI)

excess mortality

- **People with SMI**, including psychotic disorders, bipolar disorder, severe affective disorders, **on average die at a younger age** compared to the general population. *[UK: ♀ 7-18, ♂ 8-15 years earlier]*

- **majority of preventable deaths in SMI**



- **Meta review of health interventions in people with SMI**

Cochrane Database of Systematic Reviews
Database of Abstracts of Reviews of Effects
Campbell Collaboration Database of Systematic Reviews Database of Promoting Health Effectiveness Reviews
+ searches of citation lists

['mental disorders' OR schizo* OR depress* OR bipolar*]
AND
[interventions OR treatment]
AND
[mortality OR survival]

comparing an **intervention** with a **control group** for people with SMI ✓
RCTs, quasi-experimental designs, observational studies ✓
pre-existing physical conditions ✗
(...)

Systematic Reviews meeting all criteria: **n=16**

Baxter, A.J., Harris, M.G., Khatib, Y., Brugha, T.S., Bien, H., & Bhui, K. (2016). Reducing excess mortality due to chronic disease in people with severe mental illness: meta-review of health interventions. *BJPsych*, *208, 322-329*.

- **Meta review of health interventions in people with SMI**

Systematic Reviews: n=16

mental health interventions	***n=3***	→ **medication: ambiguous; some protective effect against excess mortality** (antipsychotics, antidepressants)	*(!)* **importance of treatment adherence**
integrative community care	***n=2***	→ **may reduce physical morbidity & excess mortality**	**effective ingredients of interventions** *(?)*
intervention for lifestyle factors	***n=10***	→ **can reduce the profile of risk factors** (eg, diet & weight)	*(!)* **long-term studies needed**
health parameters screening/monitoring	***n=1***	**?**	*(!) Urgent need of trials:* - *identify barriers to provision of physical health monitoring*

Baxter, A.J., Harris, M.G., Khatib, Y., Brugha, T.S., Bien, H., & Bhui, K. (2016). Reducing excess mortality due to chronic disease in people with severe mental illness: meta-review of health interventions. *BJPsych*, *208, 322-329*.

Which part of their life are people with schizophrenia most dissatisfied with?

Neelam Laxhman

Background

- Quality of life central outcome in health care
- Objective and subjective quality of life (SQOL)
- SQOL measured as satisfaction with life domains
- Patients with schizophrenia = reduced SQOL
- But: Which domains are they most dissatisfied with?

Methods

- Merged dataset from 5 studies with >1000 patients
- Manchester Short Assessment of Quality of Life

Satisfaction Scale						
1	**2**	**3**	**4**	**5**	**6**	**7**
Couldn't be worse	**Displeased**	**Mostly Dissatisfied**	**Mixed**	**Mostly satisfied**	**Pleased**	**Couldn't be better**

How satisfied are you with….?
Life as a whole
Job
Finance
Quality of friendships
Leisure activities
Accommodation
Personal safety
People that you live with/Living alone
Sex life
Relationships with family
Physical health
Mental health

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Leisure activities
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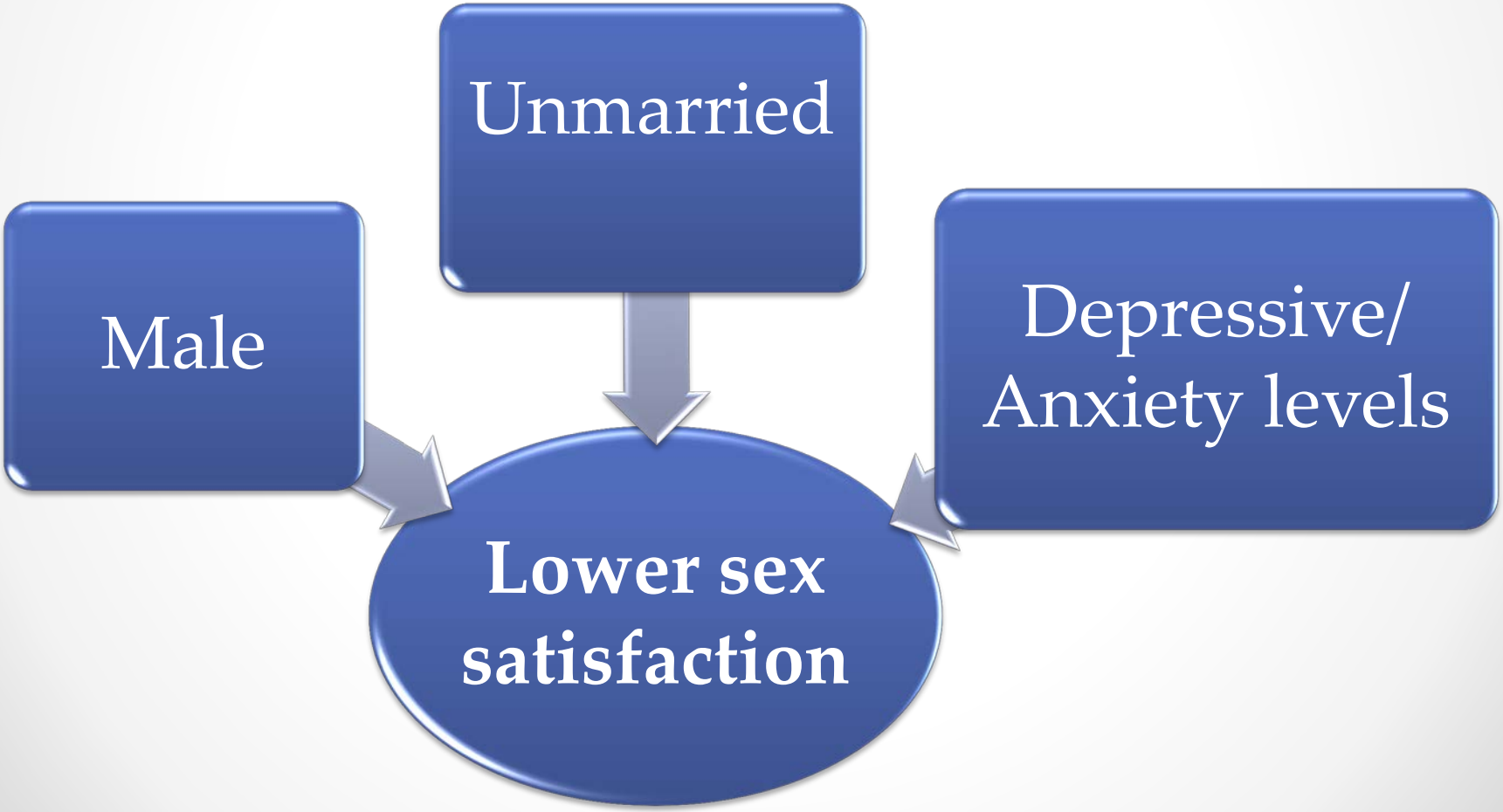
Personal safety
People that you live with/Living alone
Sex life
Relationships with family
Physical health
Mental health

Satisfied with, mean (SD)	Total
Sex life	3.7 (1.8)
Life as a whole	4.2 (1.6)
Job	4.0 (1.7)
Finance	3.9 (1.7)
Friendships	4.4 (1.7)
Leisure	4.3 (1.6)
Accommodation	4.8 (1.8)
Personal safety	4.7 (1.6)
Live with	4.8 (1.6)
Family	4.8 (1.6)
Physical health	4.4 (1.6)
Mental health	4.2 (1.7)

Results

- Significantly lower satisfaction than with any other life domain
- The only domain that patients – on average – are explicitly dissatisfied with.

Factors influencing sex satisfaction



Implications

- Awareness of which life domain patients are dissatisfied with
- Addressing concerns in consultations
- Interventions to help patients?
- Research?

Does a syndemic explain the exceptional levels of psychosis in East and South-East London?

Constantinos Kallis and Jeremy Coid

Incidence of schizophrenia

Age-sex standardised incidence rates		
Authors (year)	**Location**	**IRR**
Kirkbride et al. (2006)	Bristol	20.4
Kirkbride et al. (2006)	Nottingham	23.9
Kirkbride et al. (2006)	SE London	49.4
Coid et al. (2008)	East London	50.2
IRR: per 100 000 person-years		

Incidence of schizophrenia

- SE London, East London IRRs: Highest rates in the UK
- Probably the highest rates in global literature
- Study to (partly) explain highest rates

The environment and schizophrenia

- Hypothesis: Incidence of schizophrenia variation depends on combination of genetic and environmental factors
- Extended phenotype in general population (van Os et al. (2010))
- Gene-environment interactions used to explain increased vulnerability in addition to heritability

The environment and schizophrenia

- Majority of cases with psychotic experiences never progress to clinical state of psychosis
- But high prevalence of psychotic experiences leads to high incidence of psychosis

Syndemic

- Aggregation of two or more diseases in a population
- Positive biological interaction that exacerbates the negative health effects of any or all of the diseases
- Should not be confused with co-morbidity

Aims

- Racial and ethnic disparities in British young adult men (18-34) for syndemic
- Main: representative sample of Great Britain (n=1999) combined with a boost sample of young BME men (n=991) (to increase power)
- Hackney sample of young men (n=760)
- Ethnic disparities between White men in main sample (reference) and other groups in main sample and Hackney sample

Syndemic in Hackney, East London

- Syndemic model using Confirmatory Factor Analysis (CFA) for mental health, substance misuse, violent/crime and sexual health factors (first order factors)
- Second-order general syndemic factor
- Test of effect-modification of ethnicity by survey location on the general syndemic factor

General syndemic factor comparisons

	Main			Hackney			Location by ethnic differences[a]	
	White	Black coefficient	Asian coefficient	White coefficient	Black coefficient	Asian coefficient	Black contrast	Asian contrast
General ***syndemic*** factor	Ref.	-0.066	-0.371†	0.409†	1.177†	0.414†	0.834†	0.376#

Reference: main survey White

[a]Location contrasts for ethnic group's difference in coefficient from White

#P < 0.05, ¶P < 0.01, †P < 0.001

Adjusted effects

Adjusted effects on psychotic experiences according to BME group and survey

	White		Black		Asian	
Psychosis measures	Main	Hackney	Main	Hackney	Main	Hackney
Number of PSQ symptoms (M, SD)	Ref.	1.68	1.69	3.47***	0.78	1.43
PSQ 3+	Ref.	1.59	0.55	6.01***	0.59	2.33
Hypomania	Ref.	1.70	0.44	4.37***	0.48	3.64***
Thought insertion	Ref.	3.16**	2.62	6.53***	1.48	4.66***
Paranoid ideation	Ref.	0.99	1.24	4.77***	0.38*	0.94
Strange experiences	Ref.	1.51	1.22	3.99***	0.61	1.00
Hallucinations	Ref.	1.68	1.16	2.55	0.29	1.77
Psychiatrist/psychologist & PSQ 3+	Ref.	2.36	0.66	6.21*	0.47	1.72
Admission to psychiatric hospital & PSQ 3+	Ref.	1.44	-****	5.73*	0.46	4.88*

Note. ǂ) Reference group. All weighted estimates (AOR, 95% CI). Adjusted for age, being single, non-UK born, social class, and IMDR. With Bonferroni correction (based on 5 estimates for each outcome): *** $p < 0.0002$; ** $p < 0.002$; * $p < 0.01$. ****: estimate not obtained due to data sparseness

Adjusted effects on psychotic experiences according to BME group and survey

Conclusions

- No differences in psychotic experiences between White, Black and South Asian men in Great Britain
- Extreme differences between Black and South Asian men in Hackney and White men in the general population

