News on Research in ELFT

Stefan Priebe

Research Governance 2017/8

- All performance criteria of research governance fully met
- Good performance in research management
  - reduced costs per recruited patient (now £71 vs overall £94)
  - mean number of days to site confirmation = 15 vs overall 37
- Background of more complicated bureaucracy

Research Grants held in ELFT

- Tackling chronic depression (TACK)
  NIHR: 2017-2022; £2.5m; PI = **Vicky Bird**
- Improving quality of life through expanding social networks (SCENE)
  NIHR: 2017-2022; £2.7m; PI = **Domenico Giacco**
- Effectiveness of group arts therapy (ERA)
  NIHR: 2018-2021; £1.4m; PI= **Catherine Carr**

Research Presentation Day 2017:

‘By this time next year,

ELFT will have a new research strategy!’


WATCH
THIS
SPACE

But:

- Research Committee
  - Chair: Ken Batty, NED
- Research Plan, considering
  - role of NHS Trust in Research
  - various benefits for ELFT

Frank Röhricht: Medical Director for Research, Innovation and Medical Education

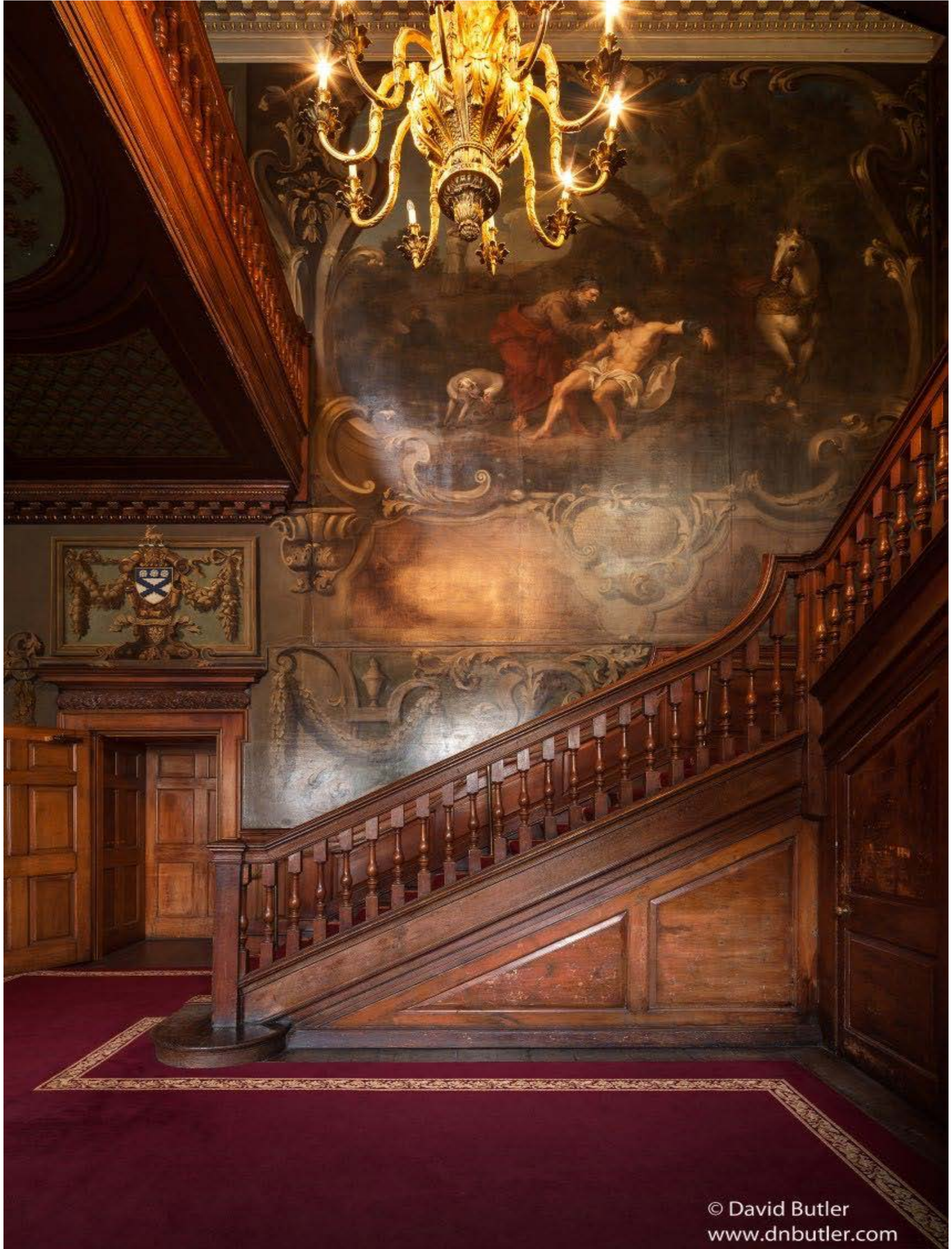
Queen Mary University of London

- New:
  Bart's Institute of Population Health Sciences
- Director: Chris Griffiths
  Teaching Director: David McCoy
  Research Director: Stefan Priebe
- Centre for *Primary Care and Mental Health*, including
  Unit for Social and Community Psychiatry

