

Mental Health Care for Refugees

Evidence and recommendations for good practice

By [Domenico Giacco](#) and [Stefan Priebe](#) of the Unit for Social and Community Psychiatry

In light of the recent refugee crisis, the World Health Organisation has commissioned to the Unit for Social and Community Psychiatry, WHO collaborating centre for mental health service development, a review of the evidence on mental health needs of refugees and good practice for their care. The main findings are presented in this article.

Mental health needs of refugees

Overall, the rates of mental disorders identified in refugees vary substantially across studies.

This heterogeneity is mainly due to three factors:

a) The characteristics of the groups studied – for example background, qualifications and motivations – vary widely.

b) The context and situation in the host country: generally speaking, the poorer the host country the higher the rates of mental disorders in refugees.

c) The quality of the studies: studies of higher methodological quality generally report much lower prevalence rates than poorer studies with small and non-random samples.

Considering these problems, the most comprehensive reviews of the literature showed that:

- major depression rates in refugees are similar to those in the general population in Western countries;
- the prevalence rate of psychosis in refugees is around 2%, similar to psychosis rates among the general population in western countries (Llosa et al., 2014);
- refugees are about ten times more likely than the age-matched general population to have post-traumatic stress disorder (PTSD);
- 9% of refugees in general and 11% of children



Image © Unicef.

■ Families arrive at a reception centre for refugees in Idomeni, on the Greek-Macedonian border.

and adolescents have PTSD.

Hence, the very fact of being a refugee seems not to be the most significant criterion for the potential risk of mental disorders.

However, refugees can be exposed to various stress and traumatic factors that can negatively affect their mental health. These are commonly categorised as pre-migration factors (such as persecution, economic hardship), migration factors (physical

danger, separation), and post-migration factors (detention, hostility, uncertainty).

Once a mental disorder has become manifest in a refugee, post-migration factors are critical to whether the disorder (in particular depressive disorders) will become chronic. Lower mental disorder rates were linked to being in employment, having appropriate living arrangements, and feeling accepted in the host country.

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RESEARCH ASSISTANT WINS POSTER PRIZE



William Harvey Day is the annual research day for Barts and the London School of Medicine and Dentistry, part of Queen Mary University of London. First started in 1990, it is an opportunity to celebrate innovation and expertise in research. As well as the lecture series, posters of work carried out within the School are shown on the day and there is a competition for internal contributions. Eoin Golden of the Unit for Social and Community Psychiatry presented a poster on the EPOS trial (How effective is a new technology-supported intervention in improving patient's quality of life?) which won a prize for the 'Population Health' category.

HOW TO WRITE A SUCCESSFUL GRANT OR FELLOWSHIP APPLICATION

Successful grant writing takes careful thought as well as considerable skill. Experienced investigators appreciate just how much work and background development are required. However, those new to the 'game' are sometimes under the misconception that if they have a good research idea or it is clinically important, they are bound to succeed. 'Do good science and the rest will follow!' Unfortunately, this just is not true writes Professor Masud Husain of the University of Oxford in an open access paper in *Practical Neurology* (August 2015). Prof Husain offers helpful and practical advice to those writing applications. In addition, the MRC has published '12 top tips for writing a grant application' on its insight web journal (www.insight.mrc.ac.uk)

MORE PRIZE-WINNING POSTERS



At the 3rd International Clinical Trials Methodology Conference (ICTMC) held in November 2015, Paulina Szymczynska a PhD student in the Unit for Social and Community Psychiatry won the Student

Poster Prize for her poster titled "The Trialists' Perspectives on the Participant Retention in Mental Health Randomised Controlled Trials". Competition was very strong with 235 posters displayed at the conference. Put on by the MRC Network of Hubs for Trials Methodology Research, the ICTMC is an opportunity for people conducting research into the methods for trials to come together with those designing, conducting and using trials, to find and discuss the most appropriate ways to improve health by improving trials.

QUEEN MARY UNIVERSITY OF LONDON TOPS THE GUARDIAN LEAGUE TABLE IN LONDON

Queen Mary University of London, with whom the Trust collaborates extensively both in research and teaching, was placed number one in London for both Medicine and Dentistry and, even more impressively, second in Medicine and third for Dentistry from amongst all UK Universities.

Mental Health Care for Refugees: Evidence and recommendations for good practice

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Challenges in providing refugee mental health care

There are several specific challenges to providing mental health care to refugees, the extent of which varies depending on a range of factors, including where the refugees have come from and the amount of time they have spent in the host country.

- a) Language barriers: refugees often have a poor command of the language of the host country, requiring an interpreter during consultations. Even if interpretation is available, the lack of direct communication may complicate proper assessments.
- b) Belief systems: different belief systems may hinder mental health assessments and conflict with the practitioners' understanding. An example is the possible tendency to seek physical explanations for psychological problems.
- c) Cultural expectations: refugees may have different views on what to expect from mental health care and on what kind of information they want to disclose. This may impact on whether they accept a mental health diagnosis and treatment.
- d) Establishing trust: Refugees may be particularly distrustful of services and authorities because of previous negative experiences. Moreover, they may be unfamiliar with the health care system in the host country.

Good practice in providing mental health care to refugees

The most important strategy for reducing the risk of mental disorders in refugees once they have arrived in the host country, is general support: meeting their basic needs and ensuring their safety, and that they are accepted and integrated into mainstream society. Integration, including support in the national education system, is especially important for children and adolescents among refugee groups.

More specific evidence-based recommendations for good practice are:

- Establishing outreach programmes for larger and difficult to reach groups of refugees. Outreach should aim to establish a trusting relationship, facilitate first contacts with professionals in the host

country, and help refugees to overcome barriers in accessing mainstream services for physical and mental health care.

- Adopting a generalised and multidisciplinary approach, in which physical health care and mental health care are provided with as little fragmentation as possible and facilitated by flexible administrative procedures. This is particularly relevant for refugees presenting with multiple health needs.
- Optimising the coordination of services. Research has shown that in almost all western countries, experts identify the fragmentation of care systems as a major problem for marginalised groups, such as refugees. Coordination should include specialised, as well as generic, services.
- Providing sufficient information about entitlements and available services both to refugee groups and to the professionals dealing with them. Even in well-resourced areas, this information is often missing or presented in ways that are not fit for purpose. New technologies may support this and also help the provision of interpreting services.

How can good practice for mental health care of refugees be implemented?