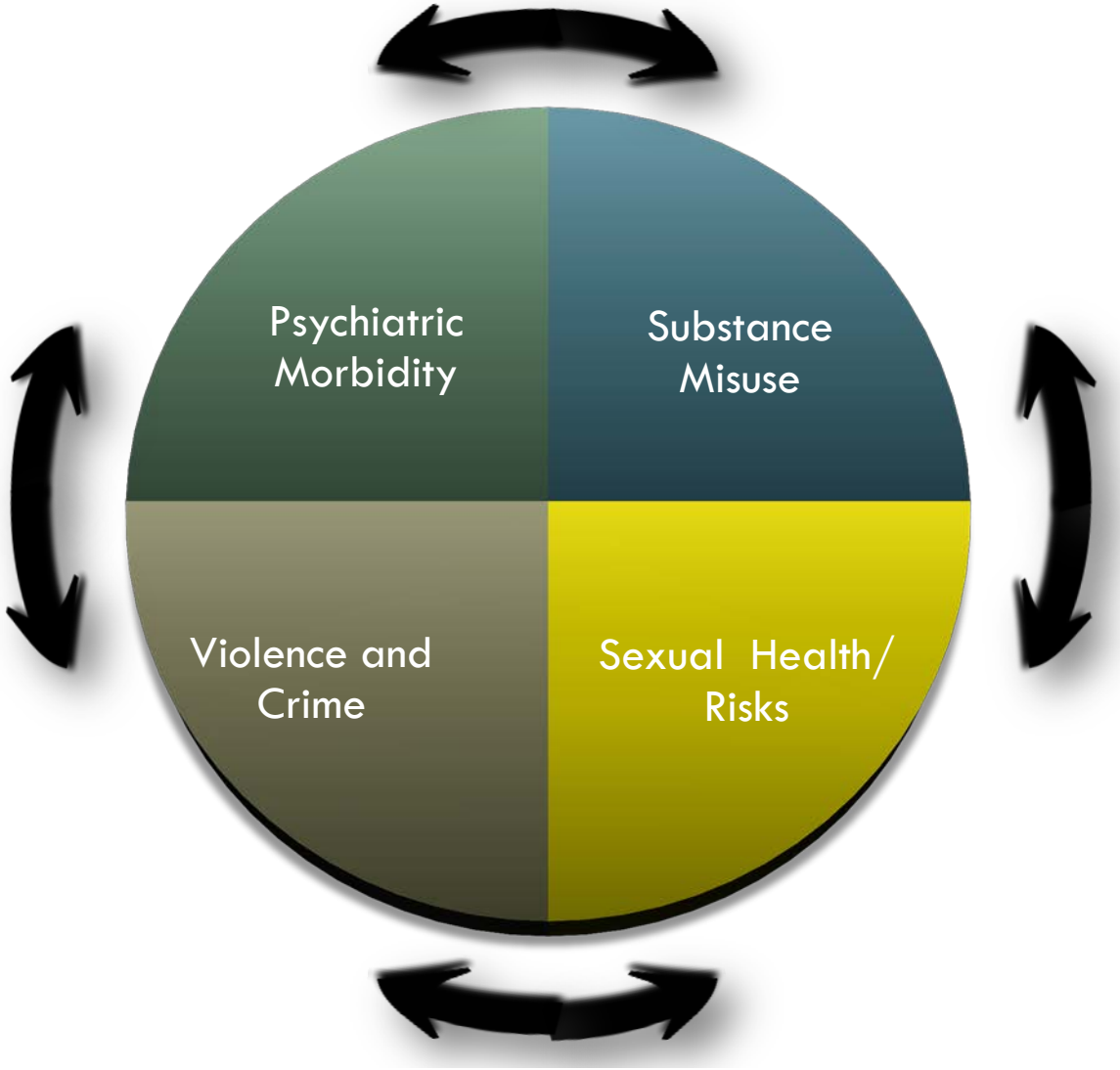
Conclusions

- These differences are not explained by social class or socioeconomic deprivation
- Explained by a syndemic showing a specific area level effect in Hackney

Conclusions

- Correspond to the extended phenotype hypothesis to explain the high incidence of clinical psychosis in Hackney
- Requires public mental health preventive interventions

Syndemic in Hackney, East London



World Health Organization

GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE
VIOLENCE PREVENTION ALLIANCE / ALLIANCE POUR LA PREVENTION DE LA VIOLENCE

Urban Birth, Urban Living and Work Migrancy: Psychotic Experiences Among Young Chinese Men

Jeremy Coid

Professor of Forensic Psychiatry

Violence Prevention Research Unit

Queen Mary University of London

East London NHS Foundation Trust

Br J Psychiatry. 1983 May;142:439-55.

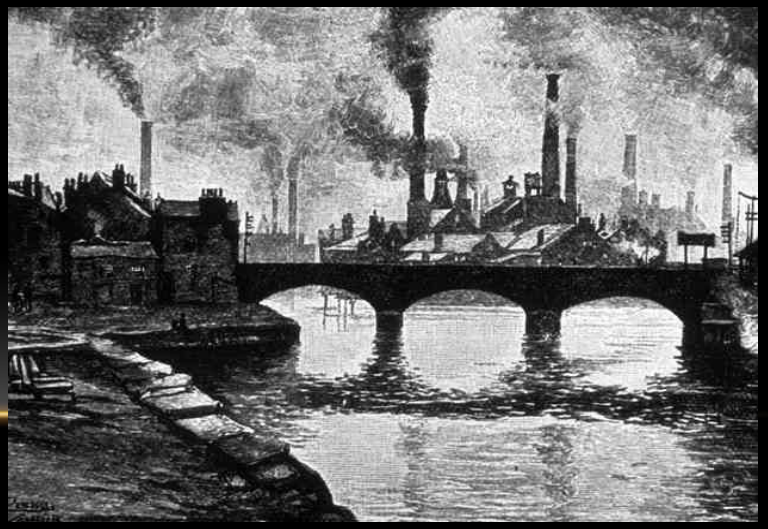
Was insanity on the increase? The fifty-sixth Maudsley Lecture.
Hare E.

Obituary: Dr Edward Hare

No psychiatrist has ever applied the methods of historical research as powerfully as Edward Hare in his explorations of the waxing and waning of psychoses over the last two centuries. Thus he elucidated their likely causation.

(Gerald Russell)

- Strong links between Schizophrenia and:
  - Urban birth
  - Urban upbringing
  - Urban residence at presentation
- Increased incidence schizophrenia directly due to these exposures ?



- Stress and the extended endophenotype (van Os)
- No previous study of urban birth, urban living, and migrancy in country undergoing rapid urban development
- China: increase 13% to 55 % urban living 1952 to 2012
- Additional factor of migrant workers

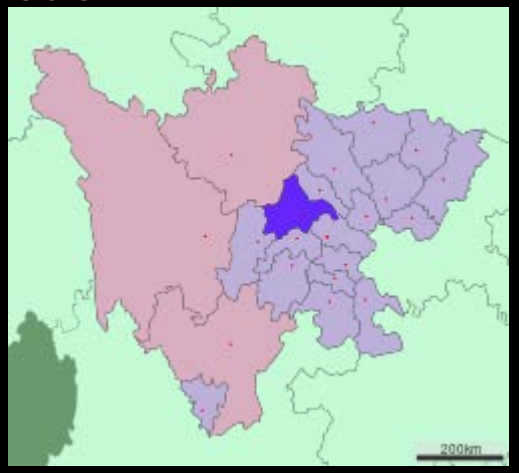
Research Questions

What are the effects on PEs of:

1. Urban birth ?
2. Urban living ?
3. Residential instability ? (time in current location)
4. Work migrant status ?

Method

- Survey – 2 waves 2012 and 2013, Greater Chengdu, Sichuan Province, PRC
- Three circular areas from city centre to rural areas
    - Multistage stratified random method
- Self-administered Questionnaire. Mandarin
- Psychosis Screening Questionnaire (PSQ)
- Weighted sample 4,238 men, 18-34 years

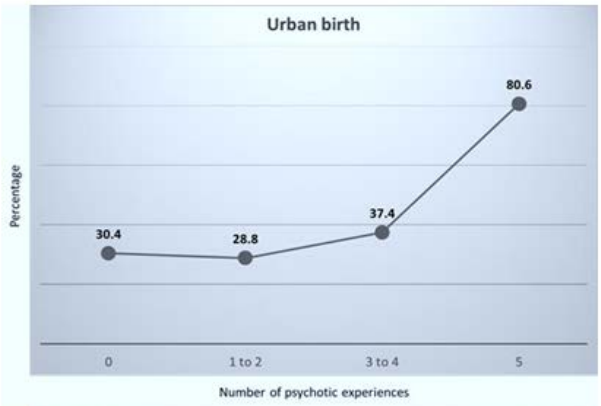


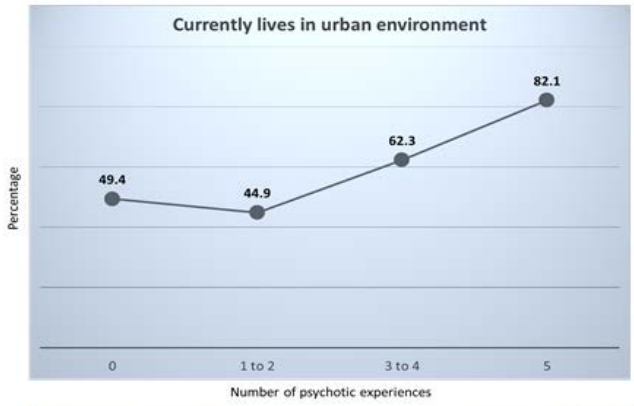
Results (1)

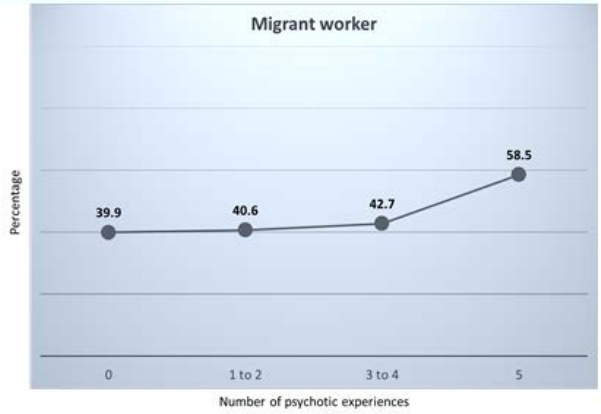
- 31% experienced one or more PEs in past year

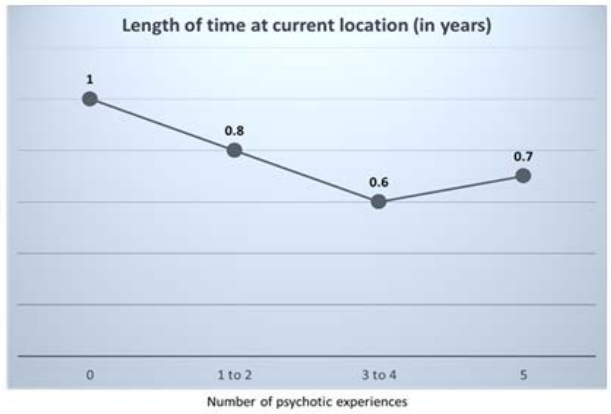
Results (2)

Figure 1: Distribution of urbanicity/ migrancy across different levels of psychotic experiences



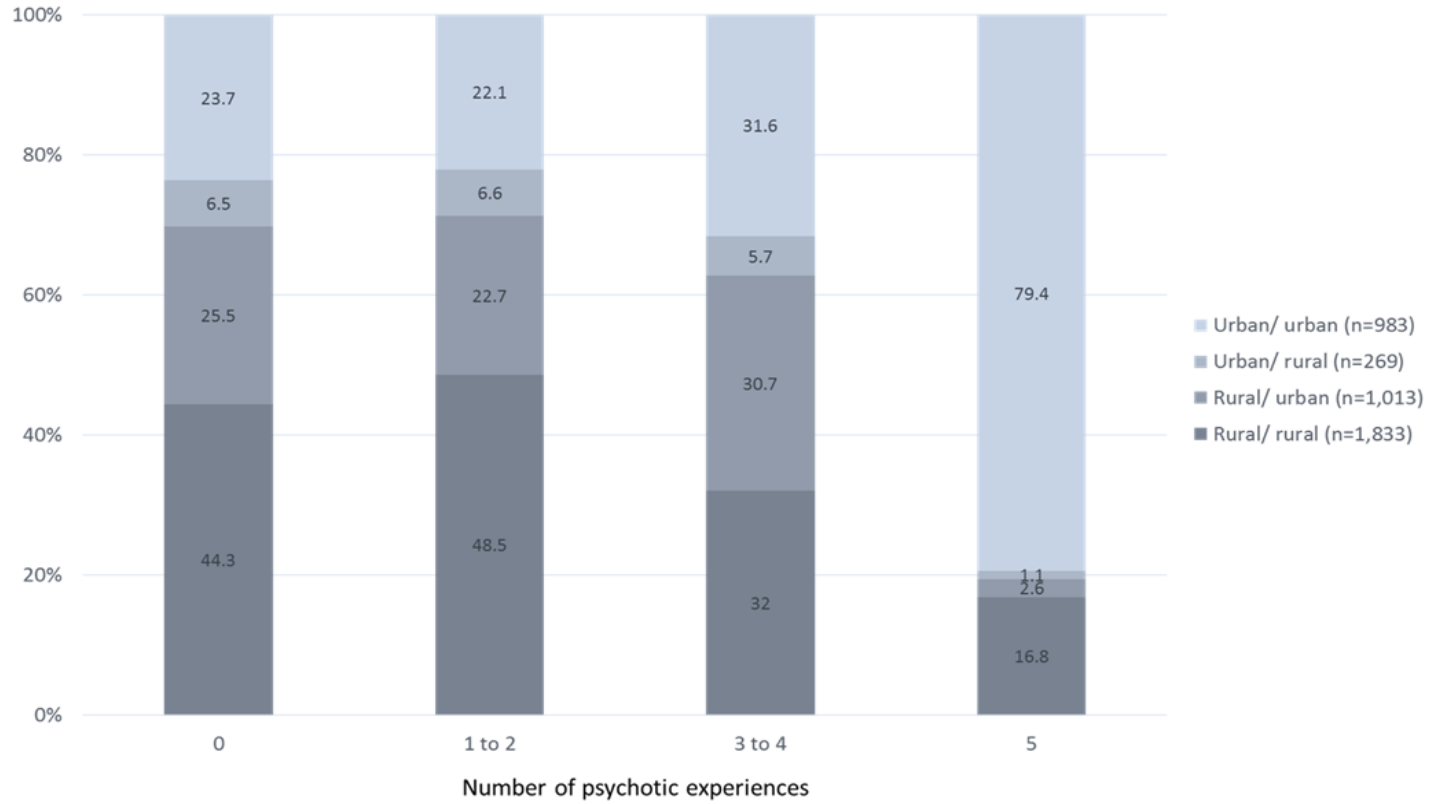






Results (3)

