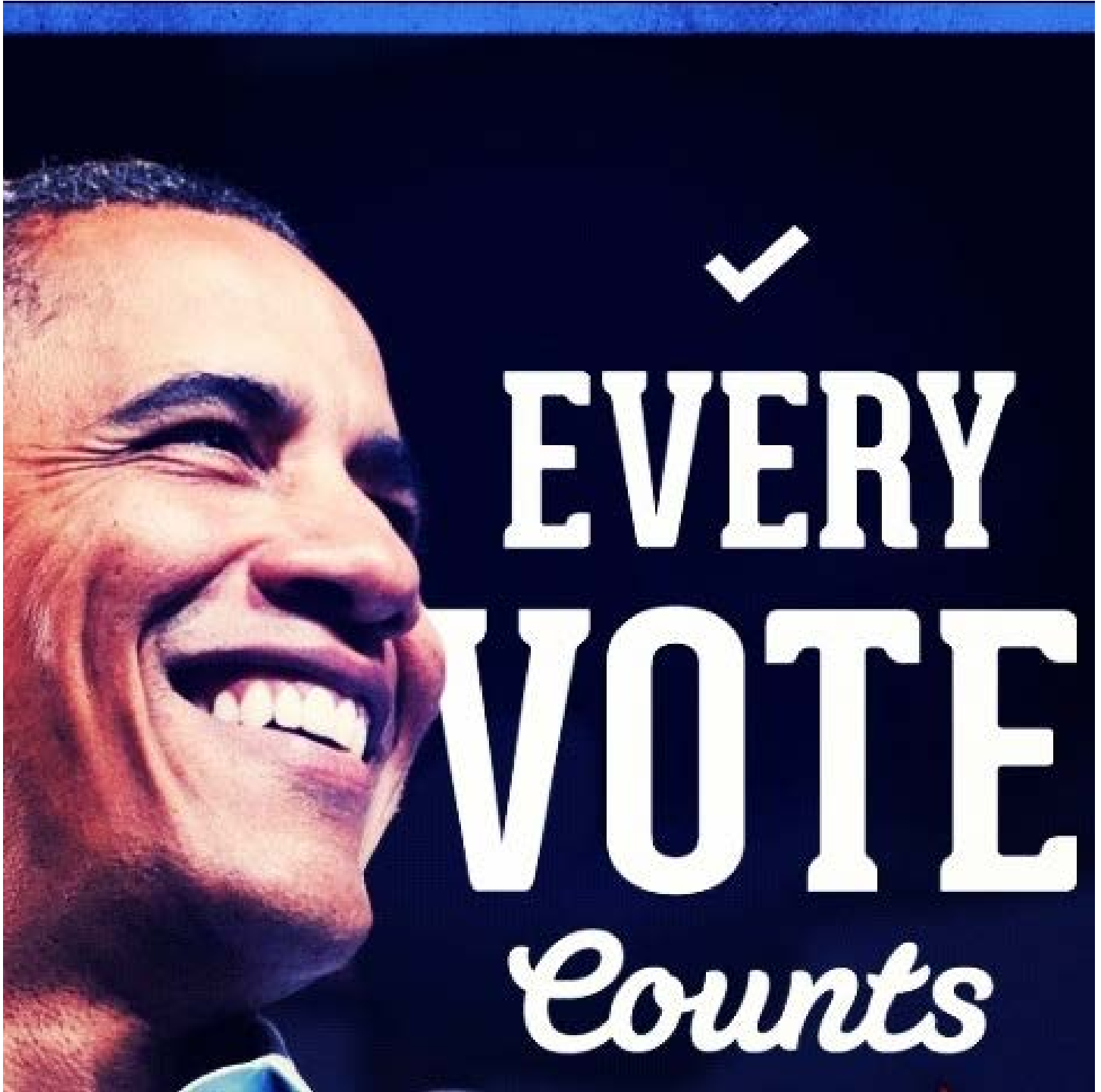
Robin Brexit and other updates

Stefan Priebe


BREXIT
SHOULD WE STAY
OR SHOULD WE GO?
CITY OF LONDON
CNBC


EVERY
VOTE
Counts

Brexit vote

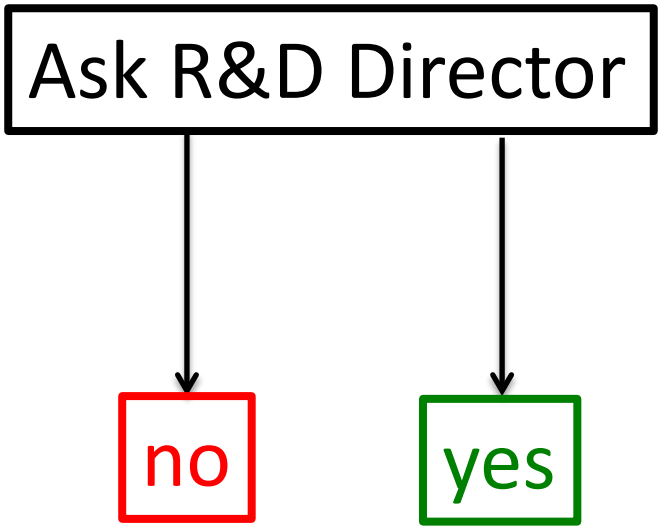
- 101 votes
- 26% for Brexit
- 74% for remaining in Robin Brooks Centre
- Despite complaints about exaggerated air-conditioning
- We will remain - for the time being!

Research 2016/7 (I)

- All performance criteria of research governance fully met
- Good performance in recruitment to studies
- More complicated bureaucracy

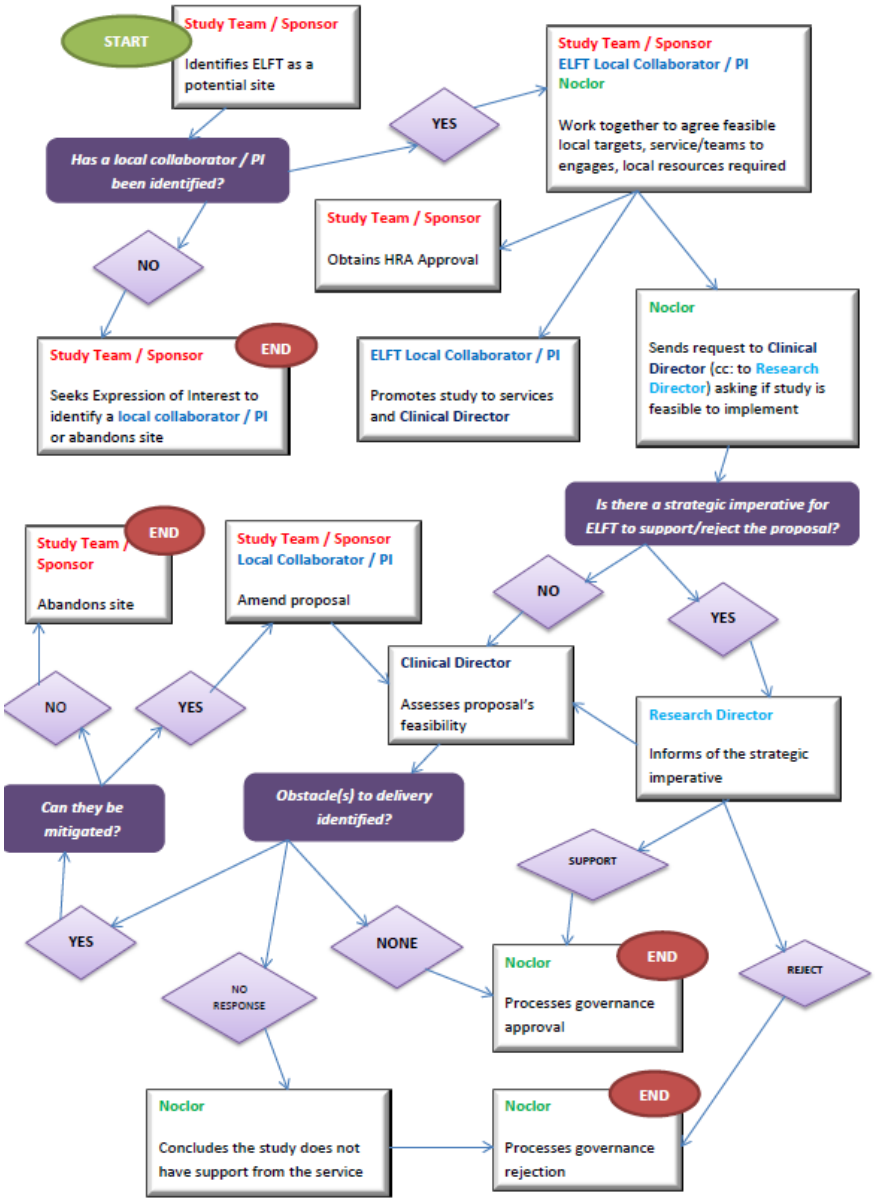
2000

Research approval in ELFT



2017

Research approval in ELFT



Research 2016/17 (II)

- Significant losses of senior mental health researchers in East London overall
- Substantial external grants for Social and Community Psychiatry
- Two major new research programmes started:
  - TACK – V. Bird
  - SCENE – D. Giacco/S. Priebe
- New NIHR Global Mental Health Research Group

Research 2016/17 (III)

- New EC grant IMPULSE – N. Jovanovic
- Total research grants for £10m
- Partly due to popularity of DIALOG+

- New funding agreements with academic partners needed
- New ELFT research strategy committee being set up

Today

- Usual format with brief presentations
- Range of topics
- Feed back questionnaires
- #ELFTResearch

Are randomised controlled trials with patients with psychosis particularly difficult to conduct?

Paulina Szymczynska

Background

- Virtually all trials experience loss of participants
- Losing 20% of participants can threaten trial validity[1]
- Patients with psychosis reported as particularly difficult to engage and retain in psychiatric treatment and research[2,3] - but are they?

Research aim

Improve the current understanding of the retention of people with psychosis in trials evaluating non-pharmacological interventions.