Implementing the good practice recommendations requires funding, appropriate service organization, and staff training.

- e) Sufficient funding will ensure that enough care services are in place to deal with potentially large numbers of refugees, to make sufficient interpreting services available when needed, and to disseminate information to refugee groups and professionals.
 - f) Appropriate service organization can help reduce administrative barriers and complex referral procedures, optimise the allocation of resources, and ensure good coordination. New technologies may help with this.
- Training and supervision programmes for mental health professionals may enable staff to develop a better understanding of the background and experiences of refugee groups, and equip them to provide the best possible advice and treatment in a culturally appropriate manner.

Upcoming Events Research Training Sessions

The Academic Unit at the Newham Centre for Mental Health holds fortnightly training sessions on a variety of topics of interest to those undertaking research in the NHS. The training is held from 11:00 – 12:00 on a Wednesday in the Lecture Theatre; for more information, contact Husnara Khanom by email at Husnara.Khanom@elft.nhs.uk

Date	Title	Presented by
7 September 2016	<i>Self Stigma</i>	Elizabeth Corker
21 September 2016	<i>Elements Website and REF</i>	Jeremey Claridge
5 October 2016	TBC	
12 October 2016	<i>Sustainability in Mental Health</i>	Dr Francis Mortimer
19 October 2016	<i>Project Master File</i>	Carolanne Ellis

WHO event explores the future of mental health care



World Health Organization

The Unit for Social and Community Psychiatry, established jointly by ELFT and Queen Mary University of London (QMUL), has hosted 18 experts from five European countries to discuss and explore options for how mental health care could be provided in the future.

Mental health care has improved over the last few decades in line with increased funding, but there have been no new significant research discoveries or service models. Innovation is therefore required, and by looking at the way past innovation has been carried out, this is likely to be driven by social values and social models.

The Unit for Social and Community Psychiatry (USCP), in collaboration with the World Health Organization (WHO), has been looking at how new

social scenarios could drive forward the science and practice of mental health care.

Professor Stefan Priebe, the USCP Director, said: "This has been an exciting and most encouraging event. Ideas of social psychiatry may lead to real innovation and possibly radical changes of how mental health care works in the future, what research will focus on, and how professionals will be trained. These changes may take time to materialise, but research at QMUL aims to contribute to them and begin to shape them now."

The discussion considered different future social scenarios, how they might progress research and practice in psychiatry, and what this would mean for the training of professionals.

At the end four speculative potential scenarios of

- future mental health care were designed:
- Mental health care would be determined by human rights issues and without coercion. Patients will control service models and the funding of their care. Psychiatrists will actively engage with politicians to advocate for human rights of patients.
 - The social context of individuals would be modified in order to improve their mental health. This will require a deeper understanding of how social interactions influence mental health and better research methods for studying these interactions and developing new interventions.
 - Mental health care would be provided almost exclusively via online tools and only emergency services will be available on a local basis. Care will be largely virtual using artificial intelligence, linking patients to both real and virtual social contacts.
 - Mental health care would be part of an integrated and holistic health care for socially marginalised groups. Access to services will be regulated based on social deprivation.
- The team will continue to work on developing and revising these scenarios, with a view to publishing their final findings in the near future.

Can mental health interventions change social networks?

It is widely understood that people with severe mental illnesses, such as psychosis often have small social networks, with an average of 6 contacts. These contacts are usually made up of family members, mental health professionals and friends.

Multiple reasons have been recognised for the difficulty in establishing social relations, some being illness related, such as symptoms or being socially disadvantaged, where being unemployed may reduce the likelihood of establishing new contacts. The challenge in mental health is to overcome the issues surrounding patients with small social networks. Previous interventions have focused on social skills training, to equip patients with enough social skills to socialise, but results have found that they mainly fail in helping patients to create real life contacts. There has been little research into whether specifically targeting small social networks leads to an increase in social contacts.

A systematic review (Anderson et al, *BMC Psychiatry* 2015) included reviewing all randomised controlled trials (RCTs) whose primary aim is to improve the social networks of patients with psychosis, to determine the effectiveness of existing psychosocial interventions. A total of five papers met the inclusion criteria, as their primary aim was to increase social contacts. These studies were conducted in, Italy, Ireland, Netherlands, Spain and Israel. The interventions offered to patients across these studies were, patients working closely with staff to identify areas of interest and how they could get involved in social activities, one included a volunteer + stipend, meeting with a volunteer to do activities



in the community or a stipend only (\$20). Another intervention involved delivering groups, namely guided peer support, where a nurse would initiate a discussion related to illness within a group and allow group members to guide the discussion.

Another study involved delivering social cognition training, where patients worked in groups to discover their social cognitive impairments. Both the control and intervention group received 'social mentoring' which involved weekly meetings with a mentor to help set goals related to the patient's social life, such as organising finances.

Lastly, was the integrative psychological therapy (IPT) intervention, where they used a structured group where they focused on cognitive differentiation, social perception, verbal communication and social skills training and problem solving. The experimental group also had a therapy dog, where it was believed the presence of a therapeutic animal can have a positive effect on social interaction. It was found that four out of the five interventions, successfully increased social network sizes.

Peer support groups, social cognition training, integrative psychological therapy and working alongside staff to establish areas of interest and help approaching activities in the community.

To conclude, it could be said that although previous research has failed to show an increase in social networks following social skills interventions, interventions that directly target social connectedness appear to be promising, especially when interventions include a member of staff who offers support or delivers the intervention.

Care Planning and Care Coordination in Community Mental Health: What makes it collaborative, recovery-focused and personalised?

By **Professor Alan Simpson**
City University of London

This is a summary of the findings from a research study, Cross-national comparative mixed methods case study of recovery-focused mental health care planning and coordination: Collaborative Care Planning Project (COCAPP) which was carried out by a team of researchers from three universities: City University London in England, and Cardiff and Swansea Universities in Wales.

The research was carried out in six NHS mental health service provider organisations: four in England and two in Wales. One of the reasons for carrying out the research in both England and Wales is that Wales has a legal framework in place called the Mental Health Measure, introduced in 2010.

This is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. In England, care planning is informed by guidance and is not legally required.

Although there are two different systems in England and Wales, both mean that people receiving mental health services should have a care coordinator, a written care plan and regular reviews of their care. With the introduction of the recovery approach and personalisation, it is now expected that care planning and coordination should be recovery-focused and that people will be taking more control over their own support and treatment.