Figure 2: Psychotic experiences, place of birth and current place of living



Results (4)

PEs	1-2	3-4	5
	AOR	AOR	AOR
Urban birth	1.03	1.10	7.87***
Urban living	0.80	0.93	2.25
Migrant worker	0.90	0.88	1.82
Time current location	0.76*	0.56**	1.14

Adj: survey wave, age, other urbanicity/ migrancy

Conclusions (1)

1. Chinese men in Chengdu – higher prevalence of PEs than other countries
2. Stressful exposures – rapid urbanisation and residential instability
3. Urban birth – specific environmental exposure – only high (5) level PEs, not lower levels

Conclusions (2)

Two different psychopathological processes:

1. ↑ levels PEs due to rapid urbanisation – extended psychosis phenotype (van Os)
2. More severe psychotic condition following exposure to urban birth (neurotoxin, infection?)

The Revolving Door in East London: a 10 Year Follow-Up of Readmissions of First Episode Psychosis

Simone Ullrich
Jeremy Coid
Constantinos Kallis
Mark Freestone

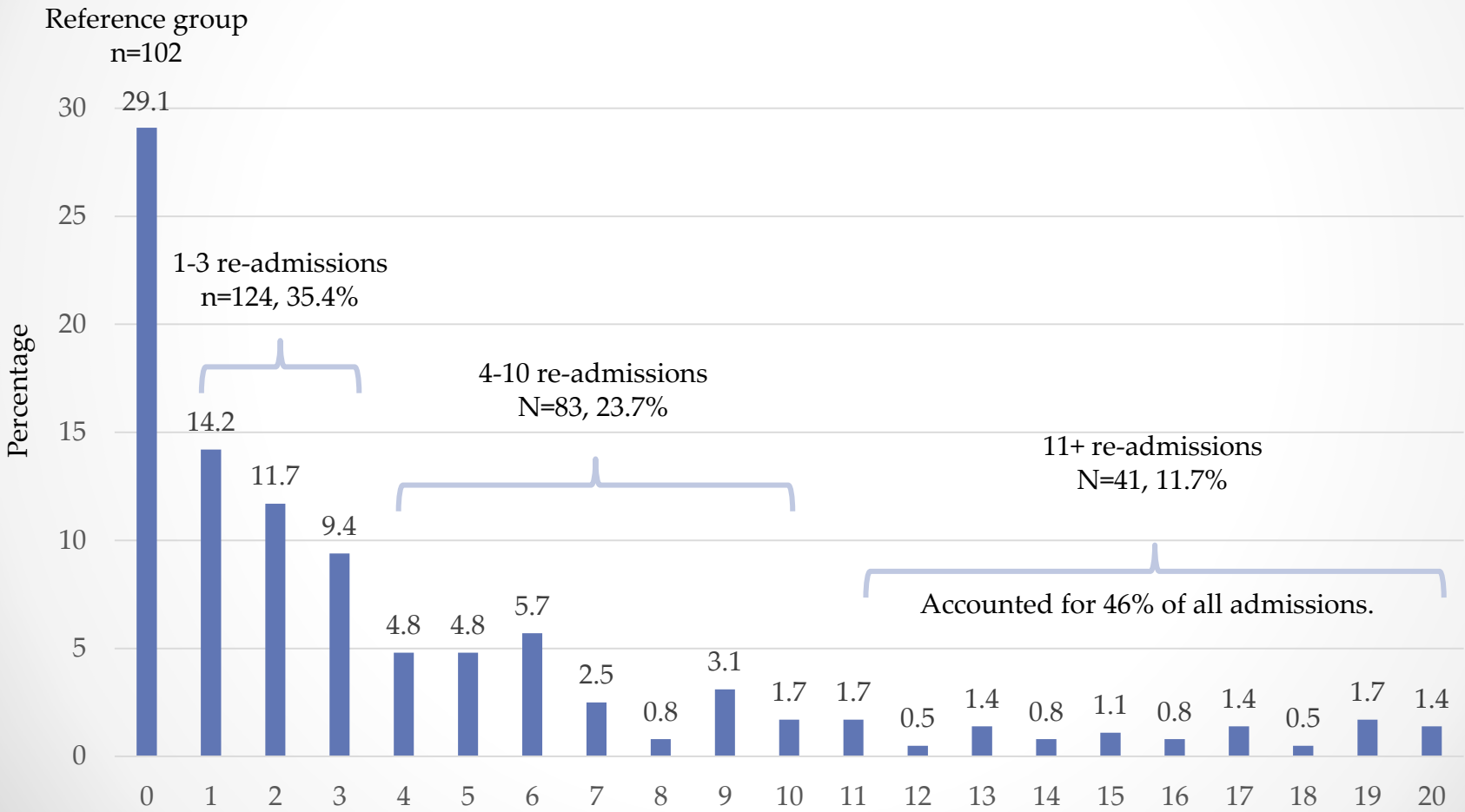
Background

- Anticipation of risk factors for re-hospitalisation
- Organisation of health care systems and the allocation of public health resources
- Previous admissions predict future hospitalisation
- Small group of patients receive large amount of resources

East London First Episode Psychosis Follow-Up

- N=490
- City & Hackney, Tower Hamlets, Newham (1996 – 2000)
- NIGB Section 251 ethical approval
- 2010 - 2013
- Medical records 53 in Trusts in primary and secondary care across England
- 2.9% moved abroad/ deported, 5.5% deceased, 4.7% untraceable
- Full 10 year follow-up for 82.2%

Number of Inpatient Readmissions per Patient over 10 Year Follow-Up



Static Risk Factors - Demography

	1-3 readmissions	4-10 readmissions	11+ readmissions
Young age	✓	✓	✓
Single	ns	ns	✓
Male gender	ns	ns	✓
Ethnicity	ns	ns	ns
UK born	ns	ns	✓
Location	ns	ns	✓ (Hackney)
Hostel/ NFA	ns	✓	✓
No educational qualifications	ns	ns	ns

Static Risk Factors – Family History

	1-3 readmissions	4-10 readmissions	11+ readmissions
Criminal	ns	ns	✓
Severe mental illness	ns	ns	ns
Substance abuse	ns	ns	ns

Note. Reference group: no readmission after first presentation

Static Risk Factors - Childhood

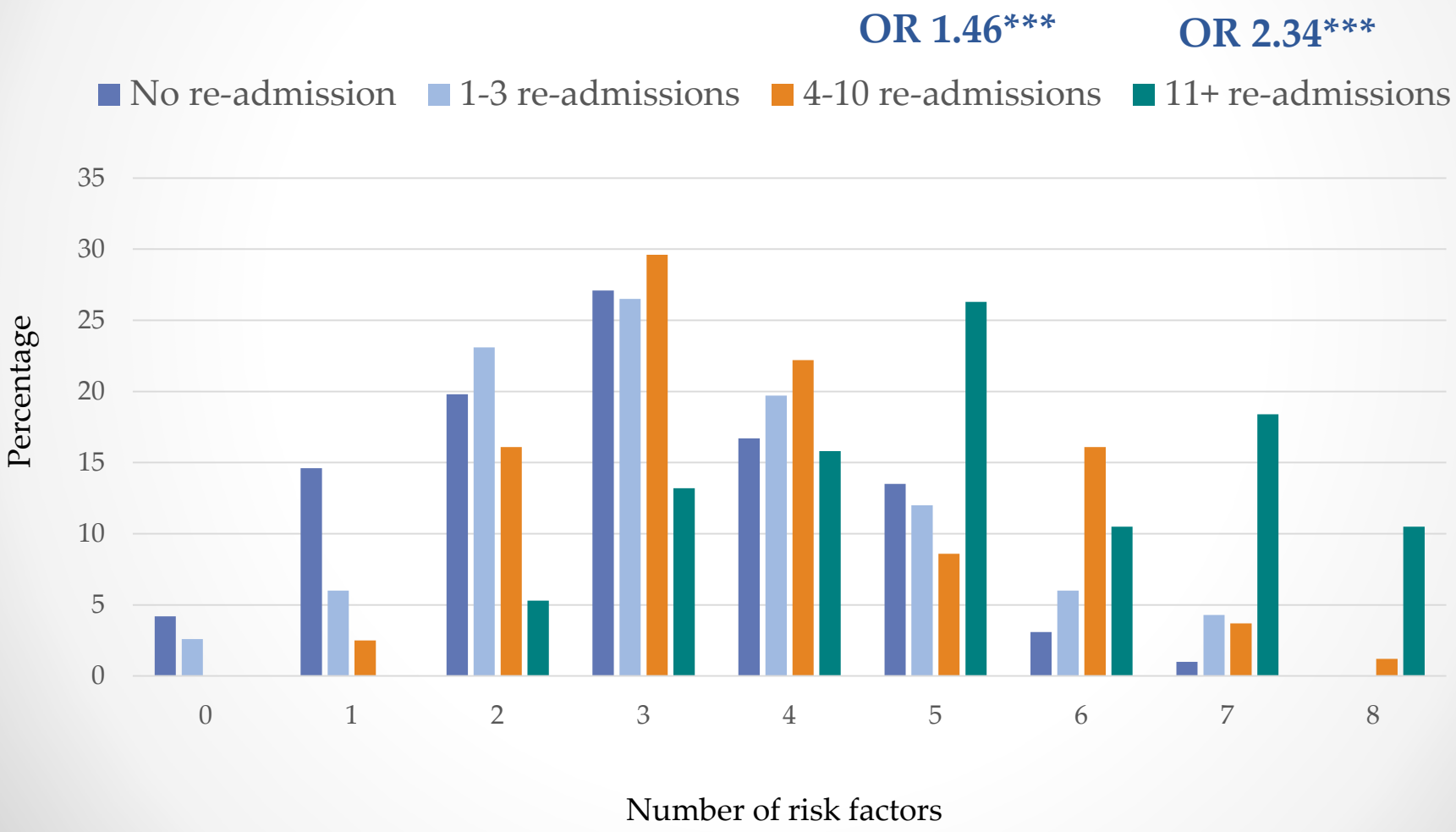
	1-3 readmissions	4-10 readmissions	11+ readmissions
In care	ns	ns	ns
Poverty	ns	ns	ns
Parental discord	ns	✓	✓
Physical abuse	ns	ns	ns
Sexual abuse	ns	ns	ns

Static Risk Factors - Clinical

	1-3 readmissions	4-10 readmissions	11+ readmissions
Diagnosis	ns	ns	ns
GAS	ns	ns	ns
Length of prodrome	ns	ns	ns
Antisocial personality disorder	ns	ns	ns

Note. Reference group: no readmission after first presentation

Vulnerabilities: Dose-Response



Dynamic Risk Factors - Clinical

	1-3 re-admissions	4-10 re-admissions	11+ re-admissions
Delusions	✓	✓	✓
Hallucinations	ns	✓	✓
Thought disorder	✓	✓	✓
Negative symptoms	✓	✓	✓
Depression	✓	✓	✓
Mania	ns	✓	✓
Alcohol – before/ after	ns	ns	ns
Alcohol – after	ns	ns	ns
Drugs – before/ after	ns	ns	✓
Drugs – after	✓	✓	✓
Deliberate self-harm	ns	✓	✓
Suicide attempts	✓	✓	✓
Compulsory admission	✓	✓	✓
Compliance with medication	✓	✓	✓

Note. Reference group: no readmission after first presentation

Dynamic Risk Factors - Adversities

	1-3 re-admissions	4-10 re-admissions	11+ re-admissions
Critical life events	ns	ns	✓
Violent victimization	ns	ns	✓
Violence perpetration	✓	✓	✓

Dynamic Risk Factors - Daily Living

	1-3 readmissions	4-10 readmissions	11+ readmissions
No relationship	ns	ns	✓
Living alone/ vagrant	ns	ns	ns
Unemployed	✓	✓	✓
Living off benefits	ns	ns	ns

Note. Reference group: no readmission after first presentation

The revolving door phenomenon

BREAK

Recovery-focused care planning in mental health inpatient settings: initial results from a cross national mixed methods study (COCAPPA)

Alan Simpson

Aim

- The aim of this study was to identify factors facilitating or hindering recovery-focused, personalised, care planning and coordination in acute settings.