Methods

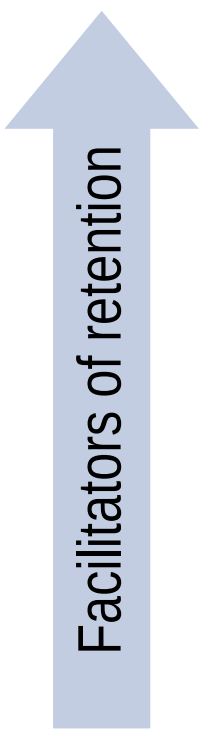
Mixed method study:

- Systematic review and meta-analysis[4]
- Individual patient data meta-analysis
- Qualitative interviews with trialists
- Qualitative interviews with trial participants

Findings

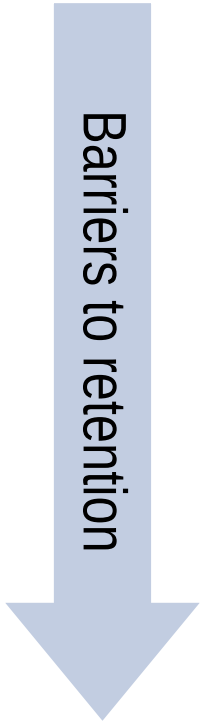
- 20% (95% CI: 17-24%) study dropout
- 14% (95% CI: 13-15%) intervention dropout
- Dropout from interventions significantly increased as the number of sessions increased
- More patients provide data at the final follow-up than the penultimate one

Findings



- Wanting to help others
- Receiving money
- Benefitting from the intervention
- Having the option to change one's mind about participation
- Being supported in making decisions
- Being contacted at the right time
- Being given a choice of meeting venue

- Invasive trial procedures or interventions
- Experiencing paranoid thoughts
- Disliking talking on the phone
- Disliking visitors
- Having to go to hospital



Conclusions

- Most current psychosis trials succeed in achieving dropout rates lower than 20% but some struggle
- People with psychosis experience specific barriers to engagement but it is possible to retain them in trials with the use of multiple strategies
- Patients depend on the support from their clinicians and researchers in making decisions about their involvement in research

Shared decision making with involuntarily admitted patients

Domenico Giacco

Background

- >58,000 involuntary admissions per year – increasing for 20 years
- Negligible clinical improvement
- Patients' initial experience important
- Calls for shared decision making

Research questions

- Can shared decision making be implemented within the first week?
- If yes, can it improve patient experience?

Intervention

Shared decision making aid

medication; activities on the ward; personal belongings; leave; legal rights; physical health; food; safety; friends/relatives; other

Communication skills

choosing options; eliciting preferences; negotiating; summarising

Results

- 14 out of 19 patients engaged with the intervention
- Average session = 29 minutes
- Improved experience of care

Results – discussed items

Most discussed	Contact with friends/family
	Legal Rights
	Physical health
	Leave
In the middle	Personal belongings
	Medication
Least discussed	Safety
	Food on the ward
	Activities on the ward

Patient experiences

- *(The clinician) explained to me the options that I have, and I was happy about the options.*

- *The most important thing is that you're giving me the opportunity to air my view… and how they're going to shift things around.*

Clinician experiences

- *Prompting them to tell us what they'd like to improve, or like to do differently, really helped our relationship… they felt listened to and like we wanted to help.*

- *it just fits really well with the sense of giving people choice and control from the start, especially with this group (that) …can often feel out of control or lacking in control.*

Conclusions

- Shared decision making can be implemented with involuntary patients within the first week
- It is appreciated by patients

- Next steps!
  - Extending the intervention
  - Testing it in a larger trial

Changing Offender-Staff Relations? Insights gained from evaluating PIPE offender units in England

Landon Kuester
Mark Freestone (PI)
Kamaldeep Bhui

Mental Health in Custody

- **26% of women** and **16% of men** said they received mental health treatment in the year before custody (Bromley Briefing, 2016)
- Prison has heightened rates of **suicide and self-harming** behaviour when compared to the general community (MoJ, 2016)
- PPO found that nearly **1 in 5 offenders** diagnosed with a mental health problem **received no care** in prison (Prisons & Probation Ombudsman, 2016)
- Personality disorder (PD) affects **60-70% of offenders** (Bradley, 2009; McRae, 2015)
- Offenders with PD showed increased likelihood of re-offense after release (Bradley, 2009; McRae, 2015)

What are **P**sychologically **I**nformed **P**lanned **E**nvironments (PIPEs)

- **HMPPS & NHS E have committed to offender rehabilitation** by delivering PIPEs as part of the Offender Personality Disorder (OPD) Pathway (Benefield et al., 2017; NHSE, 2015)
- PIPEs are psychologically augmented spaces created to reflect that people are affected by the conditions in which they live
- PIPEs are intended to 'bridge' offenders leaving therapy and entering less secure environments, including the public
- PIPEs aims to reduce reoffending, improve psychological health and workforce development:
- They are an intervention with staff as much as offenders and are "not a treatment" ®
- **£64 million** in prisons and AP sites across England and Wales (OPD)

Research Questions

1. Is the offender experience on PIPEs indicative of a **psychosocially supportive environment** that has a **positive influence on their interactions with staff and their peers**, as well as afford them the **opportunity to acquire psychological mindedness?**

2. Do staff members working on PIPEs find them to provide an opportunity for them to better understand offenders and to work with them in a safe and enabling way?

3. Is the overall relational environment of the sampled PIPEs supportive of treatment gains, and meets the standards of an 'enabling environment'?

Mixed Method Evaluation

Quantitative

- **Two waves of surveys** to investigate the quality of interpersonal relationships and the social environment in a sub-sample of PIPEs and a comparison group (EssenCES, PROQ3, GMI, SPSI-R) (**N = 178**)
- **Analysis of anonymised patient-level data** taken from national & local prison/probation databases, to examine risk and behavioural outcomes (**N = 6000**)

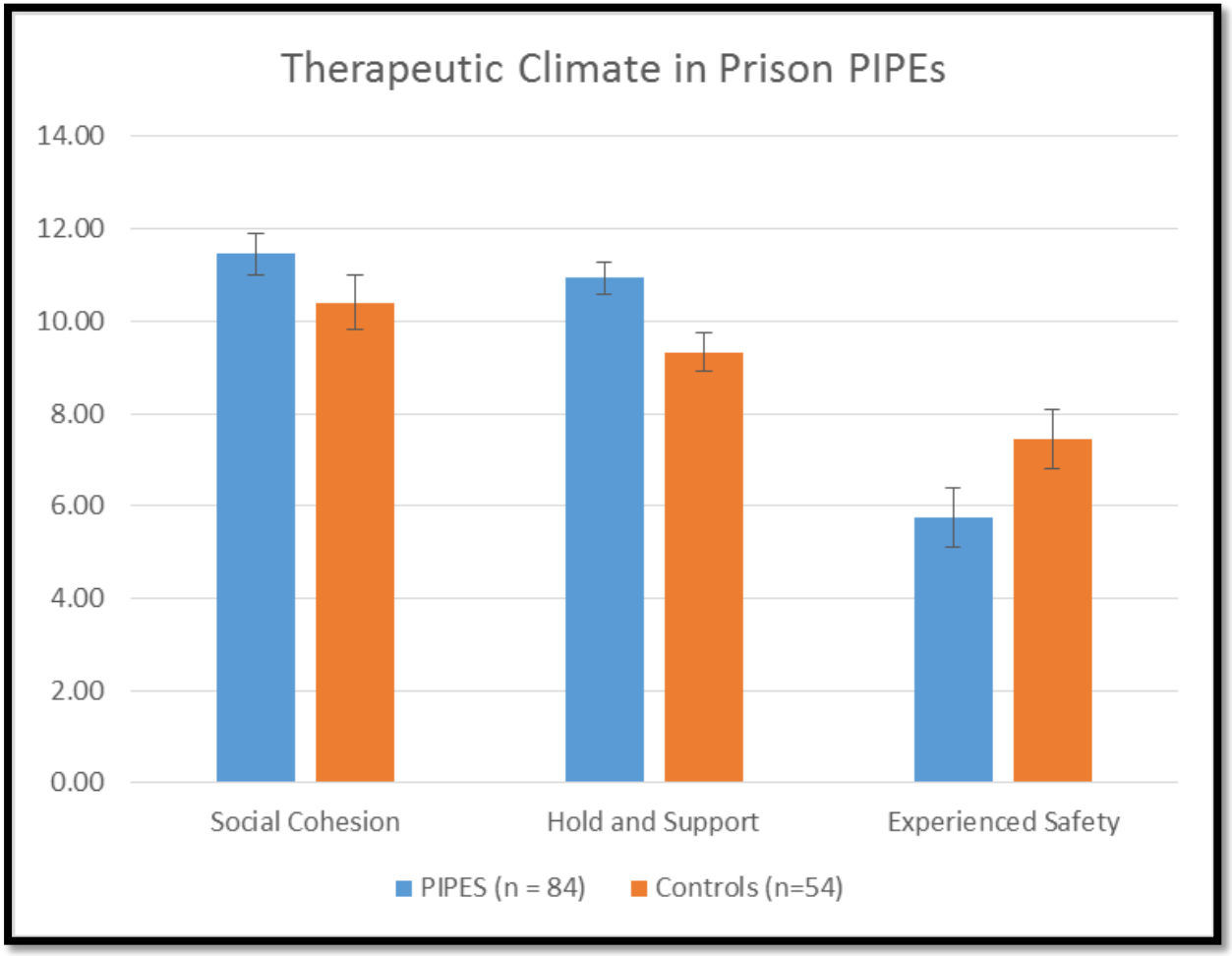
Qualitative

- A qualitative study combining **individual** (**N = 31**) **and mini-group** (**N = 6**) **interviews in prison PIPEs** where offenders and staff were asked about their experiences in PIPEs.
- **A two-wave longitudinal qualitative (LQ)** study within sample AP / AP PIPEs, which will enable a rich exploration into participants 'lived experience' in relation to time. (**N = 16; 8 participants**)
- Overall institution-level narrative focus

Location of Sample Sites

Location	Type	Maximum unit size
HMP Gartree	Male Prison	60
HMP Hull	Male Prison	50
AP Southview	Male AP	24
HMP Send	Female Prison	20
AP Holbeck House & Comparator	Male AP(s)	**

Baseline Funding from Surveys



Qualitative Findings

THEME 1: Positive governance and mattering

THEME 2: 'Incentive to act otherwise' within a closed community

THEME 3: 'Slapped with reality': Illicit drugs, violence, and staff difficulties with managing individuals and groups in a PIPE AP setting

Positive Governance Through Relationship Building

- Governing though play / keeping busy (getting lost in the experience)
- Co-production of an offender 'blueprint' / one-to-one sessions
- Understanding offenders as "whole people"
- Less violent and reactionary when you 'know someone'

Offender: I think also, with the blueprints, because they get to know more about your past, if you are having a bad day and you start kicking off or whatever, whereas on other wings you get straight away an IEP or you get nicked. Here, there'll be thinking she was saying today this is a trigger date, an anniversary or whatever, so they understand more because they get to know more about your past. They don't just read what's on the computer screen; they get to know you as a person so they can help you more.