We wanted to find out what helps and what hinders care planning for people with mental health problems to be collaborative, personalised and recovery-focused.

By collaborative we mean that care planning is completed in partnership with the service user: the care coordinator works with the service user to plan their care.

By personalised we mean that care is designed with the full involvement of the service user and designed to meet their individual needs.

By recovery, we mean 'a personal journey ... one that may involve developing hope, a secure base and supportive relationships, being more in control of your life and care, social inclusion, how you develop coping skills, and self-management ... often despite still having symptoms of mental illness.' (Anthony WA (1993) *Psychiatric Rehabilitation Journal*, 16(4), 11-23)

The focus of our research was on community mental health care. We wanted to find out the views and experiences of all of the different people involved: care coordinators (in community mental

health teams), managers, senior practitioners, service users and their carers.

1) We carried out an extensive literature review.

2) We sent out questionnaires to large numbers of people, and received replies from service users (449) and care coordinators (205); these included questions on recovery, therapeutic relationships, and empowerment.

3) We interviewed senior managers (12) and senior practitioners (27), care coordinators (28), service users (33) and carers (17).

4) We reviewed 33 care plans with the permission of the service users concerned.

What did we find?

- There were no major differences between the six sites on the empowerment or recovery scores on the service user questionnaires;
 - There were some significant differences between the sites on therapeutic relationships: where there was good collaboration and input from clinicians, relationships were rated as more therapeutic;
 - We also found significant differences between sites on some recovery scores for the care coordinators: where they saw a greater range of treatment options, the service was rated as more recovery-focused;
 - We found a strong positive correlation between scores on the recovery scale and the therapeutic relationship scale for service users; this suggests that organisations perceived to be more recovery-focused were also perceived as having more therapeutic relationships.

Some common themes across sites...

- **Austerity and re-structuring:** Cuts and merging of services, increased workloads, integration of health and social care services, refocusing of services, increased use of voluntary services;
- **Bureaucratic factors:** Administrative burden, inflexible computer systems, unwieldy documentation, little training in coordinator role/recovery approaches, high caseloads preventing recovery-oriented work;
- **Contradictory policies:** Some policy developments appeared to go against a recovery focus (e.g. Payment by Results, Community Treatment Orders); whereas others supported the recovery-focus (e.g. personal budgets);
- **There were varied experiences of care planning** from the perspectives of service users, carers and care coordinators within and across all six sites with no distinct reasons for these variations identified.
 - There is a **tension** between the standardisation

of documentation and the ability for the care planning approach to focus on the individual's needs.

Care Planning:

- Overall, there were major challenges in trying to make care planning and coordination meet the different needs of service users, practitioners, managers and commissioners;
- Care plans were seen as largely irrelevant by most service users who rarely consult them;
- Care coordinators regarded care plans as a useful record but also an inflexible administrative burden that restricts time spent with service users. Once written, they rarely consulted them.

Care planning and therapeutic relationships:

- Service users value their conversations and relationships with care coordinators more than they do care plans;
- Relationships with care coordinators, support workers, family and other carers are seen as far more important to recovery.

Risk and safety

- Risk is a very significant concern for managers and clinicians. However, it did not appear to be openly discussed with service users (or carers); they were often unaware that risk assessments had taken place;
- This appears to limit the involvement of service users (and carers) in exploring and managing their own safety, and prevents positive risk-taking from becoming a part of people's recovery.

Recovery and personalisation

- We found great variation in understandings of recovery and personalisation, both within and across sites and within groups of staff, service users and carers.

Conclusions

- Positive therapeutic relationships appear to be the most important factor in helping care planning and care coordination to be personalised and recovery-focused;
- Excessive administrative tasks and inflexible information technology should be addressed in order to increase the time staff can spend with service users and carers;
- Everyone involved needs to have a shared understanding of the ideas behind recovery and personalisation, developed in partnership with service users, carers, and frontline practitioners;
- Training may not be enough to bring about the necessary changes without also addressing the wider political and organisational issues.

We recommend research to investigate new ways of working and training to increase staff contact time with service users and carers and to improve a focus on recovery.

Adolescent Sibling Groups within a CAMHS Disability Service: Service User Perspectives



By **Bethan Manford** (Assistant Psychologist) & **Dr Carolyn Gracey** (Clinical Psychologist): Hackney Ark, Homerton University Hospital NHS Foundation Trust & **Jenny Breen** (Trainee Clinical Psychologist). Royal Holloway, University of London.

Adolescence is a period where many developmental changes take place. Identity, belonging, puberty, position of self in families and society poses many questions for young people to understand. Sibling groups provide a space where young people can meet other siblings, discuss common joys and concerns and learn to manage situations often experienced (D'Arcy et al, 2005). Sibling group participation supports self-esteem and knowledge of disability (Smith & Perry, 2004). Literature suggests that siblings of children with a disability have additional responsibilities and benefit from time and space for psychological self-adjustment (Petals et al, 2009). This research was conducted to assess how an adolescent sibling group was able to better meet the needs of young people with a sibling with a moderate or severe learning disability.

The CAMHS Disability team is a specialist tier 3 NHS provision for children with disabilities and mental health/emotional problems. Much of our work is with children with significant learning disabilities. We facilitate groups for siblings aged 6-11 and 11-19. Feedback has shown that these groups are valuable for young people to think about their wellbeing.

Siblings have opportunities to play, learn and process relationships and narratives both within and outside of family life. Our adolescent sibling's group attendance was poor and we wanted to think together with young people about ways to make the groups a better fit and to improve future attendance. There is also a paucity of services for siblings of young people with moderate-profound disabilities. There is also a paucity of service user involvement research where young people are able to influence how services are provided. We aimed to take into consideration systemic family needs where there is a child or young person in the family with a significant disability.

Methodology:

A qualitative approach was adopted using a focus group and a semi structured interview format. Questions centred around what siblings gained from the group, what they found difficult and ideas for improvements. The session was audio recorded and notes taken by facilitators and siblings for shared ownership. Participants were siblings who had previously attended group interventions for adolescents at Hackney Ark. We discussed the research with these young people who had attended previous groups and invited 7 to participate. 2 young females (aged 12) took part in the focus group. Some adolescents who were invited did not attend and we were able to ascertain factors for drop out from sending a short questionnaire by post. Reasons for not attending included: being on holiday and being the only boy in the groups. Our inclusion criteria invited young people of a similar age group (those aged 11-19), who had attended a Hackney Ark adolescent sibling group in the last two years. They also have a sibling with moderate-profound disability. In regards to ethical considerations, an information sheet was given to the adolescents and their parents. Informed consent was given by parents and young people. Right to withdraw, confidentiality and anonymity were explained to the young people.