- The results build on our *community* care planning and coordination study (COCAPP).

Location

- The study took place in 19 mental health hospital wards within four NHS Trusts in England and two Local Health Boards in Wales.

- Sites were identified to reflect variety in geography, population and setting (inner city, urban, rural).

Quantitative measures

- Surveys of service users (n=301), ward staff (n=290) and carers (n=28).

We used the following measures:

Views of Inpatient Care scale (VOICE)
- A patient-reported outcome measure of perceptions of acute mental health care,
- completed by service users.

Recovery Self-Assessment scale (*RSA)
- Measures the extent to which recovery-oriented practices are evident in services;
- completed by all.

Scale to Assess the Therapeutic Relationship (*STAR-P/C)
- Assesses therapeutic relationships;
- completed by service users and staff.

The Empowerment Scale (*ES)
- Measures empowerment, strongly associated with recovery;
- completed by service users.

Analysis: Descriptive statistics alongside reference values (build 'recovery profiles' of the sites). Across site comparisons using one-way ANOVAs and post-hoc Tukey tests. ANCOVAs to adjust for confounders and correlations to identify relationships between measures.

Qualitative methods

- We used a range of qualitative methods

Semi-structured interviews

- 36/36 service users (combined with care plan review)
- 31/36 multidisciplinary staff
- 9/24 carers

Structured care plan reviews (using template)

- 51/60 additional care plans were reviewed

Non-participant observations

- 12/18 care plan review meetings

Analysis: Framework method used to explore the relational aspects of care planning and coordination; the degree to which service users and carers participated in care planning processes and decision-making, and the extent to which practitioners were oriented towards recovery and personalised care.

Quantitative Results

- For **service users**, there were no differences found across sites for any of 4 questionnaires completed.

- For **staff**, there was a significant difference between sites on:
  - the **mean RSA total score** ($F(5, 279) = 6.35$, $p < 0.001$) and the **mean STAR-C total score** ($F(5, 273) = 3.02$, $p = 0.011$) and the mean item subscale scores of the RSA and the positive collaboration subscale for the STAR-C.
  - Provence and **Dauphine** sites scored significantly higher for the mean RSA total score.

- For **service users** we found a strong correlation between the:
  - RSA and VOICE scales ($r = -.70$, $p < 0.001$) **When recovery-orientated focus was high, the quality of care was viewed highly**
  - STAR-P and VOICE scales ($r = -.64$, $p < 0.001$) **When therapeutic relationships were scored highly the perception of quality of care also scored highly**
  - RSA and the STAR-P scales ($r = .61$, $p < 0.001$) **An association between recovery-orientated focus and the quality of therapeutic relationships amongst service users**

- For **staff** we found a small to moderate correlation between the:
  - RSA and STAR-C scales ($r = -.28$, $p < 0.001$) with considerable variability across sites.

- **Staff scored Therapeutic Relationships significantly higher than service users** on the STAR scale

Comparisons with COCAPP study

For service users ratings on:

The recovery-focus of services

- There were only small differences between total RSA scores, which can be considered **equivalent**.

Therapeutic relationships

- Using the STAR-P measure, service users consistently scored total and subscales lower in COCAPP-A than COCAPP, suggesting relationships are rated more positively in community services. The overall difference in total score varied across sites from 2.74 to 8.49 points lower.

Empowerment

- Using the ES measure, service users scored higher overall in the acute study than in the community study.

Key qualitative findings 1/2

Our results suggest much positive practice taking place within acute inpatient wards.

- Evidence of a widespread commitment to safe, respectful, compassionate care underpinned by strong values.

- Whilst ideas of recovery were evident, some uncertainty exists amongst staff about:
    - the relevance of recovery ideals to inpatient care
    - the ability of people in acute distress to engage in recovery-focused approaches.
- Service users:
    - saw inpatient admissions as important and often necessary stages in stabilising their mental state and perhaps their lives, with medication an important component.
    - rated highly staff using recovery-focused language and values.

- Many service users spoke of care being personalised
    - e.g. staff responsive/considerate in response to particular needs/concerns.

- Carers often similarly described positive views of care.

Key qualitative findings 2/2

- Most staff spoke of efforts to involve service users and carers in care planning, where possible.

However, the majority of service users:

- did not feel they had been genuinely involved in the process (as with our community study).
- did not appreciate the care plan as an integral or important part of the experience and many did not have, or could not find, copies.
- Service users, and carers, were often aware of efforts being made to keep them safe and this was frequently appreciated.
- However, as in the community study, involvement of service users in discussions about personal risk factors and safety is challenging for staff, especially with those service users legally detained.

COCAPPA/ELFT

- Scored high on RSA (recovery-focused) – **see table**
- Overall, positive VOICE scores by service users, but wide variation
- Staff rated therapeutic relationships significantly higher than did service users
- Impressive staff interviews (high on values and attempts to work in personalised, recovery-focused way)
- Strong organisational culture, e.g.
  - QI, values, respect, employing lived experience staff, peer support, 'This is Me' care plans, user feedback to improve services

Table 34: Five highest rated items by respondents in Dauphine

Rank	Service Users (mean of 3.56-3.98 on Likert scale) [a]	Staff (mean of 4.24-4.51 on Likert scale) [a]
1	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests *Life Goals*	Staff are diverse in terms of culture, ethnicity, lifestyle, and interests *Life Goals*
2	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations *Life Goals*	Every effort is made to involve significant others and other natural supports in the planning of a person's services, if so desired *Individually Tailored*
3	Agency staff believe that I can recover and make my own treatment and life choices *Life Goals*	Staff do not use threats, bribes, or other forms of coercion to influence the behaviour or choices *Choice*
4	Agency staff do not use threats, bribes, or other forms of coercion to influence my behaviour or choices Choice	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations *Life Goals*
5	The role of agency staff is to assist me, and other people in recovery with fulfilling my individually-defined goals and aspirations *Life Goals*	Staff believe that people can recover and make their own treatment and life choices *Life Goals*

Delivery of diabetes care for people with severe mental illness: a survey of health professionals

Dr Kathleen Mulligan

Background

- People with SMI have two-fold increased risk of developing diabetes

- In people with diabetes those with SMI have:
  - higher mortality
  - a greater risk of acute complications
  - less likely to receive recommended diabetes health checks
  - more likely to smoke, be obese
  - less than half achieve target HbA1c

- In people with SMI, those with diabetes have poorer QoL

Methods

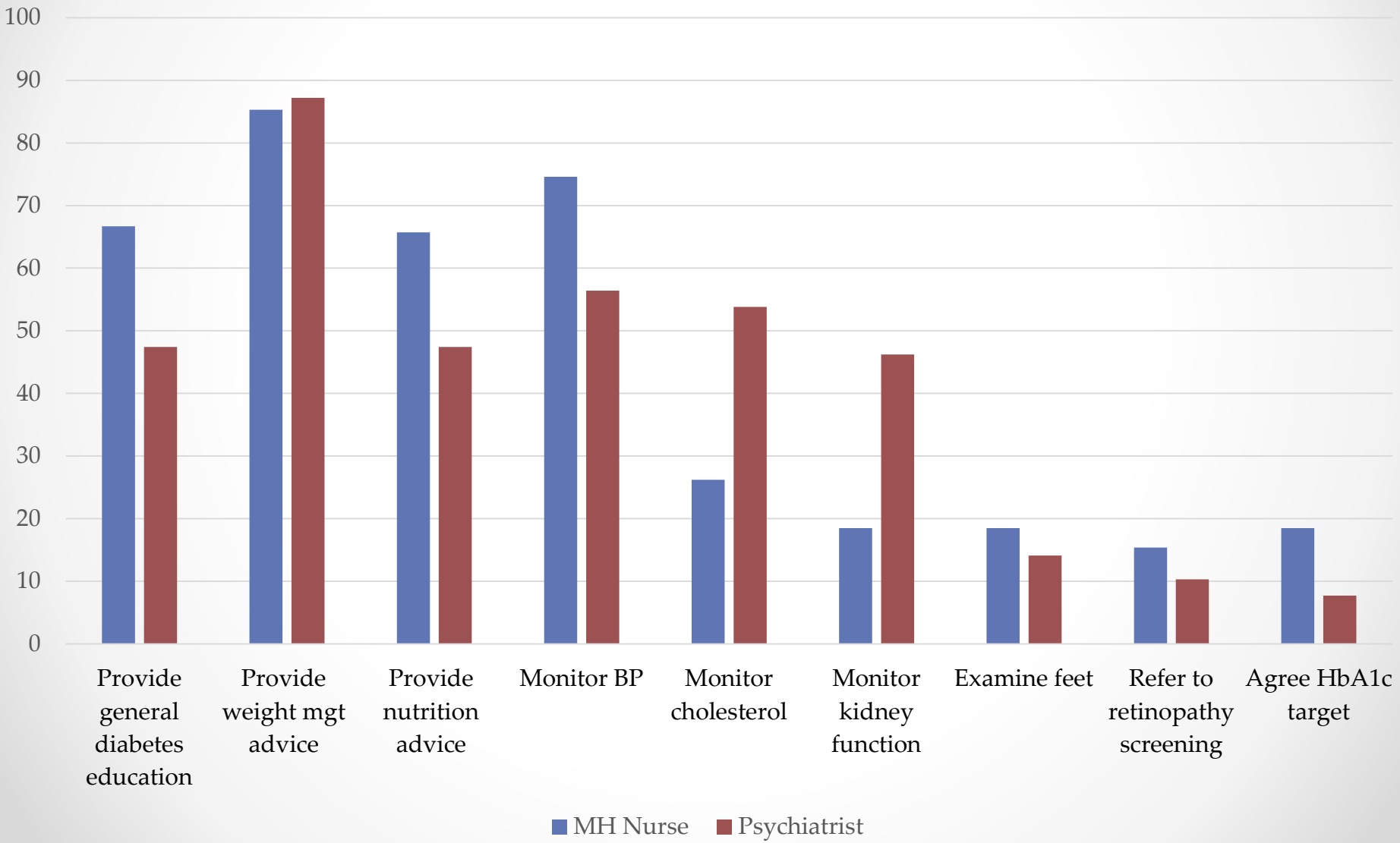
- AIMS:
  - Identify factors that impact on healthcare professionals' ability to deliver diabetes care for people with SMI
- STUDY DESIGN
  - Anonymous online survey
  - Survey questions informed by **Theoretical Domains Framework**[1] for behaviour change
- PARTICIPANTS
  - 103 Mental health nurses, 93 Psychiatrists

1 Cane, James, Denise O'Connor, and Susan Michie. (2012). Validation of the theoretical domains framework for use in behaviour change and implementation research." *Implement Science,* 7(1), 37.