Staff Express a Strong Sense of Mattering

- ‘Mattering is the extent to which an individual believes they make a difference in the world around them’
- Pride and accomplishment when they are not just ‘turning keys’
- Learning and applying new skills (being recognised / feeling like people invest in you)
- Concern about what others think (“fluffy Care Bears”)

Officer: I’m happy working on here and doing that as long as I get the buzz of that sort of, ‘Yes, that went really well and these [offenders] have got something from it,’ buzz […]

***

Officer: […] You're like a proud parent, you think, ‘Well done.' I feel that I've had part of that. They've done most of the work but I've helped them and guided them through it.

‘Incentive To Act Otherwise’ in a Closed Community

- PIPE activities (keyworking, creative sessions) and atmosphere were conducive to detailed report writing (knowledge and observation)
- Offenders can’t get detailed reports in other prison settings but express having some control over the content of reports
- Reports are obtaining certain benefits (e.g. parole / progression)

Offender: [...] but the system only can judge risk once it’s documented. So on a normal wing that won’t normally be getting documented because staff are busy, they have many other responsibilities. So, on this wing they’re supposed to have allocated time to write reports on you, to observe you and so forth. You’re working closely with them and then writing these reports that can be quite beneficial for you. So you do get a closer rapport.

***

Offender: “I've seen people come here and I know they're just keeping their head down because they know how to play the system. They know what to say when to say it and so forth”.

‘Slapped With Reality’

- Violence, drugs and antisocial behavior on AP PIPE (lacking hope for the future)
- Management style of the hostel is key (empowering staff)
- Accepting that some individuals need to return – the desire for institutionalization
- Need for a more nuanced addiction support / harm in this setting
- No difference between residents released from general unit when compared to PIPE / OPD pathway.

Where does the pathway start and end?… and where might we see fractures in the road?

Thank you!

This study was funded by the UK Ministry of Justice and Greater Manchester NHS Trust.

Co-investigator is Prof Kam Bhui

Questions, comments: m.c.freestone@qmul.ac.uk

l.Kuester@qmul.ac.uk

Exploring the value of mental health nurses working in primary care in England: A qualitative study

Kristina McLeod

Context

The situation

The service

Practice Services

iapt
Improving Access to Psychological Therapies

The service

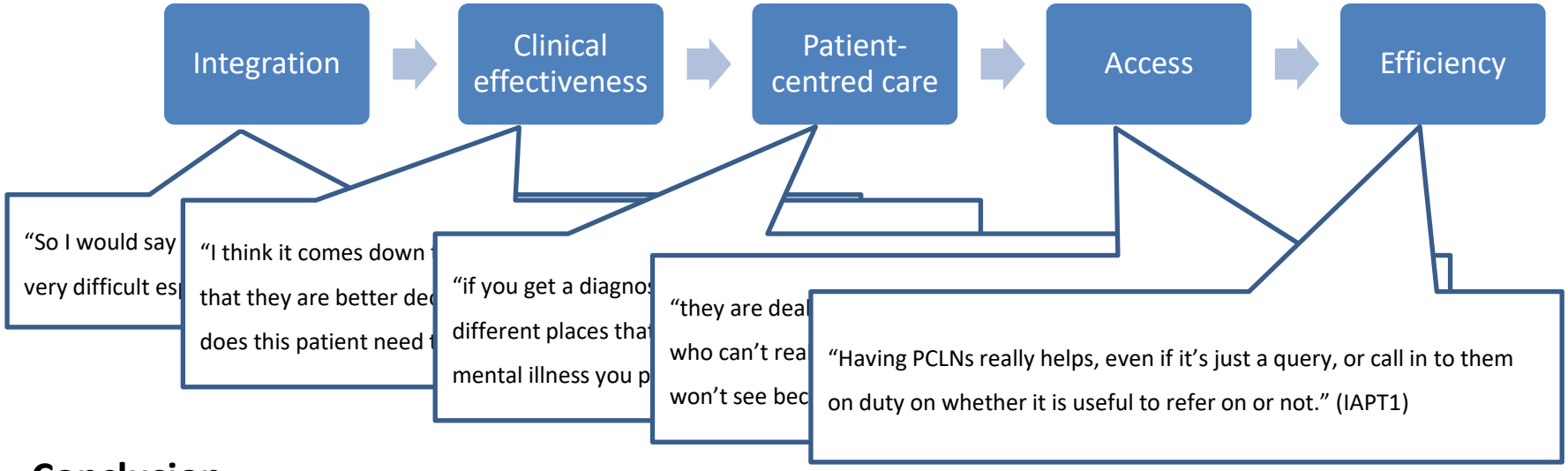
- Assessment
- Risk management
- Care planning
- Case management
- Facilitated discharge
- GP liaison

The study

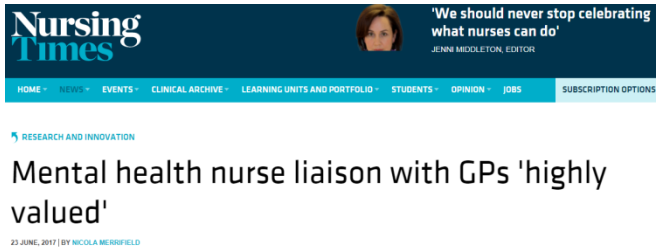
Method

7 GPs
3 senior IAPT practitioners

Results



Conclusion



Questions?

Citation: McLeod K, Simpson A. Exploring the value of mental health nurses working in primary care in England: A qualitative study. *J Psychiatr Ment Health Nurs*. 2017;00:1–9. https://doi.org/10.1111/jpm.12400

Kristina.McLeod@nhs.net
Alan Simpson, Professor Collaborative Mental Health Nursing, co-authored the paper

How do Speech and Language Therapists address the psychosocial well-being of people with post-stroke aphasia?

Results of a UK on-line survey and six focus groups

Dr Sarah Northcott

The Questions

- Barriers and facilitators to Speech and Language Therapists (SLTs) addressing psychosocial well-being

- How SLTs perceive their role

- SLTs' experiences of working with mental health professionals (MHPs)

Methods

On-line survey:

n=124 UK Speech and Language Therapists (including two free-text questions)

Focus groups:

N=23 UK Speech and Language Therapists; 6 focus groups at 6 NHS Trusts

Results

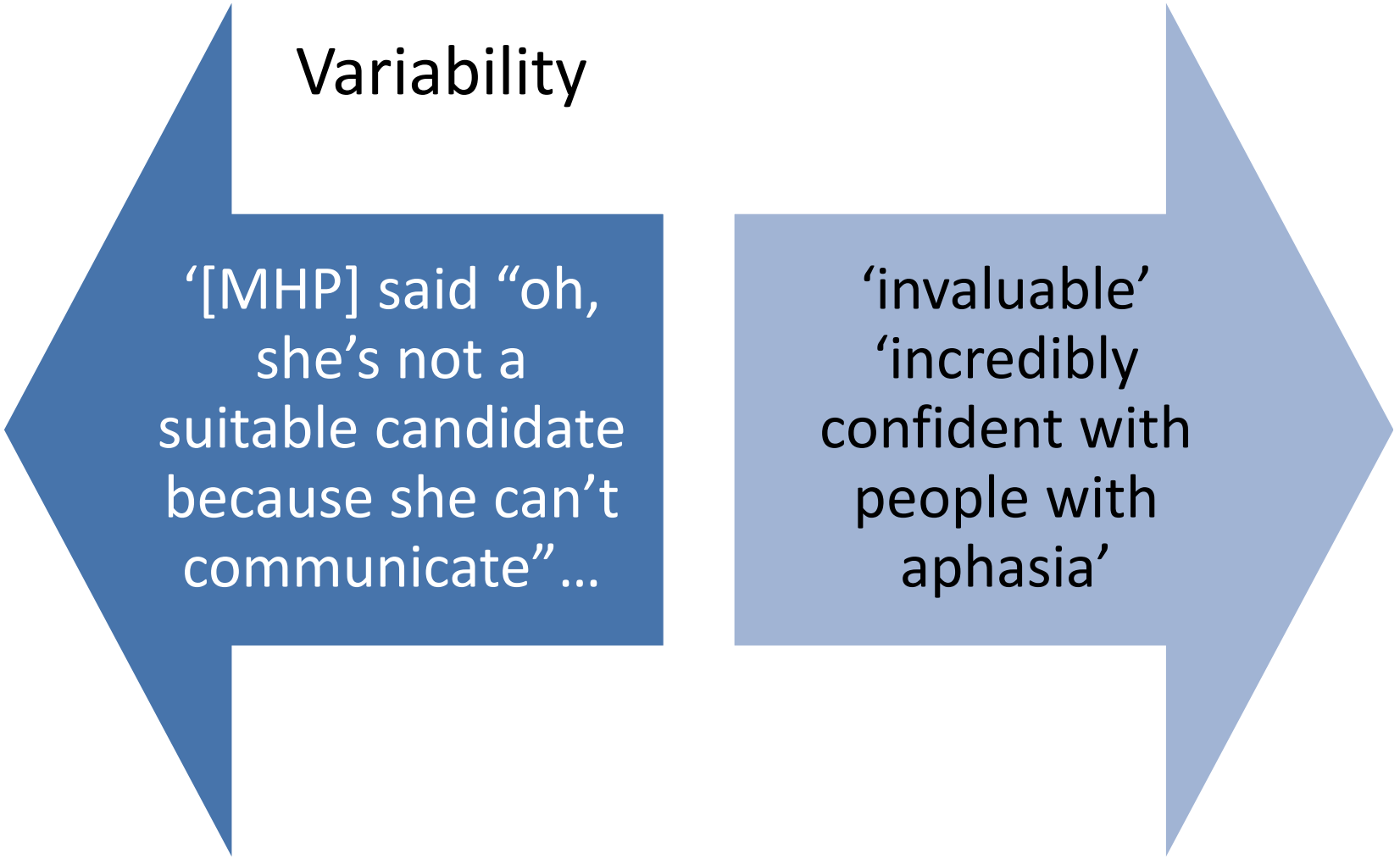
Prevalence of emotional distress

78% of SLTs said **at least half** their clients with aphasia were experiencing psychological difficulties