Several key themes and sibling narratives emerged:

- **Improved understanding and coping**
"It gave me ideas about how to cope with my brother and helped me to communicate better with him; our relationship bond is stronger"
- **Shared experiences and stories (normalising)**
"Sometimes my brother shouts and I don't know why"
"You feel like you're the only one that feels this way, like you are the only one in the world. But when you realise that other people feel this way, it kinda actually makes you feel glad and quite grateful. I can understand similar experiences"
- **Safe place**
Access to a place siblings felt empowered and

could trust group members to share thoughts and feelings "I felt I could trust you guys"

- **Roles and responsibilities**
Personal and shared, within the group, families and society "I'm kinda like the younger mum"

- **Learning and teaching**
Experts by experience, learning and teaching facilitators, each other and those in the community their siblings meet "At first it's hard to understand their communication and actions, how they react to stuff but eventually you will get used to it all and it will get easier"

- **Making connections**
Connections made with each other, with facilitators and their families. A desire for broader society to understand. "I think what stops other people coming is probably, they might feel embarrassed having a sibling with a disability. I used to be embarrassed but now cos like I understand, I don't feel that way..."

- **Championing**
Speaking on behalf of their sibling & wanting to broaden understanding to reduce stigma in the community

- **Hope and resilience**
Future positive change and an overall sense of self awareness, adaptability and various abilities to cope with stressful situations

Conclusion:

In line with previous findings, the focus group outcomes suggest that siblings benefit from attending groups at CAMHS. These groups increased adolescents' understanding of their brother / sisters disability provided a space for understanding how to manage their own emotions and reinforced strategies to improve coping. An overall theme resounding from the young people was resilience. In terms of implications, the groups built positive identities and networks for young siblings. Siblings groups can help create a broader network in the local community thus supporting the journey of coping with disability in the family. There is a need to implement service user ideas to increase attendance to the groups for adolescent siblings being led by their needs.

Recommendations:

It would be helpful to review the referral process and look further into a different venue for the adolescent groups. It would also be useful to explore further with siblings who have and have not attended who were referred to explore barriers to engagement. Having groups more frequently and in a youth hub may increase attendance and enable siblings to build stronger connections with others. Future studies could work further with siblings throughout the entire research process (co-production) and promote service user involvement

Burnout syndrome among psychiatric trainees



By **Nikolina Jovanovic**,
Clinical Lecturer & Psychiatrist Unit
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What is staff burnout and why is it important?

Recruitment and retention in psychiatry have been two issues of major concern in recent decades. While negative perception of psychiatry may discourage medical graduates from entering the field, reports from doctors leaving psychiatry have indicated reasons such as high numbers of challenging patients, depressing work conditions, job stress and low morale among staff.

Work-related burnout syndrome is characterised by high levels of emotional exhaustion, cynicism, and low sense of professional efficacy. Staff burnout has been associated with impaired patient care, reduced learning capacity, stress-related health problems, and broken personal relationships. Persistent imbalance between demands and resources seems to be a crucial contributor to development of burnout. Training years, more than any other stage in physicians' career, are characterised by this type of imbalance due to long and irregular work hours and high levels of responsibility combined with lack of professional experience. Psychiatry itself adds several very specific stressors such as perceived stigma of this profession, demanding therapeutic relationships, personal threats from violent patients and patient suicide. However, very little is known regarding burnout rates, or indeed factors influencing burnout syndrome among psychiatric trainees.

Our study

This study was created to better understand burnout among psychiatric trainees, and explore which

individual, educational and work-related factors are associated with severe burnout. During 2008 – 2012 period we asked 1980 psychiatric trainees from 22 countries to complete the Maslach Burnout Inventory (MBI-GS) and provide information on individual, educational and work-related parameters.

On average, participants had started psychiatry training at the age of 28.5, at the time of study they had completed 2.8 years of training and were 32 years of age. For the vast majority (80.2%), psychiatry was the first career choice and this decision was made mostly after medical school. Participants reported an average of 53.7 working hours per week divided between the workplace and doing work assignments at home. The majority of the sample (68.2%) was working more than 48 hours per week on average. Regular weekly clinical supervision was available to 1666 (83.9%) trainees, ranging from one to five hours per week. A total of 286 trainees (14.4%) reported not having any supervision for their clinical work.

Risk factors for burnout among psychiatric trainees

Besides national variations, results from our study show that approximately two thirds of the sample was extremely emotionally exhausted and one third of psychiatric trainees met criteria for severe burnout. In the UK sample 38% trainees met criteria for severe burnout.

The risk was increased by several individual factors such as not opting for psychiatry as a first career choice, not having children and younger age. Educational characteristics such as years spent in training and other postgraduate education were not significantly associated with severe burnout. Even

after adjusting for these individual differences, country differences in burnout rates, and years in training, three work-related factors remained positively associated with severe burnout: long working hours, lack of clinical supervision, and not having regular time to rest.

Conclusion

This is the largest study on burnout and training conditions among psychiatric trainees to date. Besides previously described risk factors such as working hours and younger age, this is the first evidence of negative influence of lack of supervision and not opting for psychiatry as a first career choice on trainees' burnout.

The effect of working hour limitations has been studied extensively and it was found that trainees who reported working more than 80 hours had higher rates of burnout than after the time restriction. In this study long

working hours increased the risk for high emotional exhaustion and severe burnout even when only hours at the workplace were taken into account (without hours spent on work assignments at home).

Supervision has been often considered as a unique learning experience for psychiatric trainees. Trainees can use it to reflect on their practice and it also supports development of competence and professional identity. In the light of the known importance of clinical supervision, it is surprising that almost 15% of trainees in this study did not receive regular weekly supervision (or did not perceive it as such). Despite several reports which have highlighted problems over structure and content of supervision, the topic lacks systematic research and remains a largely under researched area.

The impact of not choosing psychiatry as first career choice (in 19.8% trainees) on developing severe burnout could be related to the lack of interest and motivation to persevere with training, and endure its more demanding aspects. This finding needs to be discussed in the light of recruitment challenges in psychiatry.