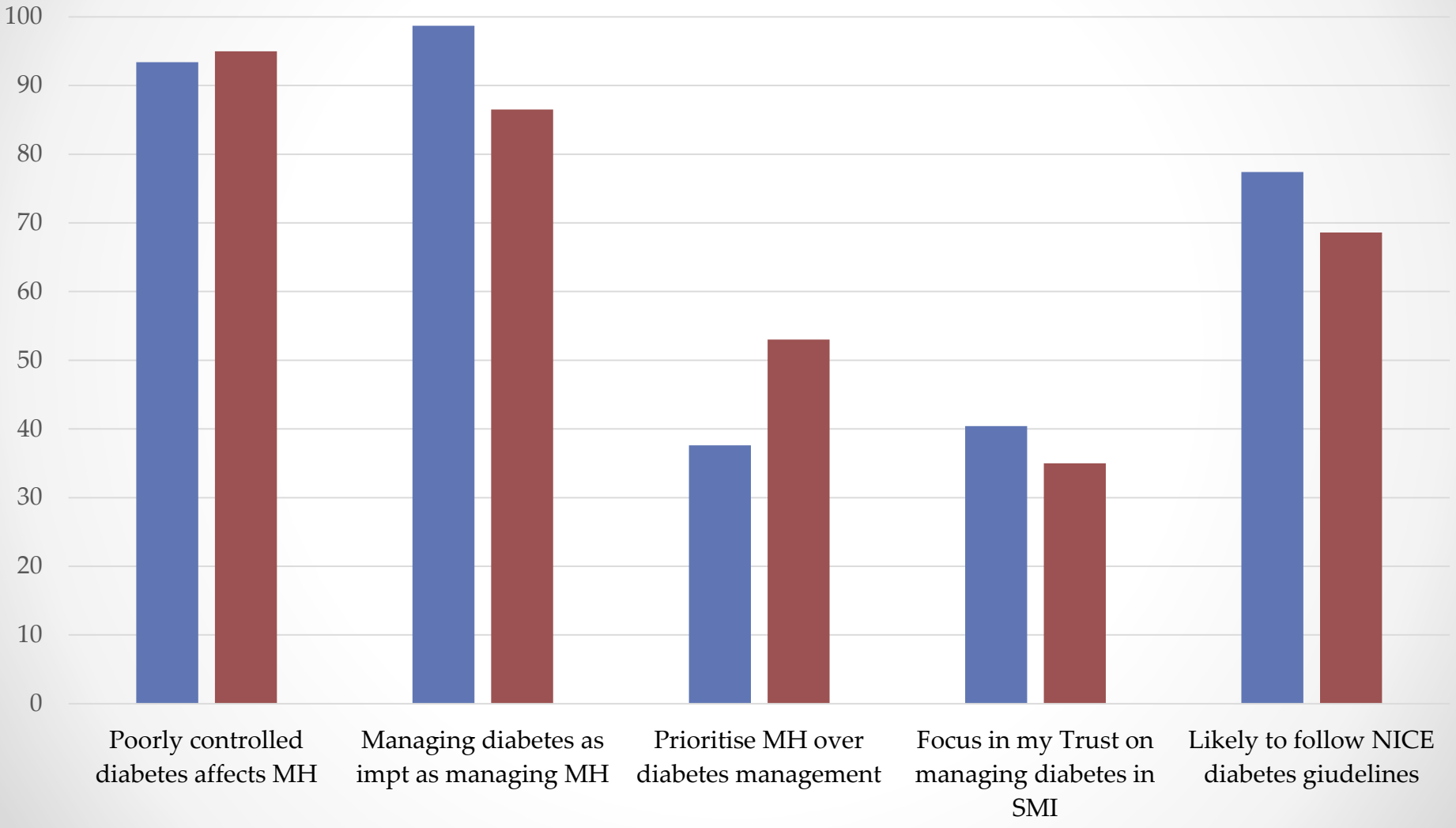
In your patients with T2DM, who is responsible for:

	MH Nurse	Psychiatrist	GP	PN	DSN	Diabetologist
Education (%)						
Deliver diabetes education	31.4	25.5	60.1	58.2	81.0	37.3
Refer for diabetes education	45.0	37.9	66.4	50.3	58.8	26.5
Advise on nutrition and PA	58.8	37.9	58.8	56.6	78.4	41.2
Monitoring (%)						
$HbA1_c$	17.8	38.2	79.5	38.2	60.5	38.2
BP	69.7	34.2	72.2	62.5	50.7	27.6
Cholesterol	28.3	49.0	85.4	41.4	42.1	32.2
Kidney function	10.9	45.6	85.6	23.1	38.8	31.3
Examine feet	10.2	14.3	78.2	32.7	59.2	33.6
Weight	69.4	43.3	74.8	56.5	55.8	34.0
Diabetes complications	45.6	45.6	81.6	44.9	74.1	50.3
Refer retinopathy screening	6.1	16.3	78.9	21.8	54.4	36.1
Psychological support (%)						
Providing psychol suppt	82.3	68.4	45.6	34.7	46.3	19.7

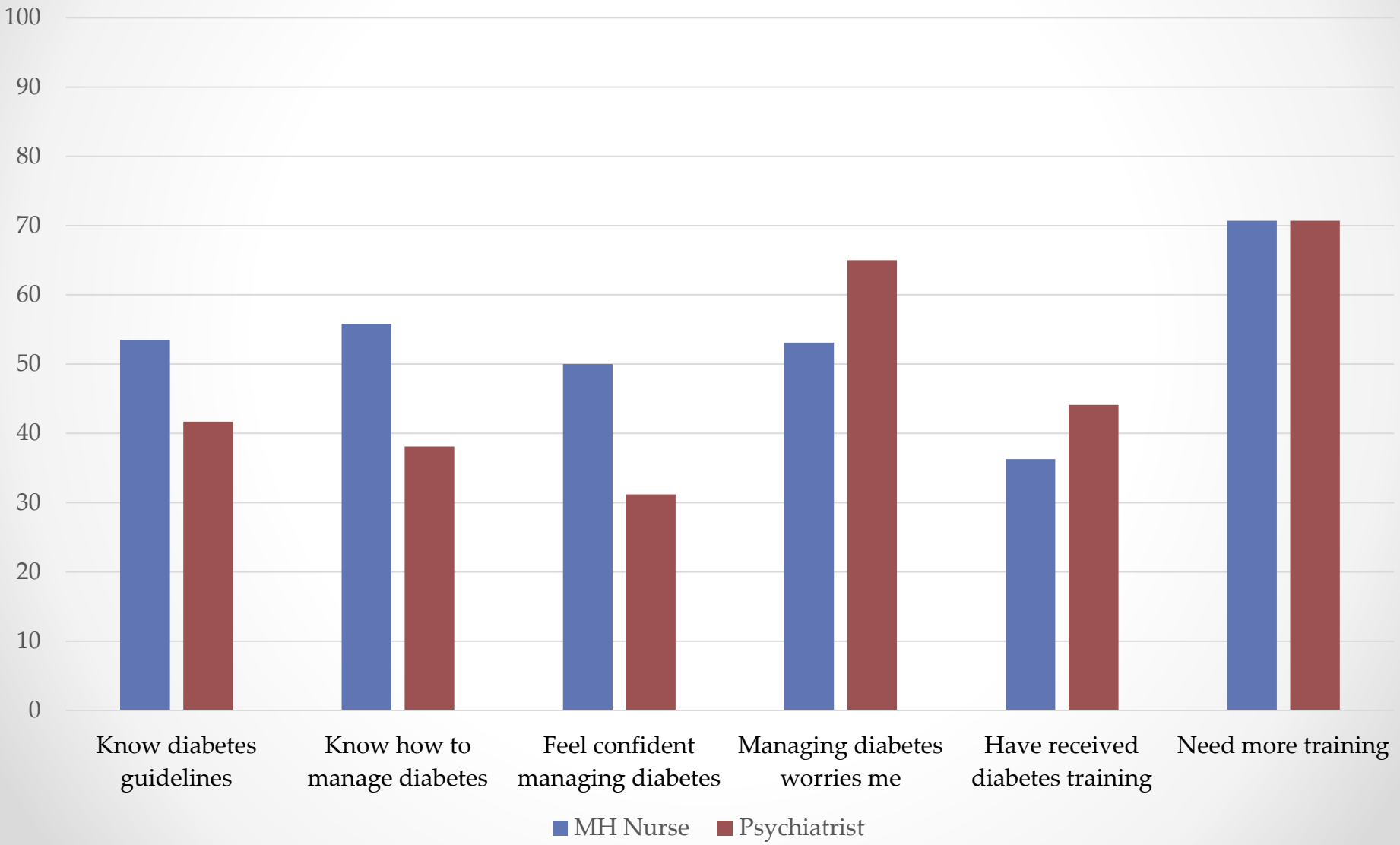
% who reported that it was part of their clinical role to:



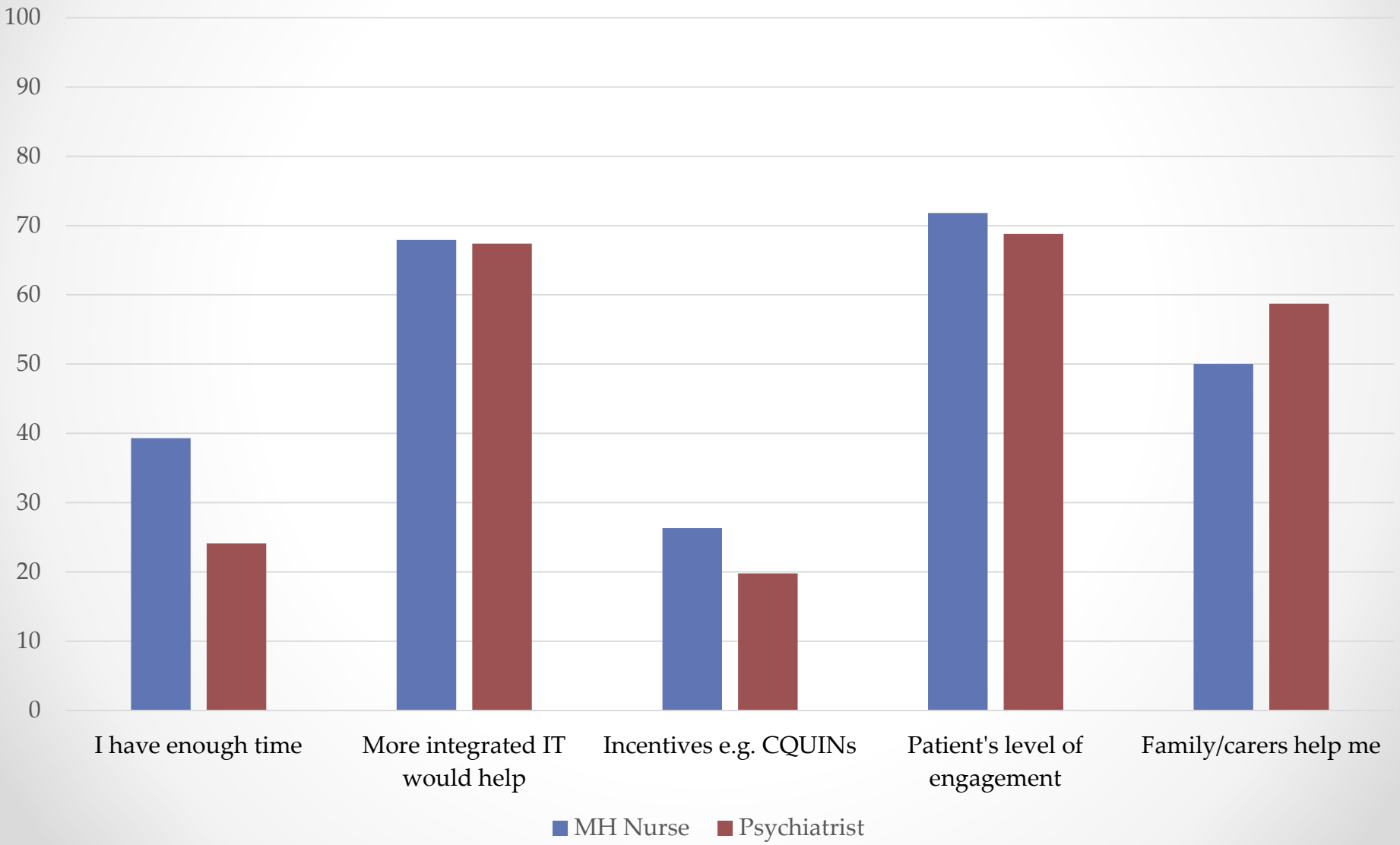
How important is managing diabetes in SMI?



Knowledge/confidence in managing diabetes



What helps / doesn't help?