Rosemarie McCabe:
Professor of Clinical Communication,
City, University of London

Today

- As usual:
  - format with brief presentations
  - range of topics
  - feed back questionnaires
  - #ELFTResearch
- Some changes:
  - not solely findings, more space for ideas
  - break in North Wing



© David Butler
www.dnbutler.com

Today

- As usual:
  - format with brief presentations
  - range of topics
  - feed back questionnaires
  - #ELFTResearch

- Some changes:
  - not solely findings, more space for ideas
  - break in North Wing
  - final words

Can volunteer befrienders make a difference to the social life of patients with psychosis?

Agnes Chevalier

Befriending benefits

Patients

- Increased confidence & mood
- Increased social activities

Volunteers

- Rich new experience
- Understanding of mental illness

Community

- Reduces social distance
- More cohesive community

FRIENDS:

MUCH CHEAPER THAN A PSYCHIATRIST

RCT

Patients (N=124)	Volunteers (N=51)
64% Male	73% Female
Age= 42 years	Age= 28 years (mode =21)
Mixed ethnicity	Mostly white
Unemployed/Living alone	FT or PT employed
Length of illness= 15 years	65% aspire to work in mental health

How did the scheme go?

Allocated to intervention N = 63

At least one meeting with a volunteer N = 49

Compliers (>12 meetings) N = 31

Results

- No evidence for an effect on time spent in activities, self-esteem, symptoms or quality of life.

- But significant differences on social contacts at 12m
  - Number of different people seen
  - “In the last week have you seen a friend?”

- These benefits remain at 18m follow-up

- Among those that adhered to the intervention experiences were very positive

Conclusions

- No evidence of an effect on clinical outcomes and quality of life
- However, evidence for significant gains in social contacts at 12 and 18 months
- Despite high drop out rate and low adherence
- The experience was very positive and fulfilling for many, although not for all

Implications

- For practice:
  - Flexible schemes
  - Realistic expectations

- For research:
  - Collect data from existing schemes
  - Exploring how to improve patient and volunteer experiences

Patients preferences of being in contact with a volunteer

Dr Mariana Pinto da Costa

Survey

151 patients with **psychosis**

Interests

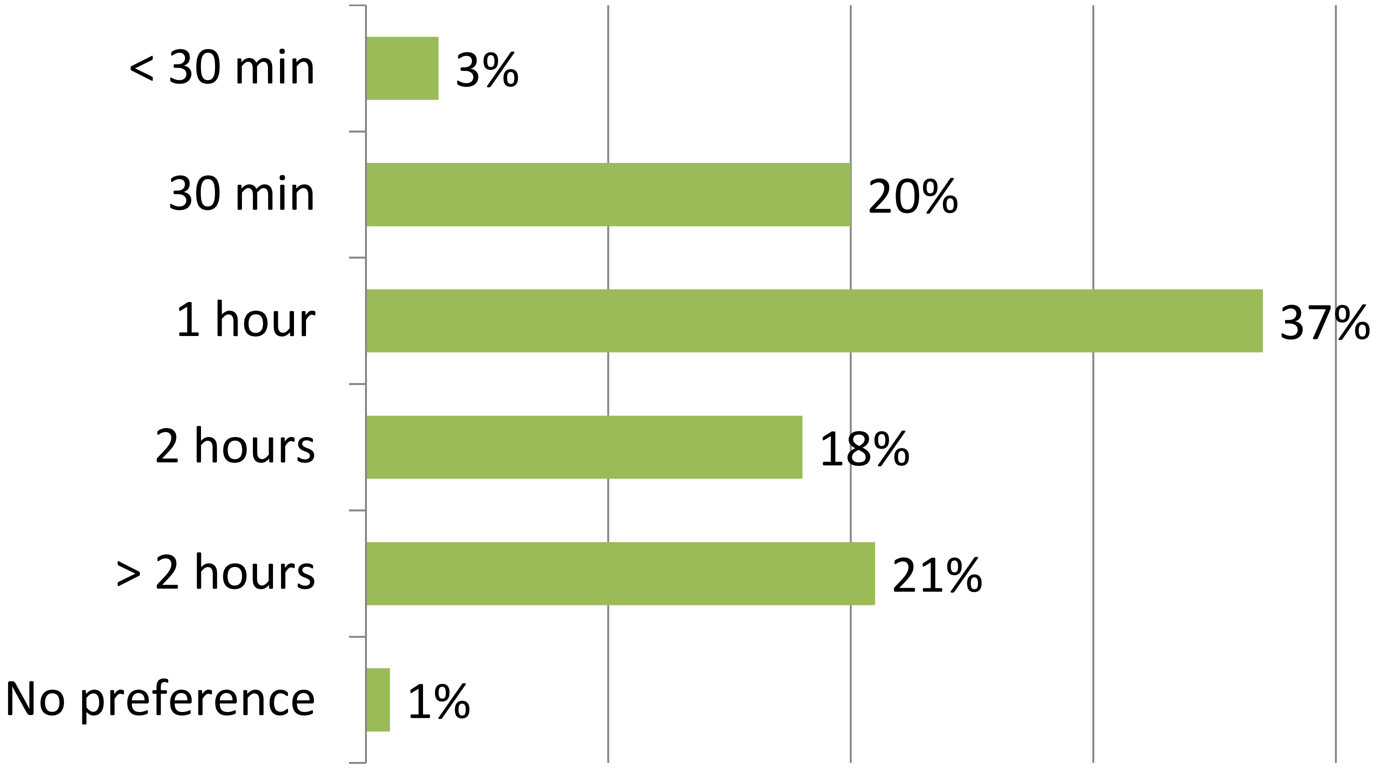
- 58% **face-to-face**
- 37% **digitally**