A starting point

This report can serve as a starting point for wider discussions regarding psychiatric training. With shortage of qualified psychiatrists, most countries today cannot afford to lose trainees for reasons such as poor training conditions and development of work-related burnout. Also with current unfilled training posts, it remains likely that trainees who fail to attain a training post in a preferred discipline will be recruited into psychiatry training presenting both challenges and opportunities for trainees and training systems.

Supporting patients with Medically Unexplained Symptoms (MUS): an innovative care pathway piloted in primary care

By **Frank Röhrich**, Consultant Psychiatrist
& Associate Medical Director

Currently, patients with MUS (also called somatisation disorder or "functional symptom/distress disorder" in newer classification systems) often have unmet health needs as a result of incorrect diagnosis; it is difficult to engage these patients in holistic care and consequently treatment is often ineffective. This is despite frequent presentation at primary and secondary care services, resulting in high cost pressures to the health economy. Existing models have not met the complex needs necessary to achieve positive health outcomes for this group

The Health Foundation gave ELFT a SHINE award of £75,000.00 to pilot a new programme in primary care offering patients with MUS a new care pathway over a period of 18 months (June 2014 to December 2015) in Newham. Professor Frank Röhrich was the lead clinician and project lead and Nina Papadopoulos was the project manager, supervisor and trainer. The project also employed a specialist doctor/researcher, Dr. Ivan Zammit, two dance movement psychotherapists, Claire Burrell and Layla Smith and a mindfulness practitioner, Stephen Smith.

The Health Foundation funded open trial project evaluated the feasibility and explored the cost/clinical effectiveness of this novel care pathway that provides a holistic Primary Care service. Health care for patients with MUS was delivered in a "one-stop-shop" fashion in GP surgeries including the following steps: Identification (via specially designed algorithm), Assessment, Engagement and Group Interventions, i.e. Mindfulness Stress Reduction (MBSR) and Body Oriented Psychological Interventions as "Strategies for Better Living" groups (SBLG). Both interventions were entirely focused towards helping patients to improve their overall coping and to foster wellbeing, without challenging and/or clarifying patient's health beliefs.

The findings of the project analysis demonstrate that despite difficulties regarding GP and patient take up / acceptance, patients who participated in the project gained significant improvements in symptom levels and this resulted in corresponding significant reduction in health care utilisation.

Experience from a nationwide pathfinder project in the UK suggests that patients with MUS from ethnic minorities were very difficult to engage and even less likely to benefit from the treatments. In this project about 75% of patients included were from ethnic minorities and a high percentage had very limited English language skills; the findings of the study indicate that the novel care pathway can

successfully provide care for this difficult to engage patient group.

Patients were identified from seven GP practices in Newham. The GP leads were keen to embed the project in their surgeries as, after presentations and training by the Project / Clinical Lead and Project Manager, they realised the potential benefit of the interventions for their patients in terms of their patients' managing their health problems more independently and effectively; also GPs were very positive about being able to offer this 'very difficult to treat' group of patients other treatment options, thus reducing their dependence on GP and specialist consultation time. The GP surgery administrative staff were very helpful in setting up clinical consultation and therapy rooms and generally ironing out admin issues that arose.

In our project a total number of N= 145 patients were referred and assessed for eligibility over a period of 10 months, and N= 98 were included in the trial intervention; N=13 declined to participate, N=31 did not attend baseline assessment, three patients did not meet inclusion criteria.

In addition to receiving an in-depth comprehensive and psychoeducational baseline assessment of their condition, 61 patients took up the offer to participate in one of the two group interventions (N=44 SBLG, N=17MBSR).

We collected outcome data for 93 patients from GP electronic recording systems (service utilisation) and through questionnaires (symptom levels and health-related quality of life). The analysis showed that the symptom levels reduced significantly from baseline to follow-up assessment corresponding with a significant reduction in service utilisation (GP contacts / consultations and referrals to specialist services). The analysis of qualitative data (feedback from patients and therapists' structured accounts) suggested that patients who participated in the intervention had additional health benefits in terms

of a more inclusive understanding of their health condition and improved self-management control / coping skills. Some systematic and significant barriers as well as enablers

to pathway implementation and also in respect of patient identification and patient uptake of the intervention were identified. GPs operate under intense time constraints, thus not allowing them to dedicate enough time to running the proposed case finding algorithm; their day-to-day running of surgeries is so tightly managed that it leaves hardly any room for research into additional treatments/interventions. The innovative approach our project was offering is a much more holistic approach and did not adhere to a traditional medical model. GPs were not always able to explain fully the interventions and benefits of this approach to patients. In addition patient engagement was very challenging as the narrative for understanding their MUS is based on the medical model. Offering a holistic treatment was not always readily and positively received.

Despite these difficulties the outcome of the project was very positive and the Health Foundation encouraged us to apply to them for further funding to disseminate the results. We applied and were awarded a further £30k for 'Spreading Innovation: Supporting Dissemination', a new project which will take place between January 2016 to January 2017. The objectives of this project are to:

- disseminate the findings of the Health Foundation funded clinical open trial
- raise awareness amongst major stakeholders in respect of the scale of the problem, associated burden to the health economy, specific clinical needs of the patient population and possible solutions in terms of care pathway developments
 - enthuse commissioners in respect of setting up a novel and innovative care pathway that combines clinical and cost effectiveness and stands good chances of reducing expenditure
 - gather a group of interested and dedicated GP mental health leads in order to develop champions for further spreading/implementation
 - contribute to upskilling primary care practitioners (GPs, nurses and dance-movement psychotherapists)
 - develop the workforce for the delivery of the novel body-oriented interventions for MUS sufferers
 - develop an information and networking platform for both clinical staff and service users

By providing a package of teaching and training for primary care providers and a cost/clinical effectiveness and implementation information package for commissioners, the project will be spreading improvements achieved in the context of the East-London pilot (Health Foundation funded SHINE innovation project). In doing so, we will embed those findings in the context of the wider evidence base relevant to providing clinical and cost effective care pathways for this particular patient group.

■ For more information contact Frank Röhrich
at Frank.rohrich@elft.nhs.uk

Double take on research quality

Combined expertise on two key aspects of Noclor's services – Regulatory Compliance and Sponsorship – ensures that support is given only to research of the highest scientific and ethical standards.

Any research study at an NHS site requires the appropriate permission before it can start, so Noclor offers specialist advice to guide researchers smoothly through the procedural web of legal requirements and forms to be completed. For all research, local permission must be sought directly from the NHS organisation where the research is to be conducted. Noclor arranges this permission for any research conducted at its NHS partner sites.