SLTs delivering psychological care

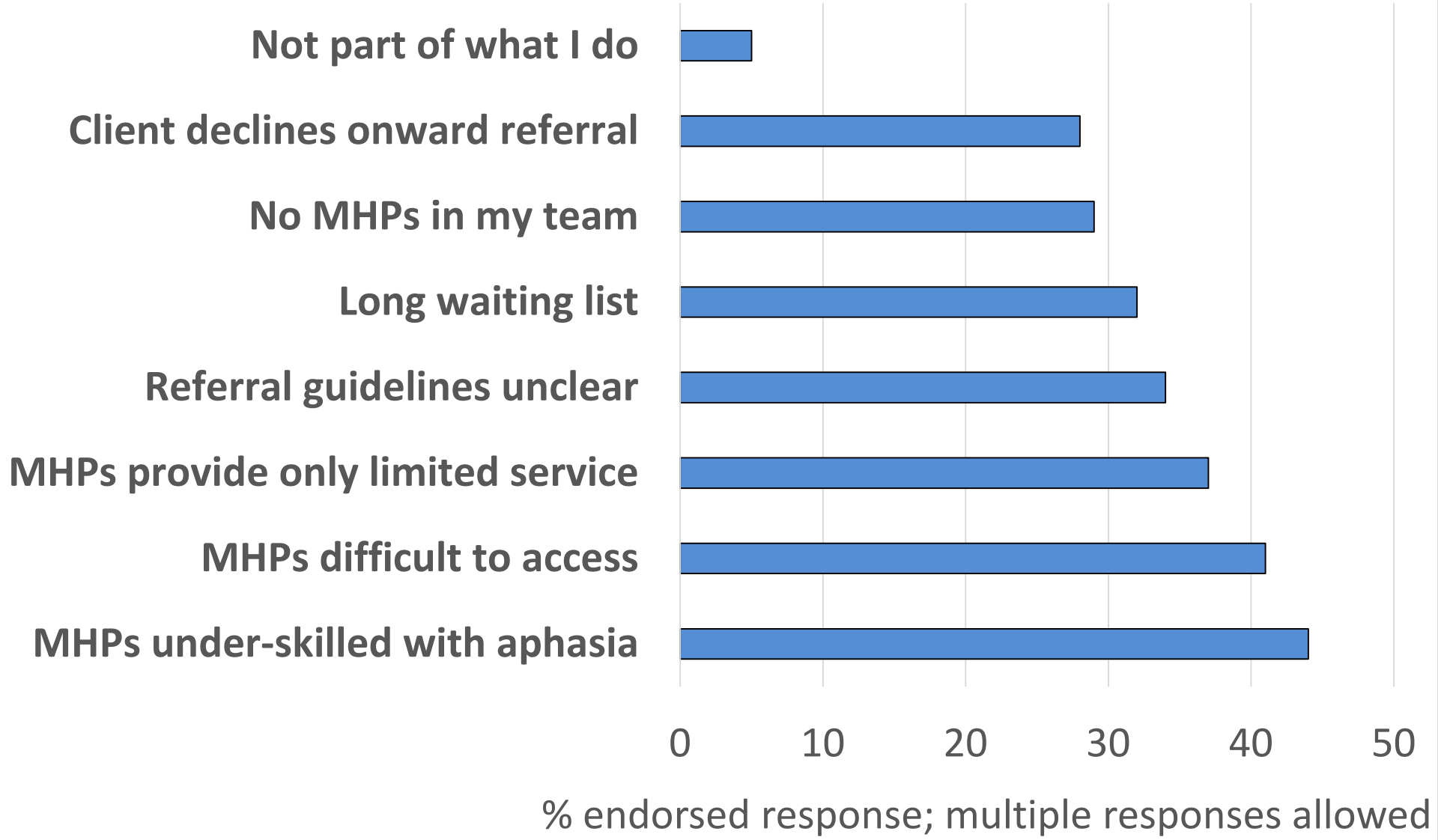
93% agreed addressing psychological needs part of their role, yet **only 42% felt confident** to do so

MHPs working with people with aphasia



Of most concern: mainstream MH services; lack of long-term support; severe aphasia

Barriers to referring to MHPs



What worked well?

Collaborative working – SLTs and MHPs

- **MHPs:** talking through cases with SLT; reassurance that if SLT felt 'out of their depth' there was someone they could turn to

- **SLTs:** giving MHPs advice and strategies on how best to facilitate communication

When it doesn't work so well…

'[MHP] had written in the notes sort of unable to communicate just start on [antidepressant drug] or something and it really angered me. I'm on the wards the whole time, **they could come down and speak to me** about this lady, considering that the day before I had written a two page entry about everything she's told me! And **[MHP is] saying that she can't communicate so I got quite riled** about that.' (FG6L521)

…and when it does

‘[MHP is] fantastic… she just **helps us all come up with ideas**, and so often once they are put into practice you can see **positive change**. You have somebody you are really stuck with and then you have one of these sessions, and afterwards you can just see that, that it works **and you’re like, wow!**’ (FG6L290)

Take home messages

- People with post-stroke aphasia are at risk of becoming depressed

- No such thing as ‘not a suitable candidate’? With SLT support, it’s possible to make conversations work well, even when someone has severe aphasia

- SLTs are keen to work with you!

Acknowledgements

Academic supervisors: Katerina Hilari; Alan Simpson

Funding: Research Sustainability Fund, City, University of London

References:

- Northcott, S., Simpson, A., Moss, B., Ahmed, N. and Hilari, K. (2017). How do speech-and-language therapists address the psychosocial well-being of people with aphasia? Results of a UK online survey. *International Journal of Language and Communication Disorders*, *52*(3), pp. 356–373. *doi:10.1111/1460-6984.12278*.
  Open access link: http://openaccess.city.ac.uk/14907/

- Northcott, S., Simpson, A., Moss, B., Ahmed, N. and Hilari, K. (2017). Supporting people with aphasia to 'settle into a new way to be': speech and language therapists' views on providing psychosocial support. *International journal of language & communication disorders* . *doi:10.1111/1460-6984.12323*.
  Open access link: http://openaccess.city.ac.uk/17216/

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Should psychiatrists always present treatments with optimism?
an experimental study

Dr Philip McNamee

Introduction

- Patient expectations influence treatment outcomes.
- Psychiatrists influence expectations when presenting treatment options.
- Normally, optimistic presentations are linked to better outcomes.
- Yet, does this also apply to patients who have already been in treatment for a long time?

Hypothesis

- Patients who are new to psychiatry will prefer treatments presented optimistically.
- Patients with longer experience of psychiatry prefer more caution.
- How to test this?

Experiment

- 4 consultant psychiatrists
- 4 video-clips with each consultant:
  a) suggesting psychotherapy – optimistic
  b) suggesting psychotherapy – cautious
  c) suggesting medication – optimistic
  d) suggesting medication – cautious

“My name is Dr XXX. I am your new consultant psychiatrist. Having looked at your records, I believe we could start you on a new medication, which you will have to take once a day for 6 weeks. I am very optimistic that the new medication will be most effective and make all your symptoms go away.”

“My name is Dr XXX. I am your new consultant psychiatrist. Having looked at your records, I believe we could start you on psychological therapy. This will be weekly one-to-one sessions with a psychologist for 8 weeks. I cannot say whether such talks will really help you, and cannot promise anything, but you might want to try. “

Sample

- 200 patients (137 outpatients, 63 from inpatient units)
- 2 groups:
  - ‘new patients’ (<3 months experience)
  - ‘long term patients’ (>1 year experience)

Procedure

- Each patient was shown four clips with the four different treatment presentations, each with a different psychiatrist
- Afterwards, 4 questions:
  - Do you believe this is a good doctor?
  - Would you have trust in this doctor?
  - Would you like this doctor to be your psychiatrist?
  - Would you like to start the new treatment with this psychiatrist?

Results

Overall

- Patients prefer optimistic presentations
- Patients prefer psychological treatments

New patients vs longer term

- ‘New patients’ very much prefer optimistic presentations
- However: for ‘long term patients’ there is no difference

Conclusion

- In general, psychiatrists should suggest treatments with optimism.
- Yet, this rule does not apply to patients with longer experience of care.
- Since other patient characteristics do not predict preferences, treatment presentations for long term patients depends on clinical judgement.

Priebe, S., Ramjaun, G., Strappelli, N., Arcidoacono, E. & Greenberg, L. (2017). Do patients prefer optimistic or cautious psychiatrists? An experimental study with new and long-term patients. *BMC Psychiatry*, 17:26, doi: 10.1186/s12888-016-1182-1.

How to ask “the suicide question”?

Professor Rose McCabe

Every

40

seconds somebody dies by suicide

cause of death
er vehicle
ly than
n are

have a
ressive

hopeless. First, they must have a serious desire to die. This usually comes about when people feel they are an intolerable burden on others, while also feeling isolated from people who might provide a sense of belonging.

Second, and most important, people

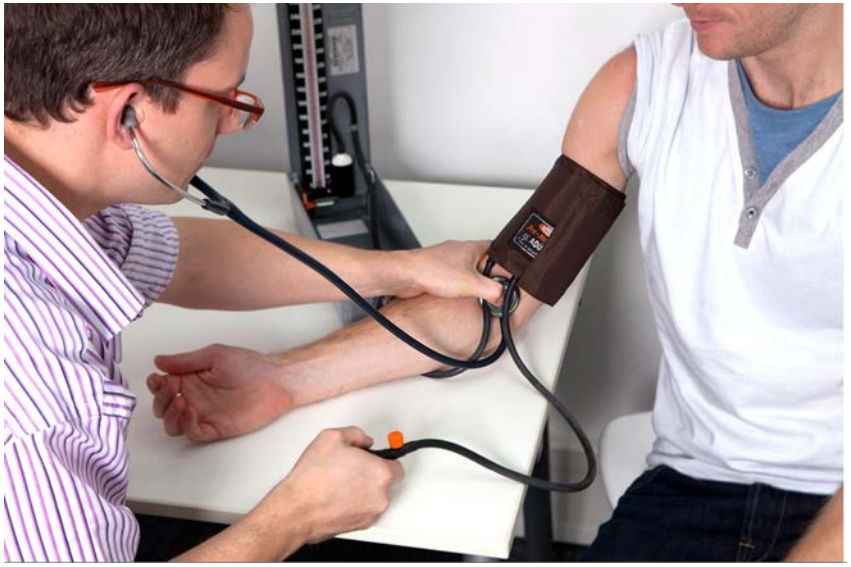
the suicidal generation

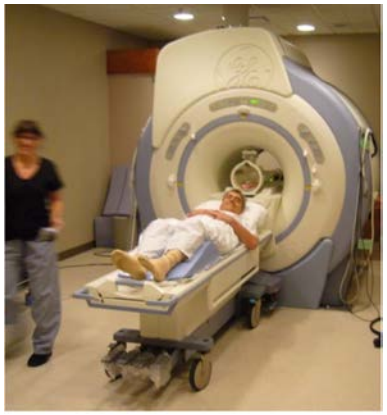
There are two ways she develops the ability preservation instinct, working up to it. In ma attempt is tentative, w mild overdose, it is onl attempts that the action The other is to becom painful or scary experie police who have been sh colleagues injured or kill become inured to the ide Both groups also have a h suicide rate. Similarly, doc who witness pain, injury a more likely to be able to co themselves – the suicide ra is significantly higher than population. Joiner describe "steeliness" in the face of th would intimidate most peop