Future research

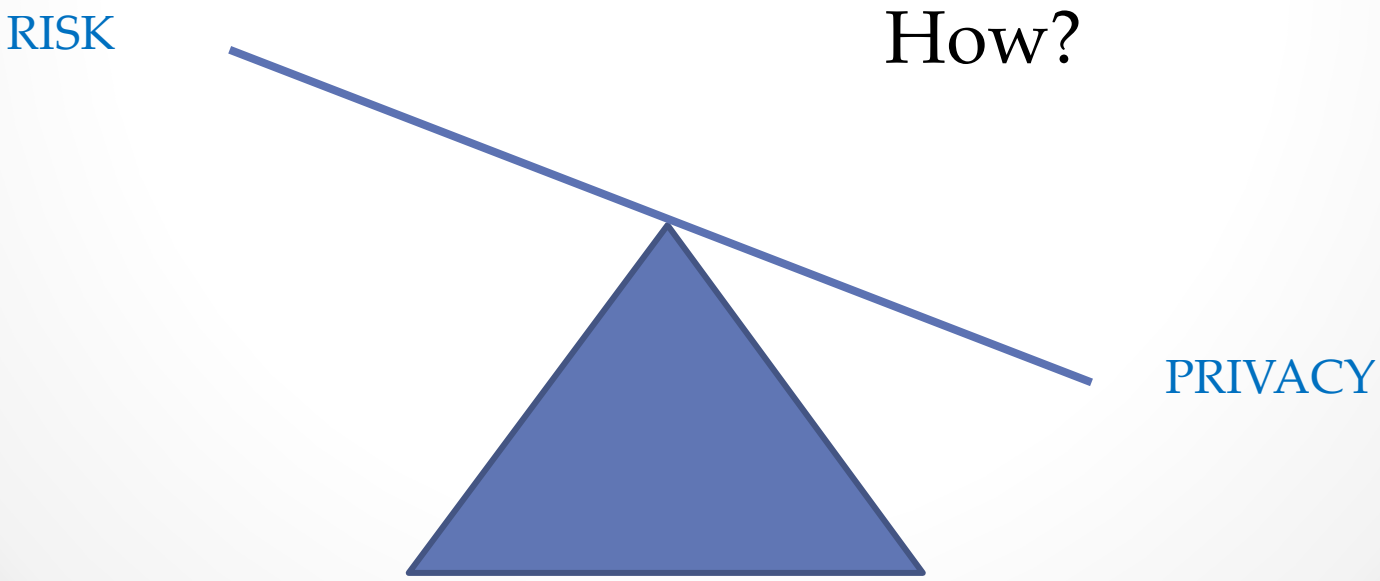
- Cross-sectional survey of service users, to identify:
  - Diabetes-related behaviours they find most difficult to implement
  - Barriers and facilitators to performing these behaviours
- Develop and evaluate an intervention for health professionals to help enhance diabetes self-management in SMI

Making decisions about continuous observation in psychiatric hospitals

Kirsten Barnicot

Background

- Continuous observation: 13-16% of inpatients
- 20% of USA nursing budget; UK NHS £35 million p.a.
- NICE: “Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them”



Moore et al. 1995, DoH 1999, Bowers et al. 2000, Flood et al. 2008, NICE 2015

Research Question

How do staff and patients experience **decision-making** about balancing **safety** and **privacy** when *initiating*, *conducting* and *ending* continuous observation?

Design

- 2 hospitals
  - West London Mental Health Trust
  - East London NHS Foundation Trust
- Individual qualitative interviews
- N = 28 inpatients

  Purposive sampling:
  - Sex
  - Diagnosis
  - Reason for observation
  - Length of observation
- N = 31 staff

  Purposive sampling:
  - Sex
  - Level of qualification

Theme 1 The conflict between privacy and safety

*P01: "You're constantly being **watched**, your every movement. You **lose your space** and it feels like you're being **invaded** and they're in **control** of you."*

*P13: "I **felt safe** because I **couldn't trust myself**, and I felt they were keeping me safe …it saved me from myself."*

Theme 2 A damaging intervention….

P05: "I hate being stared at. It makes me ***agitated****.....It made me do it* **[self-harm] more***.... because of the amount of* ***pressure*** *they put on me."*

S12: "It might actually end up making the situation ***worse*** *by* ***reducing the patient's sense of self-efficacy*** *and their own skills in managing the situation…. you can inadvertently* ***reinforce some of the behaviours****."*

vs. a short-term solution

*S12: "It's a useful **acute risk management** tool, as **a short-term measure** if they're self-harming in a very serious way that's likely to lead to permanent damage – but at some point you have to have **positive risk taking**."*

*S05: "Sometimes you have to take **positive risks**... this positive risk taking will lead you into **deciding if someone can be taken off** one to one."*

Theme 3. **Decisions made without the patient……**

*P12: "**No-one really told me why** I was on it….They **didn't tell me why** they took me off it."*

*S25: "Sometimes **a patient comes in** and we will tell an HCA go and do a one-to-one… yet we've **not even had the opportunity to read up on the risks**. It's important that a patient comes in and we get to know the risk before we say 'go do the one-to-one.'"*

vs. a collaborative approach

*S16: "It's all about **communicating**, 'This is why I'm sitting with you, for your **safety**; I'm **here to help** you. Even if you don't like it, just **trust** on that I'm here to help you. You are safe.'"*

*P22: "After a while they started to **trust me**- like 'I'm going to the lavatory, nurse, I'll be about 5 minutes' they'll **let me go**. And if I'm not back in 5 minutes, then they'd come and look for me."*

Theme 4. A stressed and fractured workforce….

Privacy ⬇	Safety ⬇
- *Staff anxiety* - *Culpability* - *Fear of blame*	*- Fear of sexual harassment claims* *- Fear of aggression* *- Tiredness* *- Under-staffing* *- Team splitting*

*S28: "What **restricts privacy** is the fact that staff are **anxious** that they're **culpable** for whatever happens for that one hour, [which] makes staff adopt a black and white approach, a restrictive approach".*

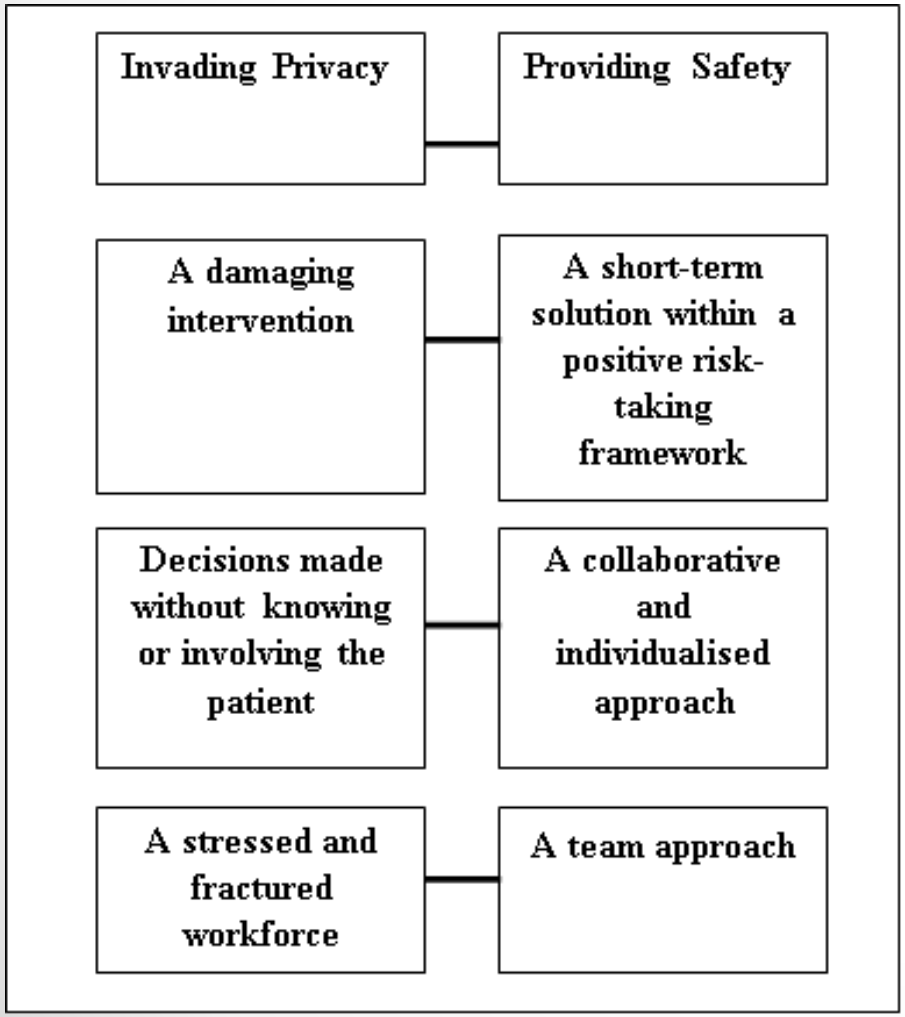
*P21: "**Slap-dash approach**, leaving me alone, **wouldn't bother to do** the one-to-one half the time..... It really upset me because I felt really **judged**... the **conflict** between nurses made me feel worse."*

… vs. a team approach

- *Practical support*
- *Emotional support*
- *Team decision-making*

*S09: "We usually try to **swap regularly**, to make sure that the person who is on one-to-one will have time off and can at least have a cup of tea. Then **reflection** - usually the staff who is able to make conversation with the person on one-to-one is quite keen to **share everything with the team**, so in a full discussion with the team you **reduce your stress**."*

Summary & Implications



Short- term

Consider negative effects

Take positive risks

Collaborate with the patient

Support each-other

Sample Characteristics

N = 28 inpatients		
		N
Sex	Male	15
	Female	13
Diagnosis	PD	10
	Bipolar	9
	Schizophrenia	5
	Major depressive	4
Reason	Risk to self	18
	Risk to others	6
	Both	4
Length	≤ 7 days	12
	> 7 days	16

N = 31 staff		
		N
Sex	Male	15
	Female	16
Role	Unqualified nursing	10
	Qualified nursing	9
	Clinical team leader	5
	Ward manager	4
Reason	Modern matron	18
	Consultant psychiatrist	6
	Clinical psychologist	4

A team approach

S31: "I do encourage staff to make decisions for themselves and for them to have a good reason behind the decision making that they have. There's a very clear supervision structure as well, so that they can discuss their decisions. And we have reflection with the psychotherapist where we would bring up decisions about one-to-one, discuss it as a team and come to - if not complete agreement - at least a centralised hymn sheet that we would work from."

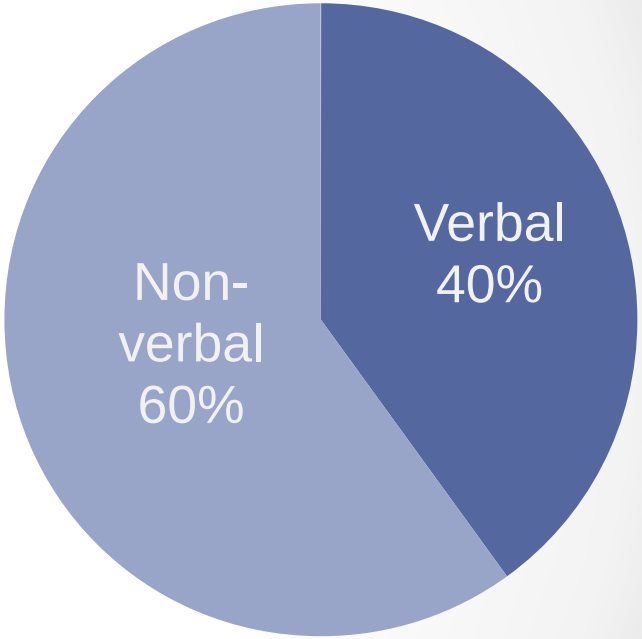
Negative symptoms of schizophrenia and social interactions

An analysis of non-verbal behaviour

Elizabeth Worswick

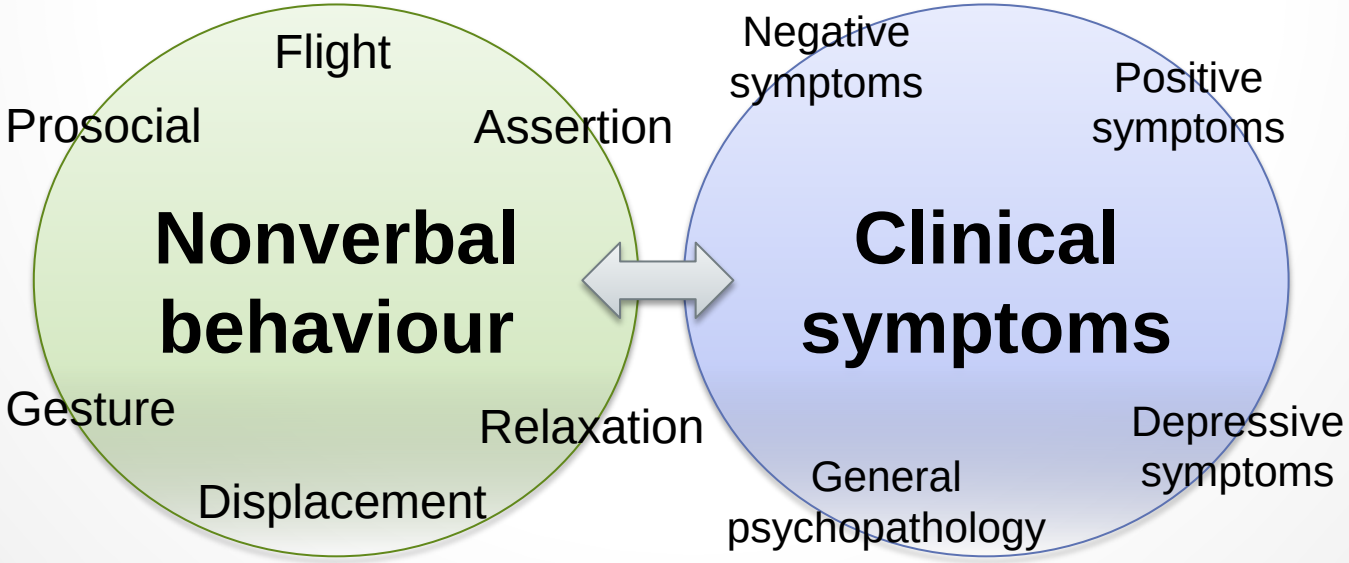
Background

- Nonverbal behaviour is fundamental to social interaction
- Schizophrenia associated with poor social functioning
- An *expressivity deficit:* reduction in nonverbal behaviour
- But, what exactly does this mean?