Studies that are awarded a research grant can be accepted to the NIHR Portfolio, which enables access to support staff and facilities from the local Clinical Research Network. Another key requirement for any research study in the NHS is that it has a sponsor, who acts as guarantor that the research is designed, conducted and reported to internationally-recognised principles of Good Clinical Practice (GCP) and relevant legislation.

Ideally, a sponsorship request should be made at the time the research protocol is being developed, or at the grant application stage. Formal declaration from the designated sponsor is required before any application to the Health Research Authority (HRA) and any other regulatory authorities can be made.

Commercial trials have commercial sponsors. For non-commercial research, the appropriate sponsor may be the funding organisation, the organisation that will administer the funding, the employer of the Chief Investigator, or the lead care organisation where the research is to take place.

Noclor provides sponsorship support services to its partners. If researchers require a Noclor partner to act as sponsor, then they should request it prior to applying for any other permission.

“Research can get results that benefit the public through innovation.”

Mabel Saili, Noclor's Research Management and Governance Manager, heads the team responsible for the research governance approval process. She helps resolve any issues that the team may be experiencing, and responds to complex queries from researchers. For support or information, contact: mabel.saili@nhs.net



“Without high-quality research, treatment cannot improve.”

Emmanuel Rollings-Kamara, Noclor's Regulatory Compliance Manager, is responsible for training his team members to ensure that they give researchers an excellent level of service, and also reviews applications for sponsorship. For support or information, contact: emmanuel.rollings-kamara@nhs.net



Social networks of patients with psychosis

By [Alkesandra Matanov](#), Research Assistant, Unit for Social and Community Psychiatry

Social networks are important for both mental and physical health as they can help individuals to cope with stress. Large studies have shown that social isolation is a major risk factor for morbidity and mortality. Individuals with psychosis may have specific difficulties in establishing and maintaining social relationships. This could impact on their well-being and quality of life. Previous research on patients with severe mental illness has shown that their social networks tend to be smaller and mainly composed of family members. Illness-related neurocognitive deficits, but also various social stressors may result in difficulties in social interactions and lead to social isolation. For example, stigma attached to a diagnosis of schizophrenia and associated disorders can significantly reduce opportunities to form relationships.

Social disadvantage resulting from loss of employment and financial problems may increase isolation further. The type of symptoms, length of illness, and frequency of hospitalisation also impact on the number and quality of patients' social ties.

Some authors argue that demographic and family structure changes in modern societies may reinforce social deficits experienced by people with psychosis. Increasing numbers of people live away from their family, or live alone. Ability to form new social relations outside the family circle is becoming increasingly important in contemporary society,

particularly in large cities.

Assessing characteristics of social networks in a systematic manner has been advocated as a priority for mental health research. In particular, their size is important both as a relevant outcome criterion of psychosocial interventions, and as a factor influencing quality of life and service use.

Against this background, the aim of our study was to systematically review the papers reporting the size and composition of social networks of individuals diagnosed with psychotic disorders, as well as the papers reporting the size of their friendship networks. The resulting paper (recently published in BMC Research Notes) contributes to information on social needs of this population, and also provides an insight on advantages and limitation of current assessment methods.

We conducted a systematic search of three bibliographic databases and scrutinised the reference lists of relevant scientific papers to identify any further literature.

We also carried out a hand search for studies in key journals, reviews on the topic and conference abstracts. Papers were included if they described studies conducted on adults (i.e. ≥18 years of age) suffering from a psychotic disorder (i.e. including a standardized diagnosis of either schizophrenia, schizoaffective disorder, “narrow schizophrenia” spectrum disorder, or “psychosis”).

Available data on the size of the total social networks and friendship networks were summarized

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OTHER NEWS

RESEARCHFISH: DEMONSTRATING THE BENEFITS OF NIHR FUNDED RESEARCH

In the current economic climate the NIHR has declared that it is vital that it can prove its worth in hard data. Researchfish (www.researchfish.com) is the main way this information is gathered and it relies on information provided by investigators during the submission period. This data contributes to reports and decision-making such as the comprehensive spending review.

All recipients of NIHR research or training awards are required to report on an annual basis through Researchfish. If you have any questions please contact evaluation@nihr.ac.uk

PROFESSOR DAME SALLY C DAVIES RESPONDS TO ‘GOING THE EXTRA MILE’

Professor Dame Sally C Davies has responded to ‘Going the Extra Mile’, the report she commissioned in March 2014 from the Breaking Boundaries Review Panel to provide an independent review of public involvement in research in the NIHR.

“Breaking boundaries” is a reference to the removal of barriers between service users and researchers. Nearly ten years after the NIHR was established, it was thought timely to consider how far the NIHR and related activity had come on in terms of public involvement, engagement and participation journey and where we would like to be in another ten years' time.

Having reviewed the report's recommendations, Dame Sally has agreed that the NIHR takes them forward. This important work will be led by Simon Denegri, who is the NIHR's National Director for Patients and the Public in Research, with support provided by the INVOLVE Coordinating Centre. The NIHR community will work in partnership to deliver the recommendations of the report.

NEW GUIDANCE ON NHS EXCESS TREATMENT COSTS

The NHS has published new Guidance on Excess Treatment Costs (ETCs) for research covering both how to meet these costs and the responsibilities of commissioners, providers and researchers in the funding of ETCs.

This guidance (which can be found at www.england.nhs.uk/commissioning/research/etc) reflects the already existing policies and principles, but is intended to provide guidance on how such costs should be identified and how the payment of those costs can best be managed by NHS bodies, in accordance with the established policy.

CORRECTION

The article on Modelling clinical decision-making for high-risk offenders using Bayesian Networks which appeared in the Summer 2015 edition of this newsletter was incorrectly attributed; the correct author of this work is Dr Mark Freestone, Clinical Research Fellow, Violence Prevention Research Unit. Our apologies to Dr Freestone for this error.