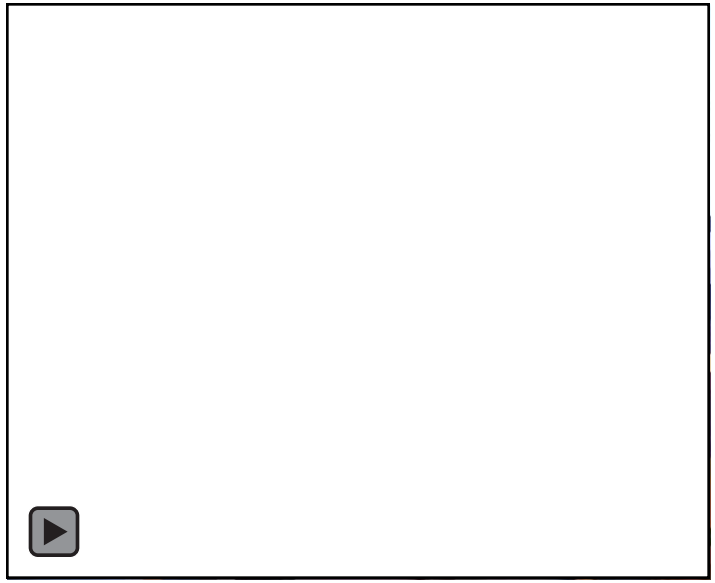
Another group that displa people with anorexia. Joiner heightened suicide rate in hi

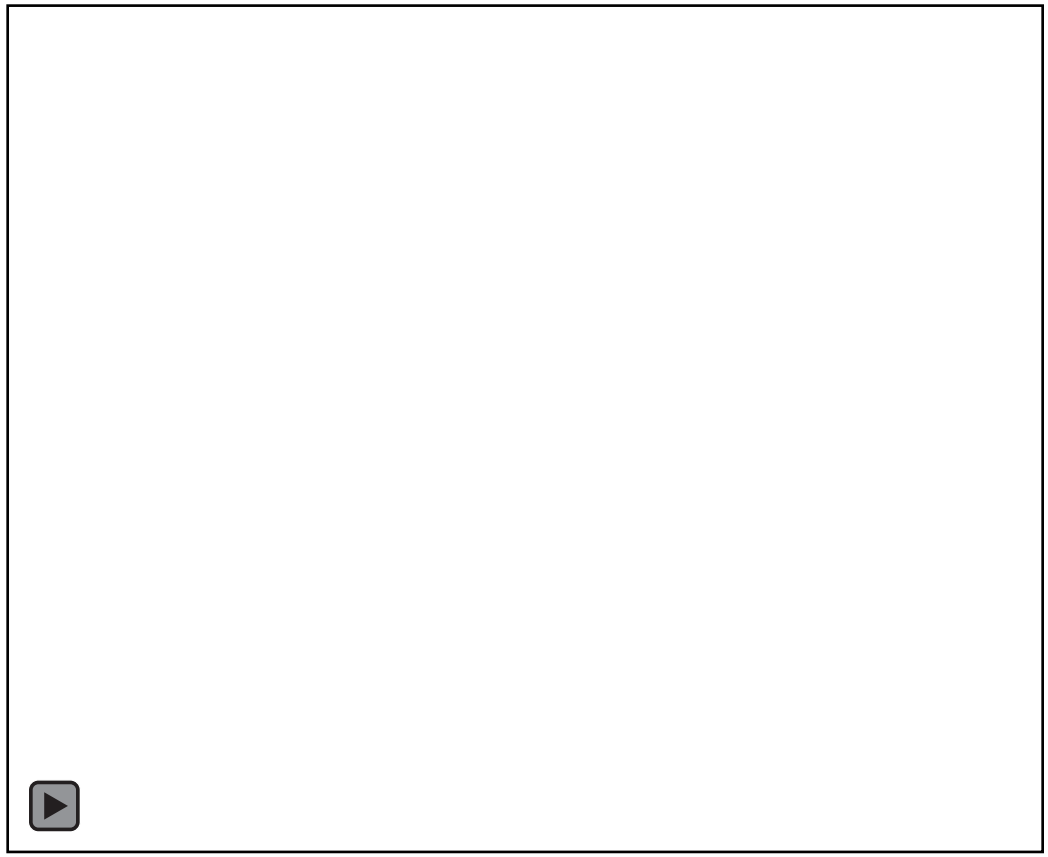
Why people die by suicide (Har Press, 2005), but it wasn't unt grasped the importance of the

That realisation began to da during a seminar in which graduate students, including Tracy Witte, who is now









Recordings & Analysis

- 319 audio/ video recorded visits for depression or schizophrenia
- 89 questions
- 40 professionals - Psychiatrists, General Practitioners, Community Psychiatric Nurses
- 84 patients
- Micro-analysis (conversation analysis) of video recordings

Research Questions

1. What types of questions do doctors ask?

2. Do the questions influence the patient's response?

Examples of Risk Questions

- Have you had any thoughts of harming yourself?
- Have you ever become suicidal at all?
- You don’t have thoughts of harming yourself?

1. ALL 89 QUESTIONS WERE CLOSED YES/NO QUESTIONS
2. ALL CLOSED QUESTIONS INVITED EITHER A YES OR A NO RESPONSE

You don’t have any thoughts
of harming yourself?

Do you have any thoughts of harming yourself?

Do you ever feel yourself that
life isn’t worth living?

Inviting a “No”

Question inviting a no

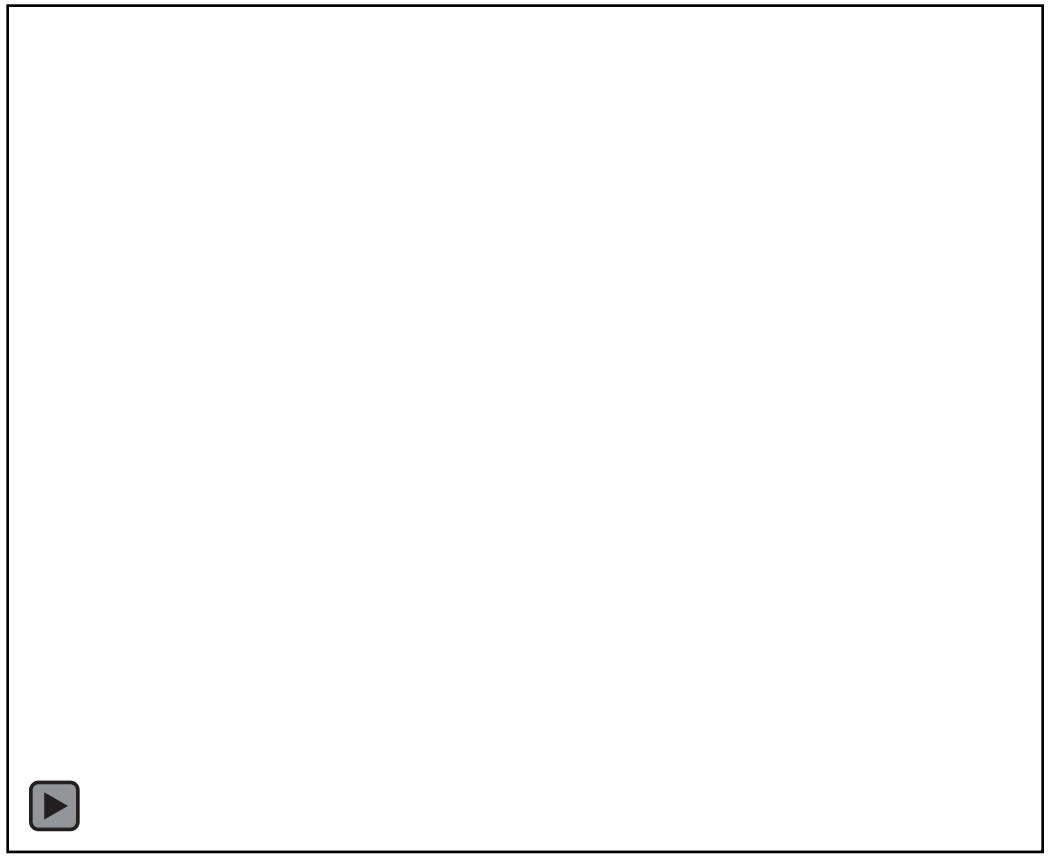
01	**DOC**	**do you ever (.)think that**	No inviting Q
02		**Life isn’t worth living?**	
		(1.4)	Long delay
03	PAT	no.	Agreement

Do you have moments then when you feel like sort of putting an end to your life?

Sometimes do you get feelings like wanting to harm yourself?

Do you feel life is not worth living at times?