13% did not use **technology**
(internet, computer, phone)

Pinto da Costa et al., submitted

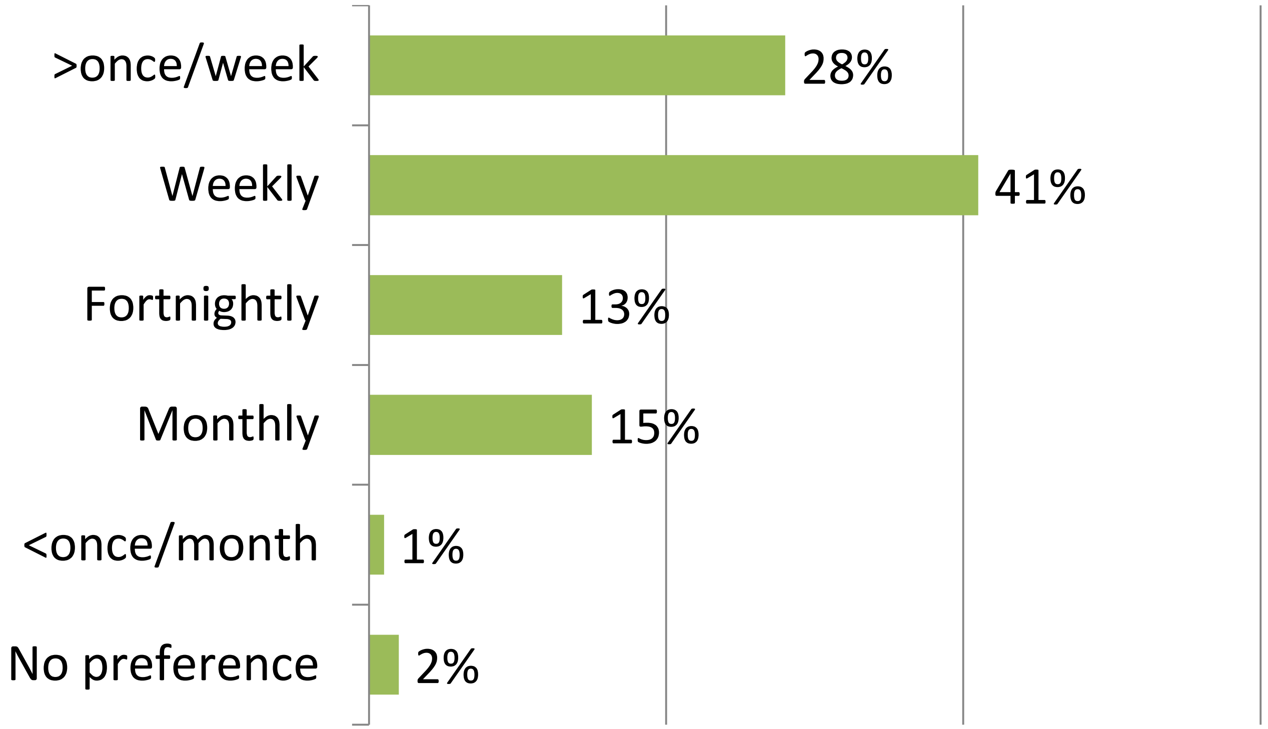
Face-to-face

Duration of the contacts