Upcoming Events

Autumn Research Seminars in the Unit for Social & Community Psychiatry

The S&CP regularly holds seminars to present to work of its members. These seminars are free, open to the public and held from 14:00-15:00 in the Lecture Theatre, Academic Unit, Newham Centre for Mental Health. For further information, please contact carolanne.ellis@elft.nhs.uk or Ruth.Cooper1@elft.nhs.uk

Date	Title	Presented by
5 Sep 2016	Improving practice and outcomes of acute mental health care	Domenico Giacco
12 Sep 2016	Media representations of mental health and arts participation	Dimitrinka Atanasova
19 Sep 2016	Implementation research: why should we do it and why should it be funded?	Jill Francis
26 Sep 2016	Retention of participants with psychosis in non-pharmacological clinical trials	Paulina Szymczynska
3 Oct 2016	Intensive group music therapy for acute adult psychiatric inpatients – development and feasibility trial	Catherine Carr
10 Oct 2016	Selective migration and changing health / deprivation relationships	Frances Darlington-Pollock
17 Oct 2016	ImprovE – Improving the practice and outcomes of involuntary hospital treatment in England – Update	Liza Mavromara
24 Oct 2016	TBC	Catherine Fung
31 Oct 2016	Synchrony Update	Julian O'Kelly
7 Nov 2016	QuEST WP2 Update	Rose McGranahan
14 Nov 2016	RADAR Update	Ruth Cooper
21 Nov 2016	ENRICH Enhanced discharge from inpatient to community health care: a programme of applied research to manualise, pilot and trial a Peer Worker Intervention	Sally Barlow
28 Nov 2016	Built Environment and Mental Health	Nikolina Jovanovic

Social networks of patients with psychosis

Continued from page 9

as weighted arithmetic means to account for differences in the number of participants across the included studies.

Our systematic research identified 23 papers which reported the size of whole social networks (20 papers) and/or the size of friendship networks (7 papers).

In terms of study setting, fourteen studies assessed patients living in the community including outpatients of mental health clinics and those who attend day centres. Two studies reported findings on the networks of currently hospitalised patients, while a further three specifically followed up patients that were previously hospitalised. Four papers reported that their samples included both inpatients and outpatients.

Social networks and friendship have been conceptualized in different ways in the studies included in the review and a variety of approaches were used

to assess them. Different frequencies of contacts occurring over varying lengths of time were considered to establish whether an individual belongs to a social network of a patient or not.

In our review, the networks with more than one category of social figures were reported in 20 studies for a total of 1184 patients. The number of friends was reported in 7 studies for a total of 1163 patients. Our findings show that patients with psychosis had on average 11.7 individuals in their social networks, while the average number of friends was 3.4. These figures varied substantially across studies, i.e. for whole social network size figures ranged from 4.6 to 44.9. The social networks were family-dominated with on average 43.1 % of network members being relatives, in contrast to 26.5 % of members categorised as friends. In terms of patients' characteristics associated with network size, having higher levels of negative symptoms and not being married may be associated with

smaller social networks.

Our findings on the average social network size and composition in patients diagnosed with psychosis are similar to those reported by the previous systematic review on patients with severe mental illness. Their networks are smaller than in non-clinical populations, and also family-dominated. This is in contrast to, for example, networks of patients with HIV, where family and friends are equally represented. With regard to the size of friendship networks, the average number of 3.4 friends found in our review was much lower than the figures reported for the general population in the UK (N = 10.6 for men and N = 7.6 for women). Previous research has found that more than half of people with severe mental illness reports problems with loneliness and this may be linked to small friendship networks.

It needs to be stressed that the studies that were included showed significant conceptual and methodological heterogeneity which limited the comparability of their results. It is necessary to develop comprehensive and conceptually-driven methods and assessment tools are needed to assess social relations of people with psychosis. In-depth explorations of specific difficulties that people with schizophrenia experience in establishing or maintaining social contacts and how their social relationships differ from unaffected controls should be carried out. These are required steps to allow the development of effective strategies to increase social support for people with psychosis and to be able to test their effectiveness. Finally, many of the examined studies were conducted in times when the internet and social media were not part of our daily interactions, and future research may benefit from exploring the virtual networks of people with psychotic disorders.

To befriend or to be a friend

Friendship is commonly held to be one of the key relationships adding richness and meaning to life. However, it is widely established that people with severe mental illness struggle to make and maintain relationships. This leads to high levels of social isolation, which in turn is linked with poor illness outcomes. One way of addressing patients' isolation is through volunteers who offer to spend their free time

with people with severe mental illness offering one-on-one support to improve their social network; this is commonly known as befriending. In England alone, there are approximately 50 NHS or independent schemes offering some form of befriending. The assumption is that befriending relates to some form of friendship, however, there is little understanding how the term is understood and practiced by different organisations, and the impact of the different definitions on both patients and volunteers.

We therefore carried out a systematic review with a narrative synthesis to explore how befriending is conceptualised and practiced. We extracted the concepts of 'befriending' used in efficacy studies, befriending manuals, codes of practice, and reports from the grey literature (20 relevant papers total), and explored the practical implications of the different concepts of befriending.

The lay understanding of the phrase 'to befriend' is 'to be a friend to'. However, the literature suggests that the term befriending encapsulates a range of relationships from very similar to natural friendships with no pre-defined goals, time restrictions, or boundaries, to one that is closer to a professional therapeutic relationship with clearly attached definitions. Understandably, there are advantages and disadvantages for both: befriending as 'true' friendship allows for development of a close relationship where one feels valued. At the same time there are risks associated with personal boundaries being crossed or emotional turbulences that might occur in natural friendships. Befriending as a more 'professional' friendship offers clear goals to be achieved and well defined boundaries between the patient and volunteer, which minimizes the risks of emotional turbulences. On the other hand, in these instances the term befriend becomes misleading for both patient and volunteer, and might lead to disillusionment and disappointment.

Some patients may benefit from new friendships with all its emotional implications, while others may prefer some form of supported companionship with clear boundaries and low emotional risks. Different schemes might be useful for different contexts. Using appropriate labels – perhaps new labels – would avoid misleading and the disillusionment of both patients and volunteers.

Studies recruiting in your trust

Volunteering in Mental Health Care for People with Psychosis

We are conducting a trial at the Unit for Social and Community Psychiatry into volunteer schemes for people with mental illness. We are interested in finding out whether patients who are paired with a volunteer companion for one year end up being less isolated, doing more activities and having more social contacts than those who don't have a volunteer. We need help identifying eligible patients who might be interested in taking part.

Patients will be considered if they

- Have a diagnosis of F20-F29 (Schizophrenia or related disorder)
- Don't need an interpreter
- Currently not receiving peer support/befriending in the last 2 years

What does it involve?

Patients will be randomly assigned to one of two groups. Patients in the first group will be matched with a volunteer companion whom they will meet once a week for 1 year. Patients in the second group will not be matched with a companion, but will be given information on local activities. Both groups will be invited to take part in questionnaires at intervals throughout the study and will receive £15 each time.