Designed for a ‘yes’



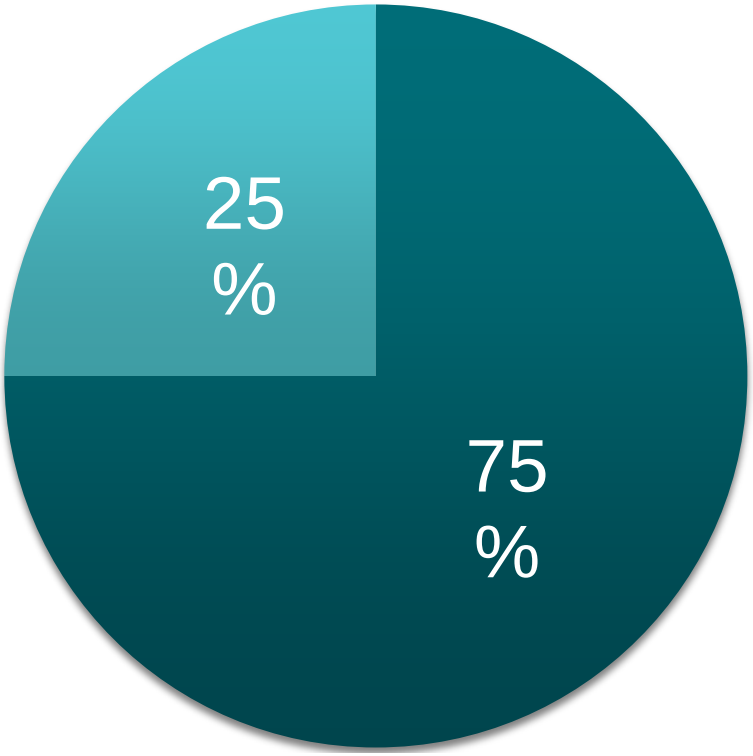
Question inviting a yes

```
01  DOC do you get lo:w in moo:d
02      occasionally?
03        (0.2)
04  PAT   °!yeah°. nods
05  DOC   °yea:h° nods sometimes fee:l like
06        Life is not worth living anymore:.
07  PAT   nods !yeah. nods
08        (0.4)
09  DOC   do you get that.
10  PAT   °yeah°.
```

Positively polarised YNI

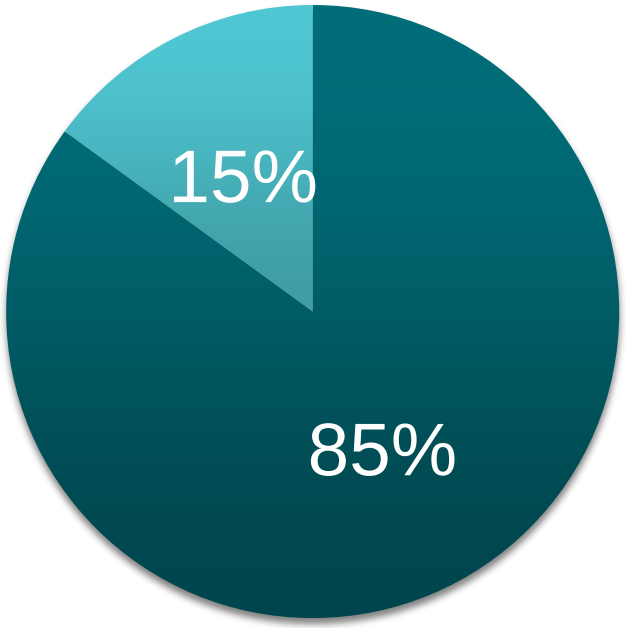
Quick agreement with a type conforming response

Questions were 3 times more likely to be designed for a No

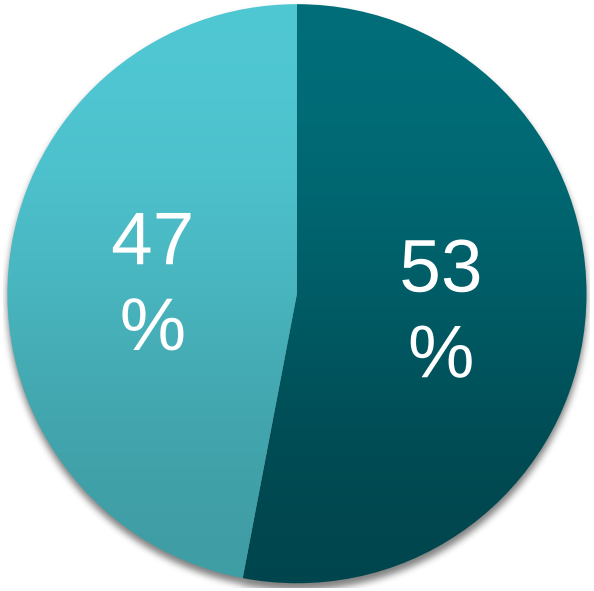


PATIENT RESPONSE: NO YES

Question designed for “No”



Question designed for “Yes”



Patients were significantly more likely to say they were not suicidal when the question invited a no

($\chi^2 = 7.2$, $df = 1$, $p = 0.016$)

s reporting more suicidal ideation a positively phrased question (2=1.7, df=1, p=0.23).

Over half doctors always used no inviting questions

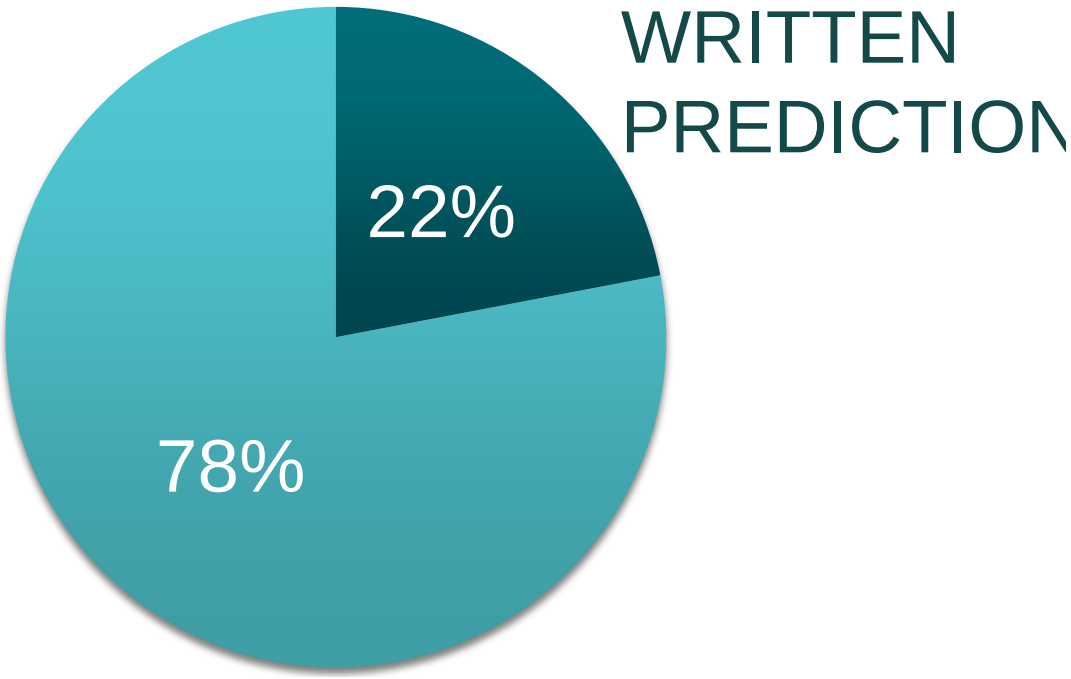
Why more likely to use no inviting questions?

- Optimisation
- ‘Workload’ implications - need for more in depth assessment, referrals, admissions
- Reluctance to escalate bureaucratic risk assessment procedures?
- May not be in patient’s best interest

Guidelines

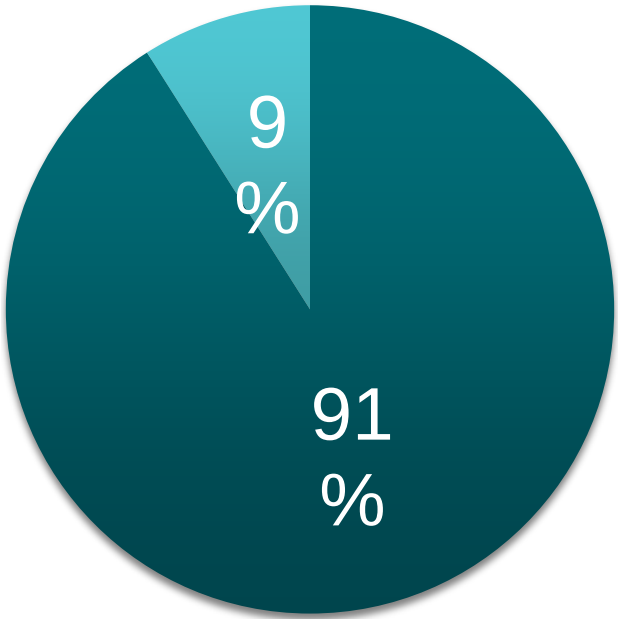
- Guidelines recommend asking non-leading questions
- All closed questions are leading
- If patients respond with a ‘no’, no further enquiry

PSYCHIATRIST NONVERBAL COMMUNICATION IN PREDICTING SUICIDE REATTEMPTS



Haynal-Reymond et al. (2005)

OBSERVER RATED NONVERBAL BEHAVIOUR OF PSYCHIATRISTS



Haynal-Reymond et al. (2005)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Most people who took their life were classified as

'low or no risk' in final contact with mental health services

Not just in the U.K.

- prior to death, patients do not communicate suicidal ideation, “deny” suicidal ideation and are classified as low risk
- In Finland, Isometsa et al. (1995) found that of 100 suicide victims seen on the day they died, suicidal ideation was discussed in only 21 appointments
- In the U.S., Smith et al. (2013) found that 85% of people who died by suicide “denied suicidal ideation” even 0-7 days prior to death

McCabe *et al. BMC Psychiatry* (2017) 17:122
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BMC Psychiatry

RESEARCH ARTICLE Open Access

How do healthcare professionals interview patients to assess suicide risk?

Rose McCabe[1*], Imren Sterno[2], Stefan Priebe[3], Rebecca Barnes[4] and Richard Byng[5]

Abstract

Background: There is little evidence on how professionals communicate to assess suicide risk. This study analysed how professionals interview patients about suicidal ideation in clinical practice.

Methods: Three hundred nineteen video-recorded outpatient visits in U.K. secondary mental health care were screened. 83 exchanges about suicidal ideation were identified in 77 visits. A convenience sample of 6 cases in 46 primary care visits was also analysed. Depressive symptoms were assessed. Questions and responses were qualitatively analysed using conversation analysis. χ^2 tested whether questions were influenced by severity of depression or influenced patients' responses.