The present study

- Videos of 63 patients with different degrees of negative symptoms in standardised interviews
- Negative symptoms assessed on specific scales
- Nonverbal behaviour assessed by independent raters



More negative symptoms linked with…

Reduced *prosocial, gesture & displacement* behaviour

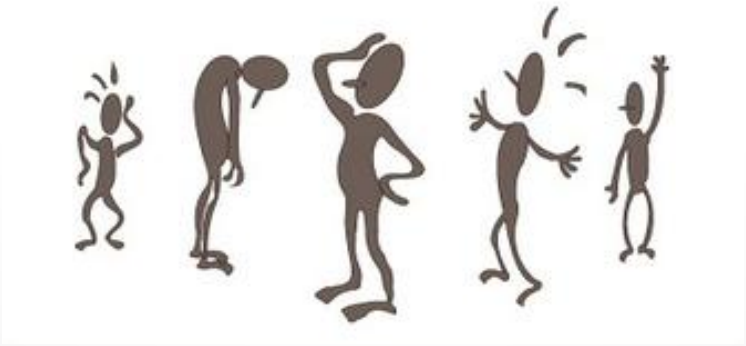
But, also…

Increased *flight* behaviour

Therefore, negative symptoms associated with a reduction in active engagement, but also an **increase in active avoidance**

Implications

- Not just reduced expression, but something more!
- Why do patients actively avoid establishing contact?
- Does it also apply in every day life situations?
- How to change this in new targeted treatments?



The Beauty of Questions

Rosemarie McCabe

BJPsych | The British Journal of Psychiatry
1–8. doi: 10.1192/bjp.bp.114.151910

Effect of questions used by psychiatrists on therapeutic alliance and adherence

Laura Thompson, Christine Howes and Rose McCabe

Background

Psychiatrists' questions are the mechanism for achieving clinical objectives and managing the formation of a therapeutic alliance – consistently associated with patient adherence. No research has examined the nature of this relationship and the different practices used in psychiatry. Questions are typically defined in binary terms (e.g. 'open' *v.* 'closed') that may have limited application in practice.

questions and tag questions. Only declarative questions predicted better adherence and perceptions of the therapeutic relationship. Conversely, 'wh-' questions – associated with positive symptoms – predicted poorer perceptions of the therapeutic relationship. Declarative questions were frequently used to propose an understanding of patients' experiences, in particular their emotional salience for the patient.

Questioning

- In general, healthcare professionals ask a lot of questions
- Questions communicate their reasoning, beliefs, expectations
- How do they design those questions?
- Are they linked to the therapeutic relationship?

1) Yes/no questions	**Do you ever feel someone is controlling your mind?**
3) Declarative questions	**So you feel anxious about that?**
2) Wh questions	**Where was that done?**
4) Tag questions	**You're on 10mg of olanzapine, aren't you?**
5) Lexical tags	**I'll write a letter to your GP, okay?**
6) Incomplete questions	**Your keyworker is?**
7) Alternative questions	**Do you feel better having stopped it or worse?**
8) Check questions	**Yeah?**
9) Wh-in-situ	**He did what?**
10) Open class repair initiators	**Pardon?**

Question type	Total	Mean (SD)	Range
All Questions	7570	51.7 (32.1)	165
Yes/ No Questions	2362	16.5 (12.2)	57
Wh Questions	1700	12.7 (10.4)	63
Declarative	1648	11 (8.3)	47
Tag Questions	842	3.9 (4.5)	25
LexTag	496	3.7 (5.2)	29
Incomplete Q's	196	1.5 (1.7)	8
Alternative Q's	159	1.2 (1.5)	10
Check Q's	85	0.6 (1.4)	7
What-in-situ	47	0.35 (1)	10
Open Class Repair Initiators	35	0.3 (0.7)	4

Declarative question

- Closed Yes/No questions
- Invite confirmation/ disconfirmation
- 90/210 declarative questions were “so” prefaced

Declarative Questions

- “So you feel a bit anxious?”
- “So you are feeling, (0.4) not so well?”
- “So: you’re quite happy being on your o:::wn”
- “Oka::y so you you think you’re better off just looking forward?”
  - “So the:: the the the things that you fi:nd difficult no:w are your self confidence?”
  - “So that’s something that you want to switch off from?
  - “So you’re under a lot of pressure at the moment?”

1 DOC .smt an what about the paranoid thoughts.
2 (0.3)
3 how are they?
4 (0.2)
5 (are they) strong?
6 (.)
7 PAT: yeah quite bad yeah.
8 (.)
9 I don't like going anywhere on my own really and that
10 now. .hhh My mum's been taking me a lot of pla:ces and that.
11 (0.4)
12 PAT: in the ca:r.
13 (0.4)
14 cos I get paranoid when I'm on the bus and
15 everything. I think other people are after me an that.
16 (0.6)
17 DOC: .hhh so you are feeling, (0.4) not so well?
18 PAT: No:::
19 DOC During the last months

Declarative Questions & The Therapeutic Relationship

	Declarative Questions	**p value**
Helping Alliance Scale Total	**.282****	0.001
Do you get along with the patient?	**.190***	0.029
Do you understand the patient and his/her views?	**.205***	0.018
Do you look forward to meeting the patient?	**.213***	0.014
Do you feel you are actively involved in the patient's treatment?	**.242****	0.005
Do you feel you can help the patient and treat him/her effectively?	**.284****	0.001

Garfinkel and Sacks (1970)

‘a member may **treat some part of the conversation as an occasion to describe that conversation, to explain it, or characterize it or explicate, or translate, or summarize or furnish the gist of it**……that is to say, a member may use some part of the conversation as an occasion to **formulate** the conversation’

(1970:350)

Formulations

- used in psychotherapy
- “so” indexes inferential connections with prior talk (Bolden 2009)
- a summary or edit of the patients’ talk
- highlight its personal / emotional salience
- display intersubjectivity
- ‘something implicitly meant by the client’ (Bercelli 2008)

Epistemics

- Knowledge claims that people assert, contest and defend in and through turns at talk (Heritage 2012)
- Speakers position themselves regarding the knowledge they and their recipients can and should have over a certain matter
- Epistemic gradient in a question =

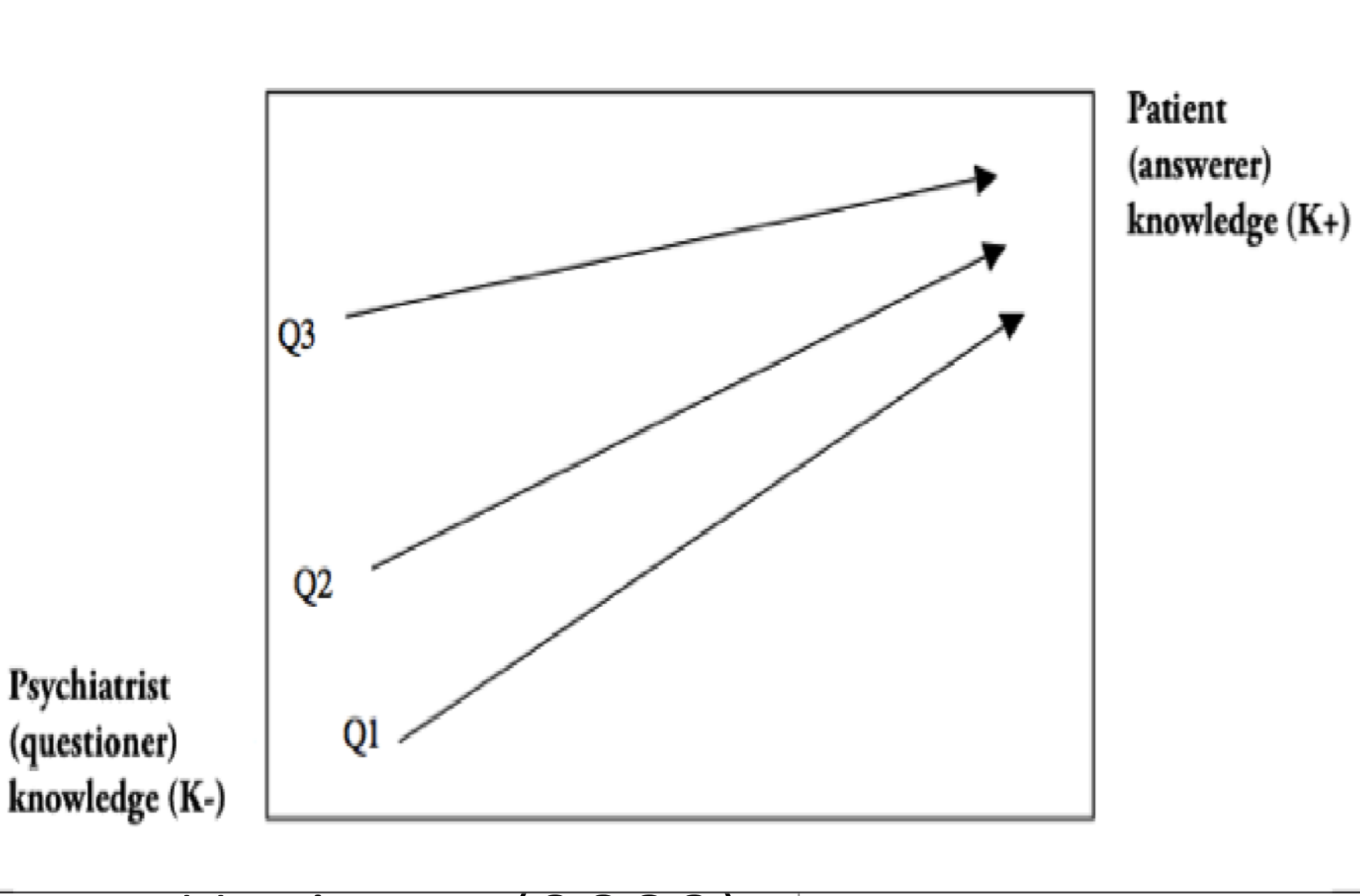
Epistemic gradient of different questions

Q1) Do you feel a bit anxious? (yes/no question)

Q2) You feel a bit anxious, don’t you? (tag question)

Q3) So you feel a bit anxious? (declarative question)