If you would like to find out more or make a referral...

Please contact Husnara Khanom by phone 020 7540 4380 ext: 2312 or email husnara.khanom@elft.nhs.uk



Recent Publications

Notification of the following publications has been received since circulation of the last newsletter. *Don't be shy!* Please send copies of papers or reference details to the Research Office (ResearchOffice@eastlondon.nhs.uk) so they can be included in this list and made available to interested staff.

- Ajaz A, David R, Bhat M. (2016) *The PsychSimCentre: teaching out-of-hours psychiatry to non-psychiatrists. The clinical teacher.* 13(1):13-7.
- Ajaz A, David R, Brown D, Smuk M, Korszun A. (2016) *BASH: badmouthing, attitudes and stigmatisation in healthcare as experienced by medical students. The Psychiatrist.* 2016.
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- Andlauer O (2015) *Optimising the diagnosis of narcolepsy: looking deeper into sleep studies. Sleep Med.* pii: S1389-9457(15)00869-2. [Epub ahead of print]
- Anyasodor MC, Taylor RE, Bewley A, Goulding JM. (2016) *Dysaesthetic penoscrotodynia may be a somatoform disorder: results from a two-centre retrospective case series. Clinical and experimental dermatology.*
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- Baig Enver M, Marcenes W, Stansfeld SA, Bernabe E. (2016) *Alcohol consumption at age 11-12 years and traumatic dental injuries at age 15-16 years in school children from East London. Dental traumatology: official publication of International Association for Dental Traumatology.*
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- Bhui K. (2016) *Ahead in mental sciences: cultural, environmental and social campaigns. The British Journal of Psychiatry: the journal of mental science.* 208(4):407-8.
- Bhui K. (2016) *On Blackstar: deaths, dying and dominions of discovery. The British Journal of Psychiatry: the journal of mental science.* 208(3):307-8.
- Bhui K. *Black holes, knowledge and psychiatric sciences.* (2016) *The British Journal of Psychiatry: the journal of mental science.* 208 (2):203-4.
- Bhui K. *Paris, protect and prevent.* (2016) *The British Journal of Psychiatry: the journal of mental science.* 208(1):100.
- Bien H, Hanulikova A, Weber A, Zwitterlood P. (2016) *A Neurophysiological Investigation of Non-native Phoneme Perception by Dutch and German Listeners. Frontiers in Psychology.* 7:56.
- Bogic M, Njoku A, Priebe S (2015) *Long-term mental health of war-refugees: a systematic literature review. BMC International Health and Human Rights.* 15:29.
- Bonavigo T, Sandhu S, Pascolo-Fabrice E, Priebe S (2016) *What does dependency on community mental health services mean? A conceptual review with a systematic search. Social Psychiatry and Psychiatric Epidemiology,* (epub ahead of print).
- Carr E, Hagger-Johnson G, Head J, Shelton N, Stafford M, Stansfeld S, et al. (2016) *Working conditions as predictors of retirement intentions and exit from paid employment: a 10-year follow-up of the English Longitudinal Study of Ageing. European Journal of Ageing.* 13:39-48.
- Chow WS, Priebe S (2016) *How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. BMJ Open,* 6:e010188.
- Clark L MP, Ridge D, Cheshire A, Vergara-Williamson M, Pesola F, White PD. (2016) *Graded Exercise Therapy guided Self-help Trial for patients with chronic fatigue syndrome (GETSET): Protocol for a randomised controlled trial and interview study. JMIR Research Protocols.* 5(2):e70.
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- Coffey M, Cohen R, Faulkner A, Hannigan B, Simpson A, Barlow S (2016) *Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. Health Expectation.*
- Coid J, Kallis C, Doyle M, Shaw J, Ullrich S (2015) *Identifying Causal Risk Factors for Violence among Discharged Patients. PlosONE* [Epub ahead of print]
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Mental Health Research in East London

Half day Conference Wednesday 5 October 2016

Are you interested in the latest mental health research? A showcase of more than a dozen projects ranging from epidemiological studies to clinical trials and qualitative work undertaken in East London.

14:00 to 17:00
Robin Brooks Centre
St Bartholomew's Hospital
West Smithfield London EC1A 7BE

Details and registration at
<https://www.elft.nhs.uk/Research> #ELFTResearch

Recent Publications

Notification of the following publications has been received since circulation of the last newsletter. *Don't be shy!* Please send copies of papers or reference details to the Research Office (ResearchOffice@eastlondon.nhs.uk) so they can be included in this list and made available to interested staff.

■ Gonzalez RA, Kallis C, Ullrich S, Barnicot K, Keers R, Coid JW. (2016) *Childhood maltreatment and violence: Mediation through psychiatric morbidity. Child abuse & neglect.* 52:70-84.

■ Ignatyev Y, Fritsch R, Priebe S, Mundt AP (2016) *Psychometric properties of the symptom check-list-90-R in prison inmates. Psychiatry Research,* 239:226-231

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■ John P, Khanom H, Cameli M, McCabe R, Priebe S (2016) *How to value patients with psychosis: An inductive study of psychiatrists' behaviour in routine consultations. Communication and Medicine,* 12:55-69.

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■ McBain H, Mulligan K, Haddad M, Flood C, Jones J, Simpson A (2016) *Self management for type 2 diabetes in adult people with severe mental illness. Cochrane Database of Systematic Reviews.*

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■ Nsamenang SA, Hirsch JK, Topciu R, Goodman AD, Duberstein PR. (2016) *The interrelations between spiritual well-being, pain interference and depressive symptoms in patients with multiple sclerosis. Journal of Behavioral Medicine.*

■ O'Kelly J, Bodak R (2016) *Development of the Music Therapy Assessment Tool for Advanced Huntington's*

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■ Priebe S, Pavlickova H, Eldridge S, Golden E, McCrone P, Ockenden N, Pistrang N, King M (2016) *Effectiveness of one-to-one volunteer support for patients with psychosis: protocol of a randomised controlled trial. BMJ Open,* 6:e011582

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■ Priebe S, Savill M, Wykes T, Bental RP, Reininghaus U, Lauber C, Bremner S, Eldridge S, Röhricht F (2016) *Effectiveness of group body psychotherapy for negative symptoms of schizophrenia – a multi-centre randomised controlled trial. British Journal of Psychiatry*

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