Results: A gateway closed question was always asked inviting a yes/no response. 75% of questions were negatively phrased, communicating an expectation of no suicidal ideation, e.g., "No thoughts of harming yourself?". 25% were

Thanks to

All of the people who agreed to be video-recorded

Collaborators

Imren Hassan, Rebecca Barnes, Richard Byng, Stefan Priebe

BREAK

NHS
National Institute for Health Research

Clinical Research Network
North Thames

noclor
RESEARCH SUPPORT

NHS

Promoting the best in research

NHS
National Institute for Health Research

Collaboration for Leadership in Applied Health Research and Care North Thames

Research Design Service London

Patients' views and experiences of family involvement in inpatient wards

Aysegul Dirik

In-Depth Interviews

- Current or recent (within 1 year) inpatient ward experience
- 42 participants:
  - 21 patients
  - 12 family/friends
  - 9 clinicians
- Hackney, Tower Hamlets and Newham

Why involve?: Patient perspectives

"In the hospital it can be quite lonely because you are there all day…it would have been nice just to…have a few more visitors" (P07)

Why not?: Autonomy

"**I had a plan in my mind to play things down as much as possible** and my partner was there saying: 'No, but he's been doing this, he's been doing that'. It's probably a good thing that I was on the ward…but at the same time I did feel slightly resentful. **It was almost like I'd been dobbed in**" (P19)

Why not?: Autonomy

"…They did it all behind my back – my brother was involved and **I still haven't forgiven him for that**…Basically he's making the decision for me…I don't think he had a right." (P14)

Protecting family: Emotional

"I'm not too sure how emotionally stable they would be…**he wouldn't know how to support me**…he would feel that he'd like 'slip up' and then **he'd blame himself.** And the same with my brother as well…I'd probably keep it as ambiguous as I could **just so that he doesn't get hurt or upset**" (P08)

Protecting family: Emotional

“I said to my dad “I don’t wanna speak to my brother” because he gets very stressed out…**despite the fact that I’d lost a degree of insight at the same time I was very aware that I was very hyper** and I was speaking about things that might upset him”(P19)

Protecting family: Ward environment

"I was worried that my wife might feel – because she's sort of kind of pretty much initiated it in a way…**I didn't want her to feel guilty**, because you know it was pretty…pretty horrific as far as I'm concerned…it was very unpleasant and…**I sort of tried to protect her" (P21)**

Protecting family: Ward environment

"Well I did want them to visit, but I didn't want them to go through and see what was going on in, in the hospital, in the ward. **It was really frightening** the second time round when I was here. …And I thought I was gonna get attacked…**They'd worry too much; that's why I didn't wanna get them involved" (P11)**

Changing perspectives

"They reminded me of who I was. And I didn't feel alone. Like I felt like I belong, **I belonged to someone**, like…I don't know how to say it in the right words? But…it's like they made me see sense, like with their support. Yeah." (P10)

How to talk about families: keep it informal

“Um, I opened up a little bit – just through general chit-chat on the ward…If someone came down and sat next to me and said ‘yes, oh what’s the relationship like with your family?’ I would just not speak about it – but I would if it was informal, like at dinner-time or stuff like that…”(P08)

How to talk about families: don't assume

"I think an acknowledgment that things are going to be difficult with family: Look, we know you don't wanna be here, we know you don't want your parents meddling in your life, but you know, **hate them for all you want, do you wanna see them? Do you wanna help them become… the carers…that can help you through this to something better?"** (P05)

Next steps

- Recruit two people with lived experience to work on in-depth analysis of all interviews (starting November)
- Analyse family/friend and clinician interviews

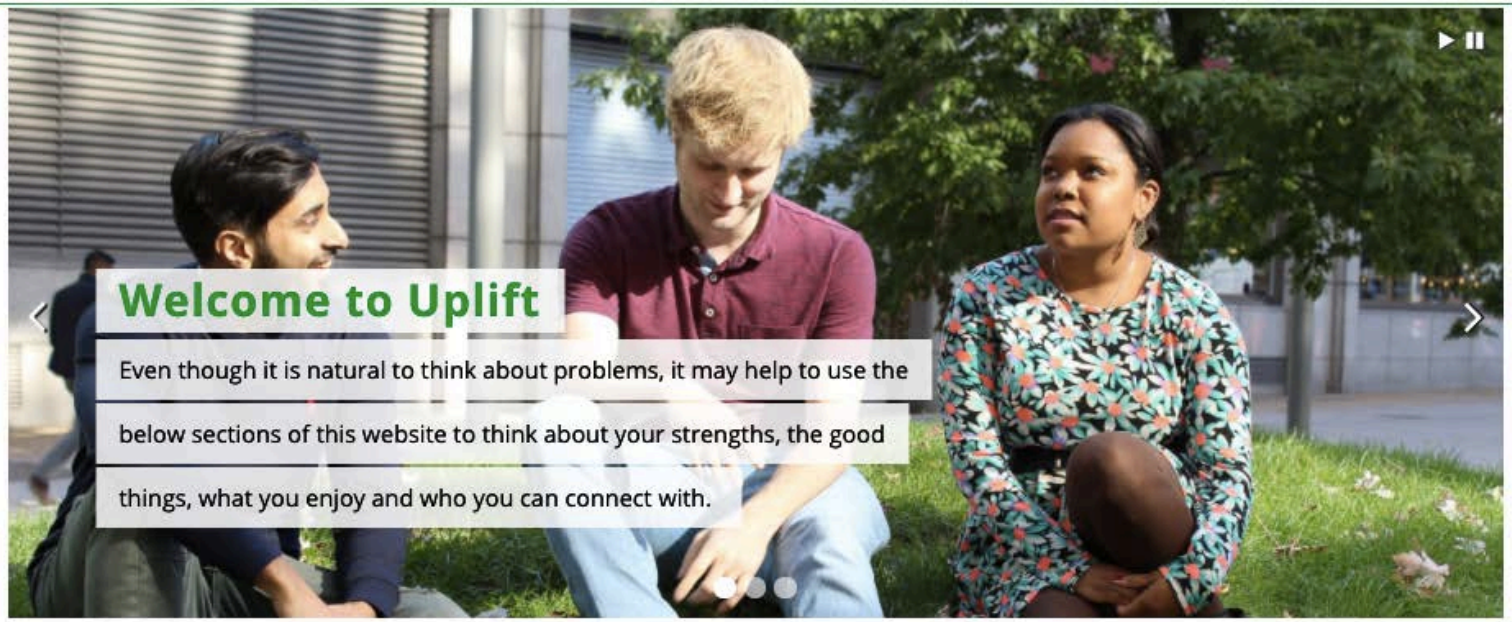
- **a.dirik@qmul.ac.uk**

‘Uplift’ – a web-based intervention using positive psychology

Sophie Walsh

Background

- Drive to use ‘web’ to improve availability of treatments for depression
- Resource-oriented approaches more appealing
- Positive psychology exercises increase wellbeing and reduce depression
- But - is this acceptable?



Strengths

Find your top five strengths and find ways to use them day-to-day.

Good things

List good things that happen.

Enjoy

Try new ways to enjoy daily sensations.

Connect

Find ways to connect with others and share your strengths.

Findings

- 103 participants – moderately depressed
- 50% minimal use (0-1 weeks)
- 30% moderate use (2-3 weeks)
- 20% high use (4-6 weeks)
- Rated as helpful by 20% of participants
- 81% reported no or minimal negative effects
- Post-test reduction in depression (PHQ-9 16.3 to 12.7)

Key differences

Some benefit

Relevant to depression: some parts achievable

Feeling empowered and valued: motivated and supported to take action

No benefit

Irrelevant to depression:

too positive

Felt unable to act and unvalued: being the input and output unhelpful and isolating

What happens next?

- Up-scaling or not?

Patient experiences of inpatient care linked with positive & negative appraisals

Agnes Chevalier

Background

- Satisfaction with inpatient treatment
- It predicts more positive outcomes
- Even within a few days of admission

Research Question

- The **initial** satisfaction with inpatient treatment is important, so …
  - Positive appraisals
  - Negative appraisals

Design

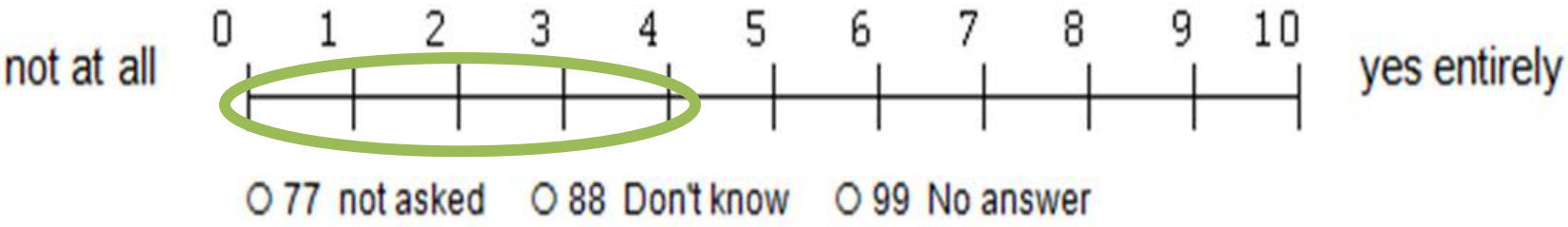
- 5 hospitals across 3 London Trusts
- Close to admission (within 1 week)
- Short individual interviews (N=61)

  + Client Assessment of Treatment

Results

- Five broad themes
    - Best place for me right now?
    - Different or cut off from society
    - Uncertainty & information
    - Relating & othering
    - Relationship with staff

Negative appraisals



Hospital makes you worse

"I thought [in-breath] locking someone up somewhere in one place, isn't gonna make them better, **it's gonna make them worse**; it's gonna make them crazy"

Lack of access

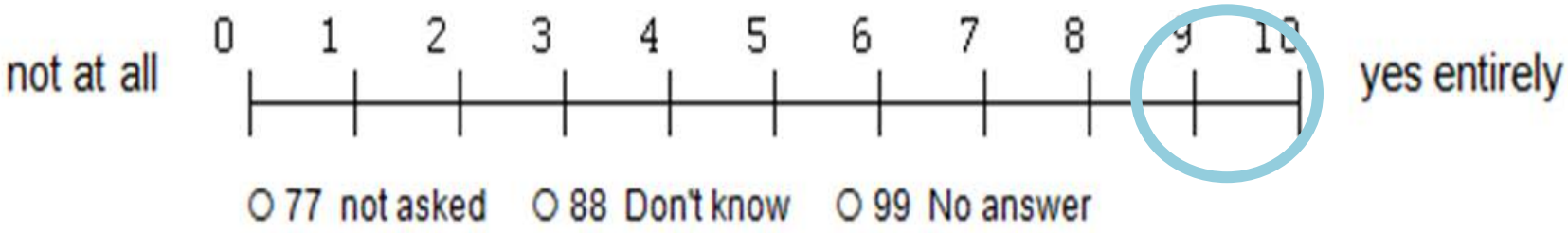
"**The lockdown.** All the keys, the locks. I understand it's got to be that way […] but I still think there's better ways, a bit of discretion…just to keep everyone calm and a little bit more reassured"

Feeling different

"I feel like I'm kind of with a **broken bone in a burns ward**"

"I think um, it would be a better idea to um, separate er, perhaps the scale of people; like if somebody's up here and somebody's down there, don't put 'em all together"

Positive appraisals



Feeling cared for

“staff have been wonderful, they really are, even down to the cleaners you know… there’s nothing, they can’t do for you […] I’m not trying to big them up just because I’m here, they are **genuinely nice people**.”