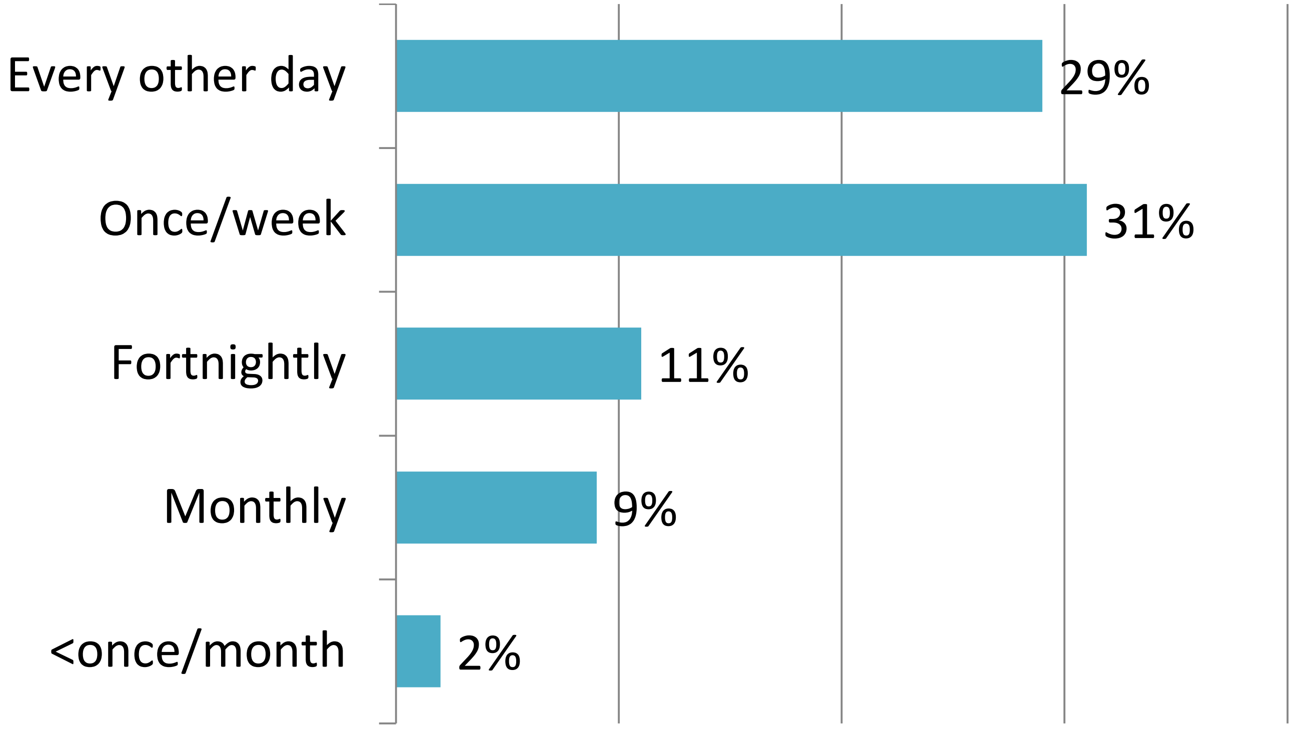
Face-to-face

Frequency of the contacts



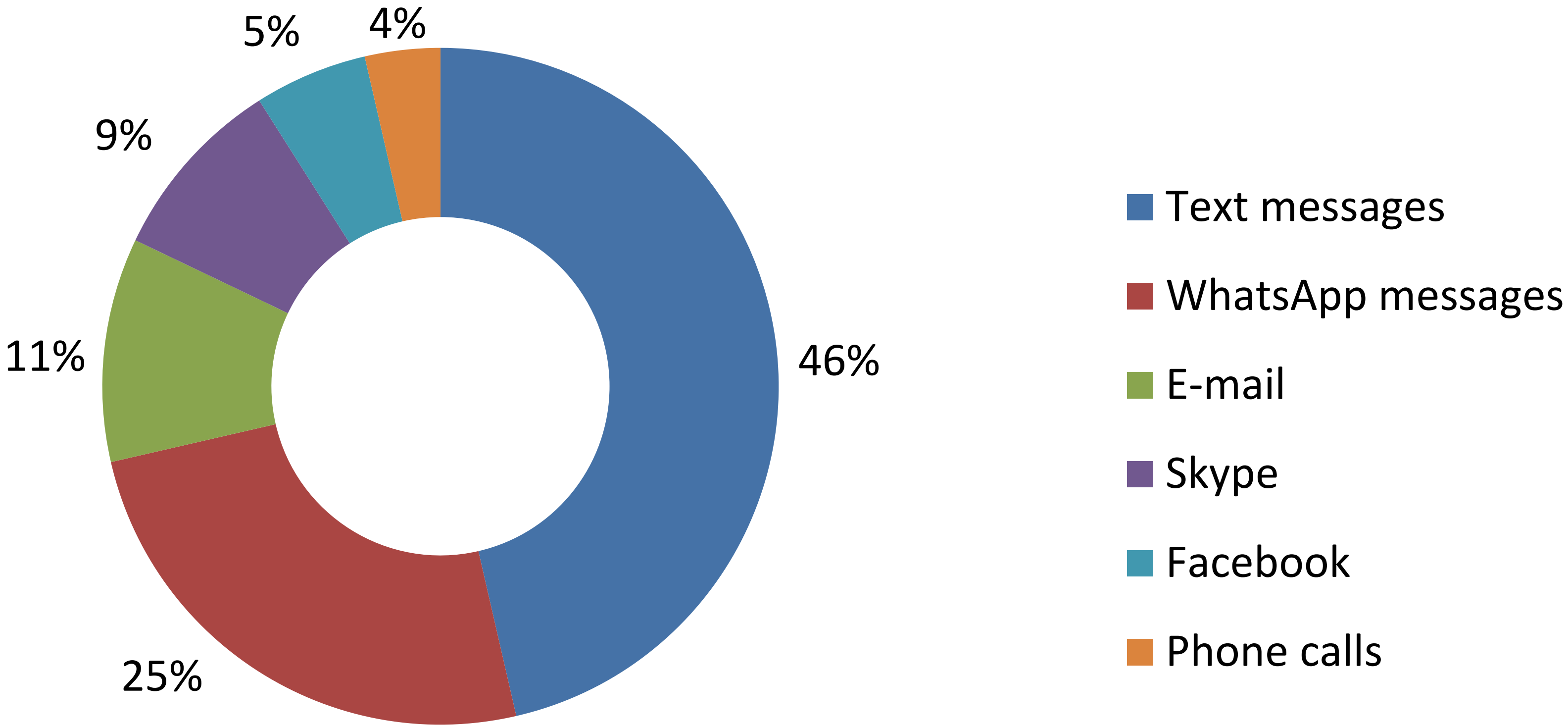
Digitally

Frequency of the contacts

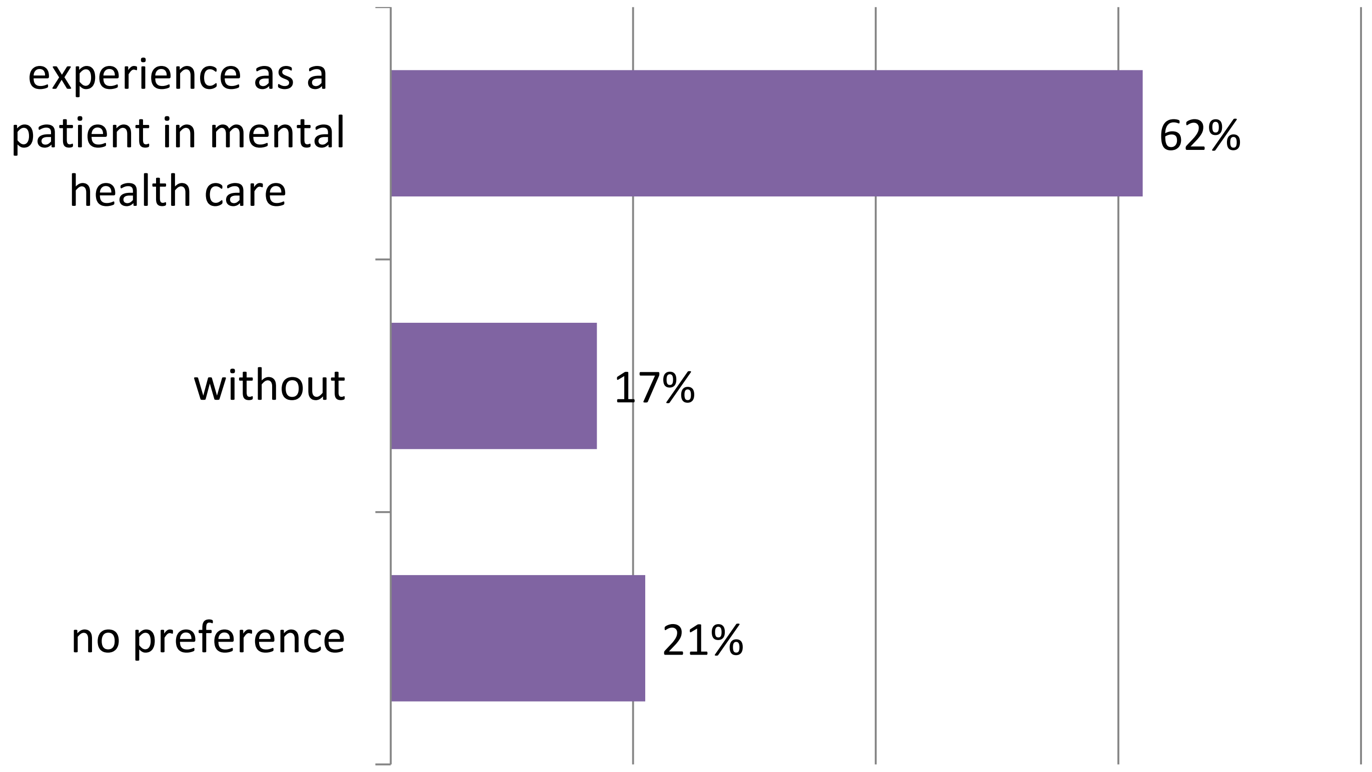