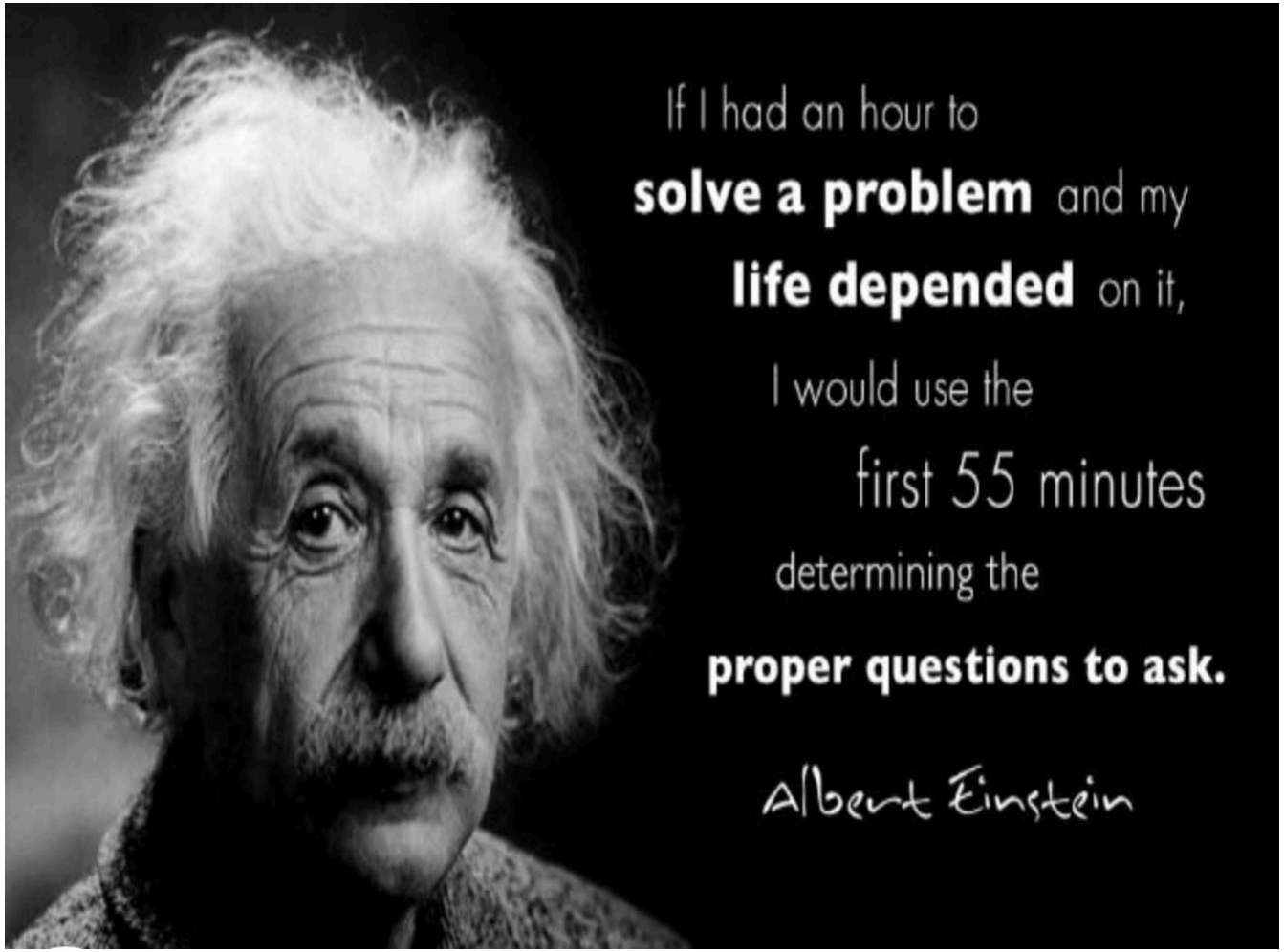
Each question displays a different stance towards ‘feeling anxious' information, only properly known by the patient



Heritage (2009)

Reviewing mental state

- “So you feel|think|find” + characterisation of patient’s personal/ emotional perspective
- within the activity of ‘reviewing mental state’
- sensitively closing down trajectories of talk and managing topic transition
- may be hearable as displays of empathy
- balance the psychiatrist’s tasks of assessment while attending closely to the patient’s experience


If I had an hour to
solve a problem and my
life depended on it,
I would use the
first 55 minutes
determining the
proper questions to ask.
Albert Einstein

Same or different psychiatrist for in- and out-patient care?

Vicky Bird

Continuity or Specialisation?

Continuity

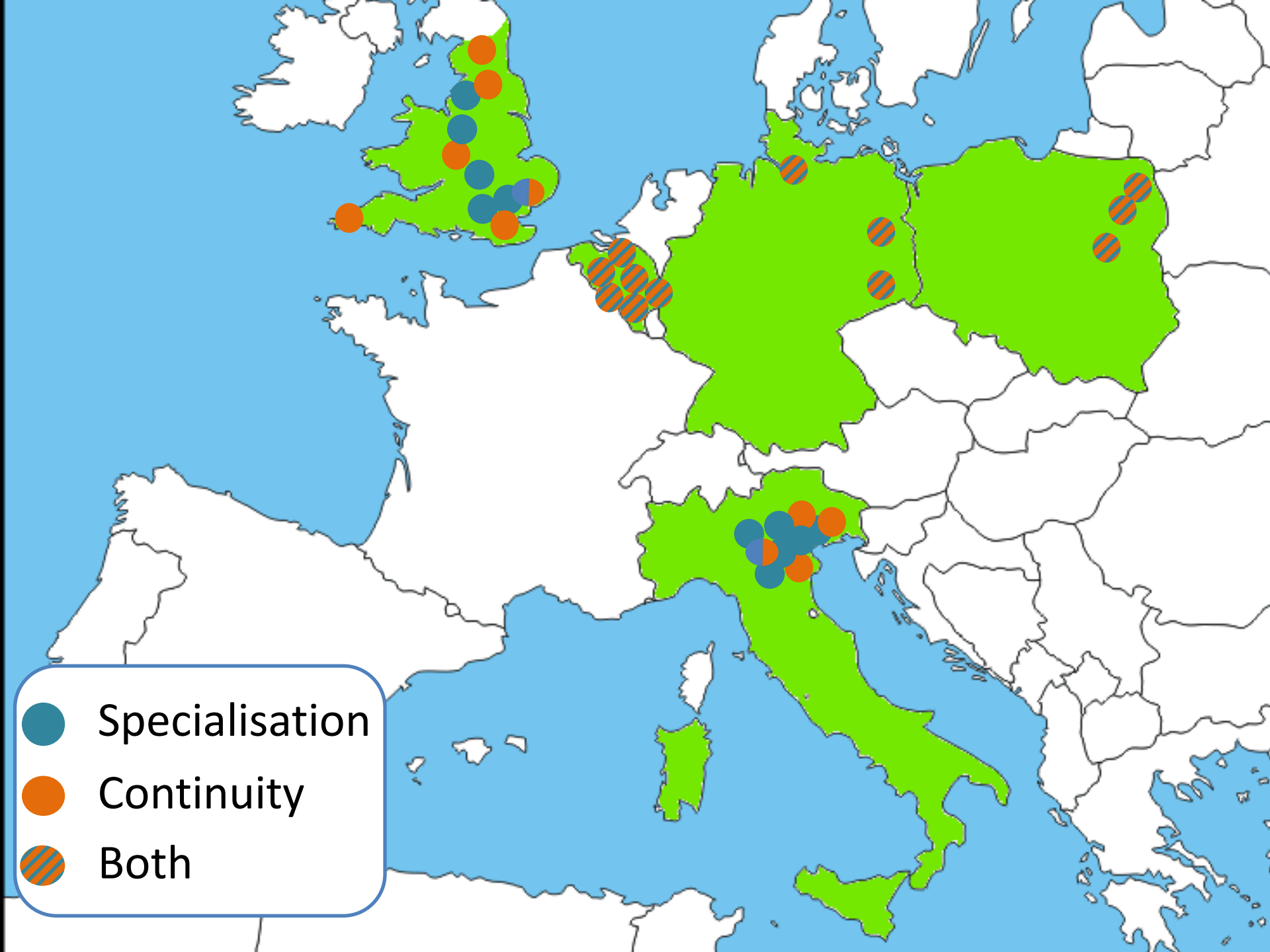
- Same mental health staff co-ordinate outpatient and inpatient care.

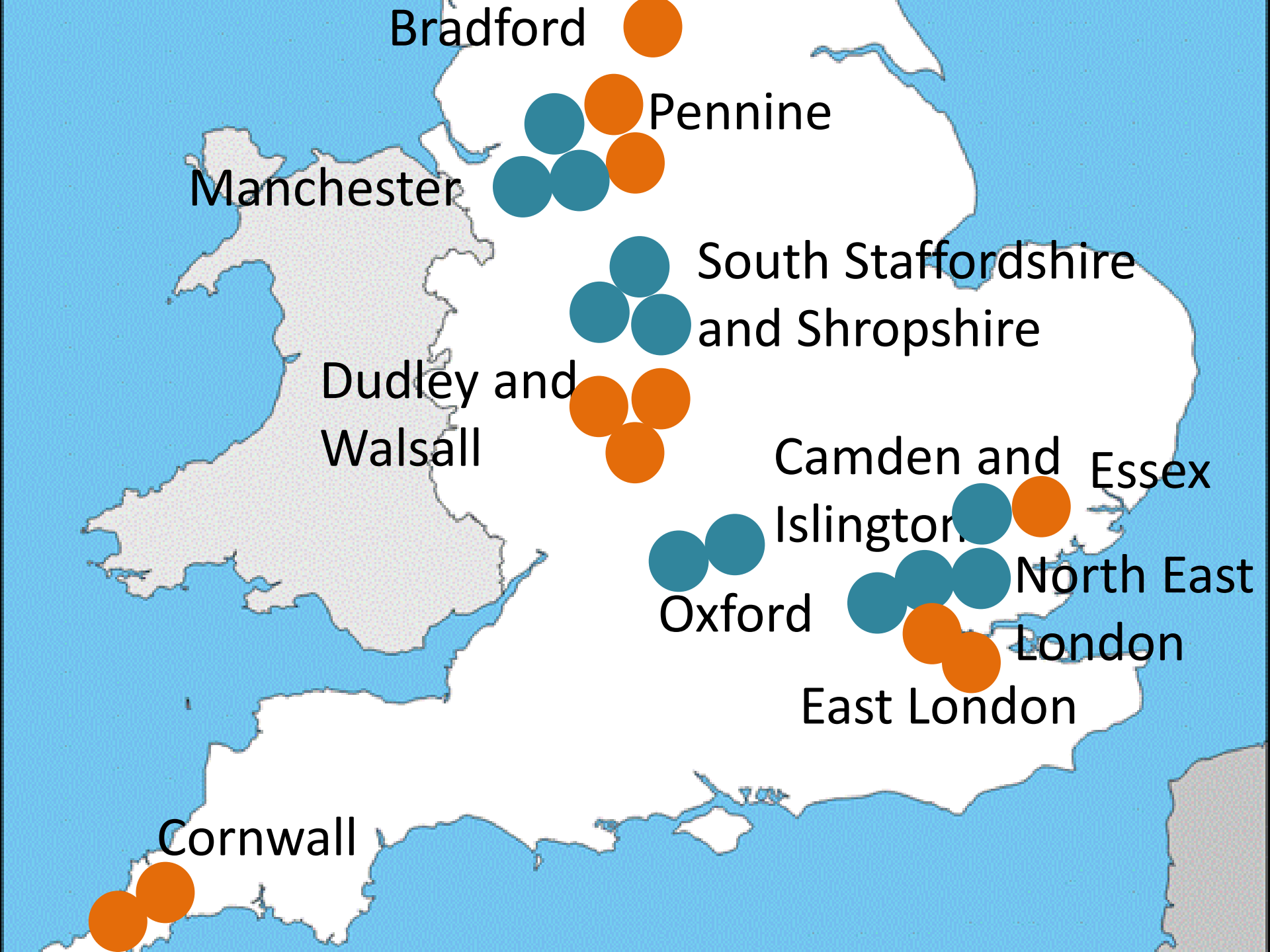
Specialisation

- Care is provided by different teams in distinct services (inpatient and outpatient), and the transition between services is coordinated through a network of regulated referrals

The COFI Study

- Natural experiment
- Comparing outcomes of patients with and without continuity of care
- 1 Year following admission to inpatient ward
- Across five countries with both approaches


Specialisation
Continuity
Both


Bradford
Pennine
Manchester
South Staffordshire
and Shropshire
Dudley and
Walsall
Camden and
Islington
Essex
Oxford
North East
London
East London
Cornwall

Inclusion criteria

- Patients approached within two days of hospital admission
- ≥ 18 years of age
- Clinical diagnosis F2, F3, F4
- Sufficient command of the language of the host country
- Exclusion: organic brain disorder; severe cognitive impairment

Follow up

- All patients:
  - re-hospitalisation
  - Social outcomes
  - Service use

- 360 sub-sample per country:
  - Quality of life and treatment satisfaction
  - Social situation and contacts
  - Detailed costs and quality of care

- 40 patients and 13 clinicians per country:
  - experiences

Preliminary UK findings

- Based on 2718 patients
- Continuity of care:

  a) **Shorter** length of stay – by circa **6 days**

  b) **Higher** initial treatment satisfaction – as measured by the Client Assessment of Treatment Scale (7 items on 11 point rating scale) - 7.0 versus 6.5

Conclusion

- COFI will be completed as planned by Feb 2017
- Inevitable methodological limitations
- So far, a clear winner in England
- Real world implications – how we organise services within the Trust (and beyond)

Closing remarks

Stefan Priebe

Thanks to

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- Karin Albani and Doris Holloway for organising the event
- All volunteers and researchers for their practical help today
- Jeremy Coid and Alan Simpson for chairing
- All speakers for their presentations
- All of you for attending!!!

finally, looking forward to

- Seeing you at the:

East London
Mental Health Research
Presentation Day
on 4th October 2017!

- Where?

➔ ***Referendum***


BREXIT
SHOULD WE STAY
OR SHOULD WE GO?
CITY OF LONDON
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VOTE
Counts