Previous experience of hospitalisation

“ I: what was your first impression?

R: (laughs) **Well I am used to it!** When I arrived, I knew I was gonna get to see the doctor and that he would ask me if I can spend some time here, they’re gonna review my medication, I knew all of these things”

Patients supporting each other

"it is a marked change from the isolation and so the company is very therapeutic"

"everybody's here for different reasons I suppose. But um, yeah, **they're not judging me; they help me**."

Conclusions

- Relationships – patients and staff
- Feeling informed

Does personal continuity improve outcomes? The COFI study

Victoria Bird

Continuity or Specialisation in COFI

Continuity

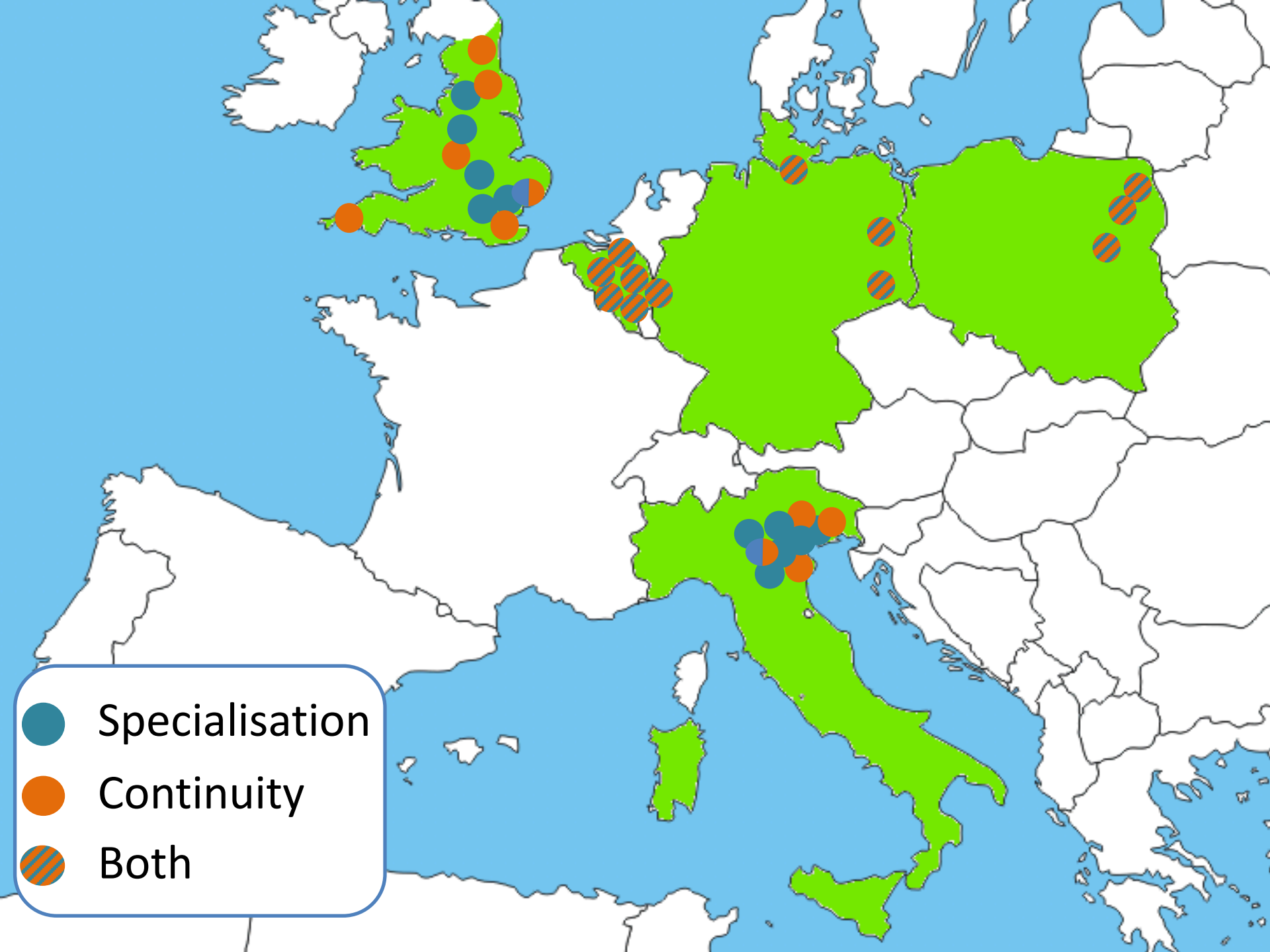
- Same mental health staff

Specialisation

- Care is provided by different teams in distinct services (inpatient and outpatient)

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
- Recruited 7304 participants


Specialisation
Continuity
Both

Index admission

- Based on 2707 UK patients

- Continuity of care:
  a) **Shorter** length of stay
  b) **Higher** initial treatment satisfaction

Readmission

- Specialisation: 25% vs Continuity: 33%
- More likely to be readmitted in continuity systems
- Associated with re-admission
  + Diagnosis of psychosis
  + Repeated admission

Number of Days

- No difference in total number of days
- Associated with increased days
  + Symptom severity
  + Diagnosis of psychosis
  + Repeated admission
  + Involuntary admission

Involuntary readmission

- Less likely to be admitted involuntarily in continuity systems
- Association with involuntary admission
  + Increased age,
  + repeated admission
  + Involuntary index admission

Conclusion

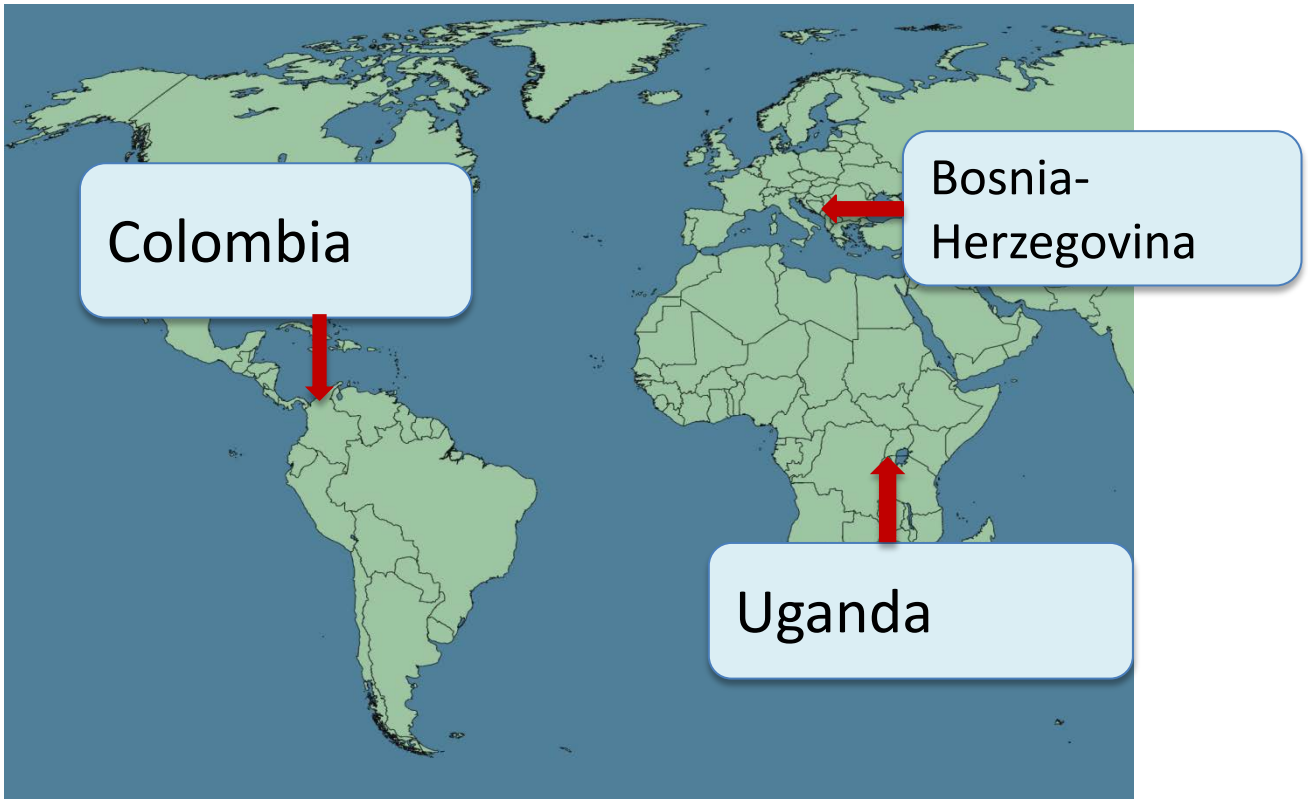
- So far, no clear winner…..
- Organisation depends on **priority:**
  - Satisfaction = Continuity
  - Readmission = Specialisation
  - Number of days = No difference
  - Involuntary admission = Continuity

NIHR Global Health Research Group on developing psycho-social interventions

Elizabeth Worswick

The Research Group

- Research Group based at Queen Mary University of London, in partnership with ELFT
- Research Groups established in three countries:



Aims

1. Adaptation and testing of **resource-oriented** approaches

2. Research capacity building

3. Exploring concepts of global mental health and international collaboration

Resource-oriented approaches

- Utilising existing strengths and resources
- Patient or community level
- Three types of resource-oriented interventions:

DIALOG+

Volunteer support

Family involvement

Next steps

- Local workshops in each country
- Research plans and protocols for RCTs
- Further specification of interventions

Next steps

- Monthly Global Health seminars at QMUL
  → Tuesday 7th November 2017

- Teaching week here at QMUL/ELFT
  → 9th – 13th April 2018

- Five week residential for overseas partners
  → April – May 2018

Closing remarks

Stefan Priebe

Reminders

- Feed back questionnaires
- All slides uploaded to the conference webpage

Thanks to

- All patients, carers and staff who supported research
- Karin Albani for organising the event
- All volunteers and researchers for helping today
- Vicky Bird and Alan Simpson for chairing
- All speakers for their presentations
- All of you for attending!!!

By this time next year,

ELFT will have a new research strategy


WATCH
THIS
SPACE

Finally, please note for next year:

16th Annual
Mental Health Research in East London

When?

3rd October 2018!

Where?

Here!