Digitally

Methods of contact



Volunteer


experience as a patient in mental health care
62%
without
17%
no preference
21%

Differences

Predictors of interest

- Face-to-face: ⬇ **quality of life**
- Digitally: ⬇ **age**

Aim

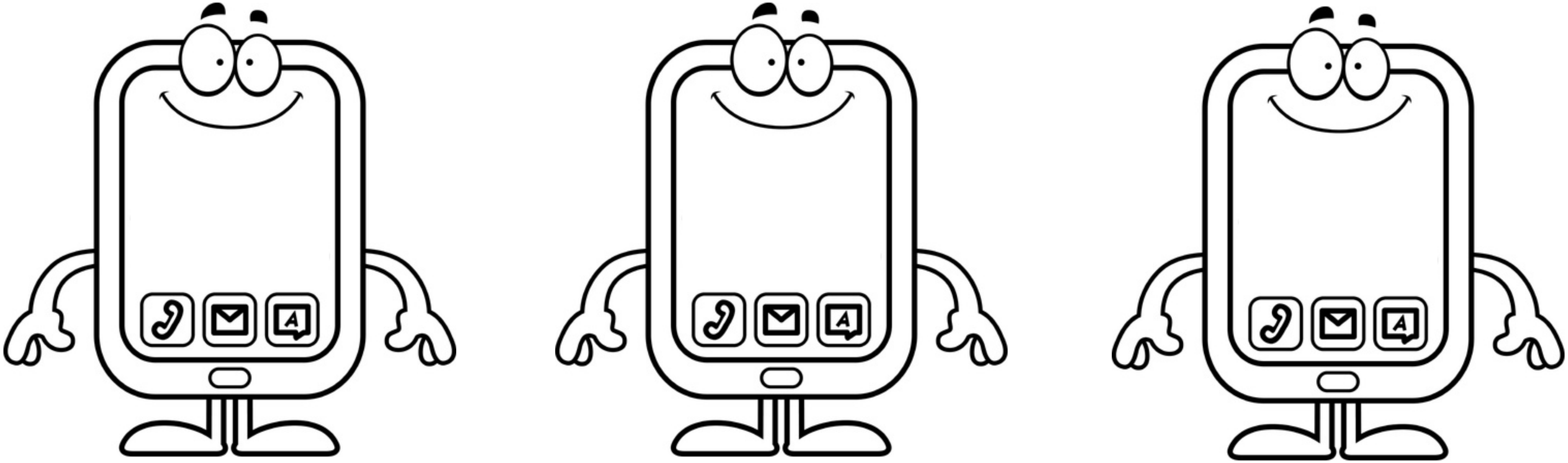
- Face-to-face: **do more activities**
- Digitally: make a **new friend**

NEW Intervention

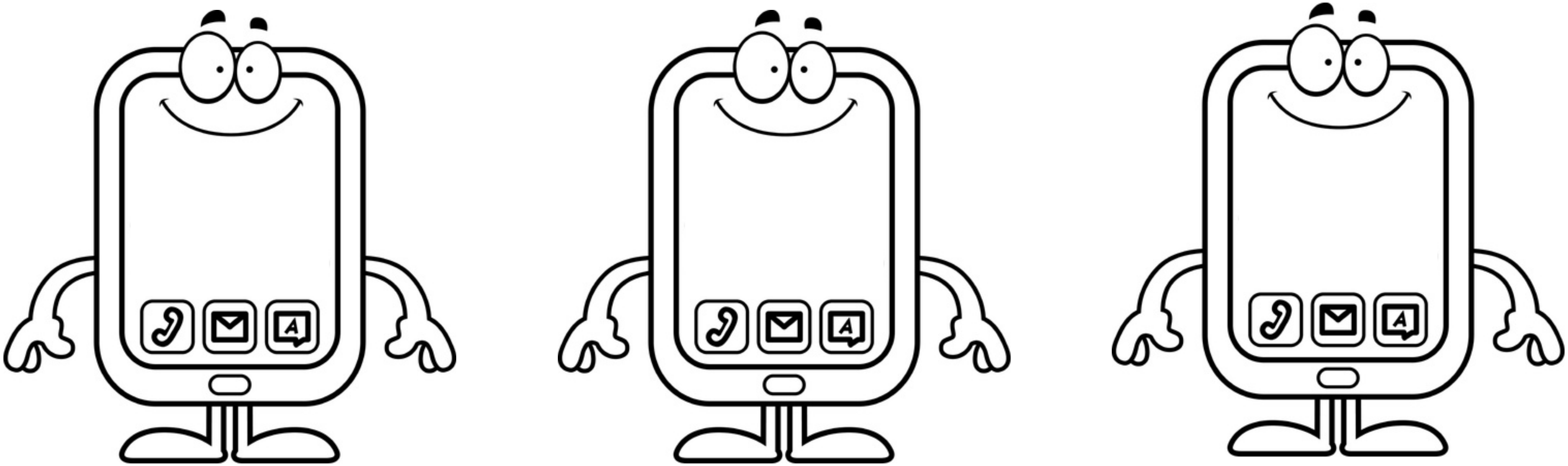
PHONE PAL

CONNECTING PEOPLE

What next?



Questions?



Contact : mariana.pintodacosta@qmul.ac.uk

Recovery Colleges
A rapidly expanding service model, but are they effective?

Dr. Sally Barlow

Research Questions

1. What outcomes are measured to assess the effectiveness of Recovery Colleges?

2. Are Recovery Colleges effective?

Outcome Measures & Evaluation

Domain	Outcome Measure	Effect
Personal Recovery	**Questionnaire of Process of Recovery (QPR) (N=3)**	**+**
	Herth Hope Index (HHI), CHOICE, Empowerment scale (ES), Empower Flower, Internalised Stigma Scale (ISMI-10) (N=1)	**+**
	Recovery Attitudes Questionnaire (RAQ-7), The Tennessee Self concept scale (N=1)	**NS**
Quality of life and mental wellbeing	**Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (N=3)**	**+**
	Manchester Short Assessment of Quality of Life (MANSA), Brief Quality of Life Interview (N=1)	**+**
Service Use	**Occupied Bed Days (N=2)**	**+**
	Community Contacts (N=2)	**+**
	Admissions (formal and informal) (N=1)	**+**
	Community Treatment Order (CTO) (N=1)	**0**

Recovery Colleges: Are they effective?

- Lack of consensus on what to measure
- We don't have conclusive evidence that Recovery Colleges are effective

Challenges

- **Studies are heterogeneous**
- **Low quality studies**
- **Absence of explicit theoretical basis**

Future directions:

- **Develop an explicit theory of change**
- **Consensus on outcome measures**
- **High quality research**
    - **Fidelity measure**
    - **Controlled research /realist evaluation**

Acknowledgements

Review Team: Professor Alan Simpson, Frederique Lamontagne-Godwin, Dr. Sebastian Gabrielsson, Dr. Julia Jones and Professor Eimear Muir-Cochrane

Dr Sally Barlow
City, University of London
T: +44 (0)20 7040 5978
E: Sally.barlow.1@city.ac.uk

Some further reading:

- Perkins, R., Meddings, S., Williams, S and Repper, J (2018) **Recovery Colleges 10 years on**. Briefing paper No.15, Implementing Recovery through Organisational Change (ImROC)

Are Arts Therapies Effective?
The ultimate trial

Catherine Carr

Arts Therapies

Evidence so far…

- Cochrane reviews – small trials

- MATISSE Crawford et al. *BMJ.* 2012;344
- NESS Priebe et al. *BJPsych.* 2016;209
- TIME-A Bieleninik et al. *JAMA.* 2017;318

→ Diagnostically heterogeneous groups

The Model

era

Preference

- Art therapy
- Dance movement therapy
- Music therapy

Random Allocation

- Preferred arts modality or
- Group counselling control
- 40 sessions, twice per week for 20 weeks

Follow-up

- Post-intervention, 6 and 12 months
- Qualitative interviews

Conclusion

- Largest ever group arts therapies trial
- Logistical challenges
- More to follow 4 years from now…..

Putting a Reference into Preference

Eliciting Patient Preferences for the Arts Therapies

Emma Windle

Choosing a treatment

- Five year forward view for mental health
- Swift, Callahan, Cooper, & Parkin (2018)
  - Meta-analysis
  - 53 studies
  - 16,000 clients
  - Preference accommodation = fewer treatment dropouts and more positive treatment outcomes

How do people choose a therapy?

Eliciting preferences in the arts therapies

Dance-movement Therapy

Music Therapy

Art Therapy


DANCE MOVEMENT
THERAPY

Researching patient preference

- How do patients choose a therapy?
- What are the reasons for their preferences?
- What is the impact of receiving their preference (or not)?

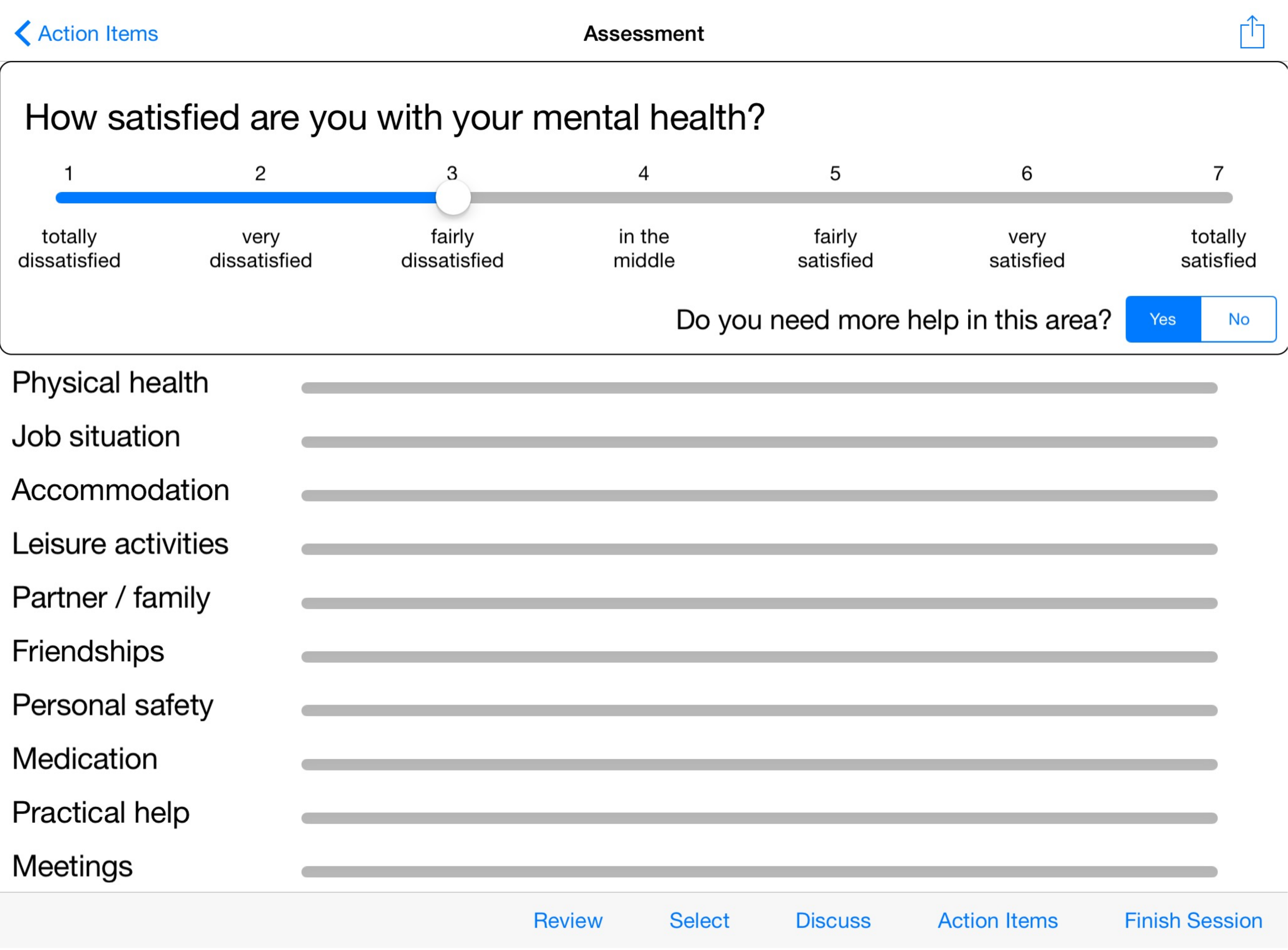
Any questions?

DIALOG+ for chronic conditions in primary care

Dr Philip McNamee

Background

- DIALOG+ is a resource-oriented approach to community mental health care
- Turns routine meetings into a therapeutically effective intervention
- Could it be applied to management of chronic conditions in primary care?



How satisfied are you with your mental health?

1	2	3	4	5	6	7
totally dissatisfied	very dissatisfied	fairly dissatisfied	in the middle	fairly satisfied	very satisfied	totally satisfied

Do you need more help in this area? [✓ Yes] No

Physical health

Job situation

Accommodation

Leisure activities

Partner / family

Friendships

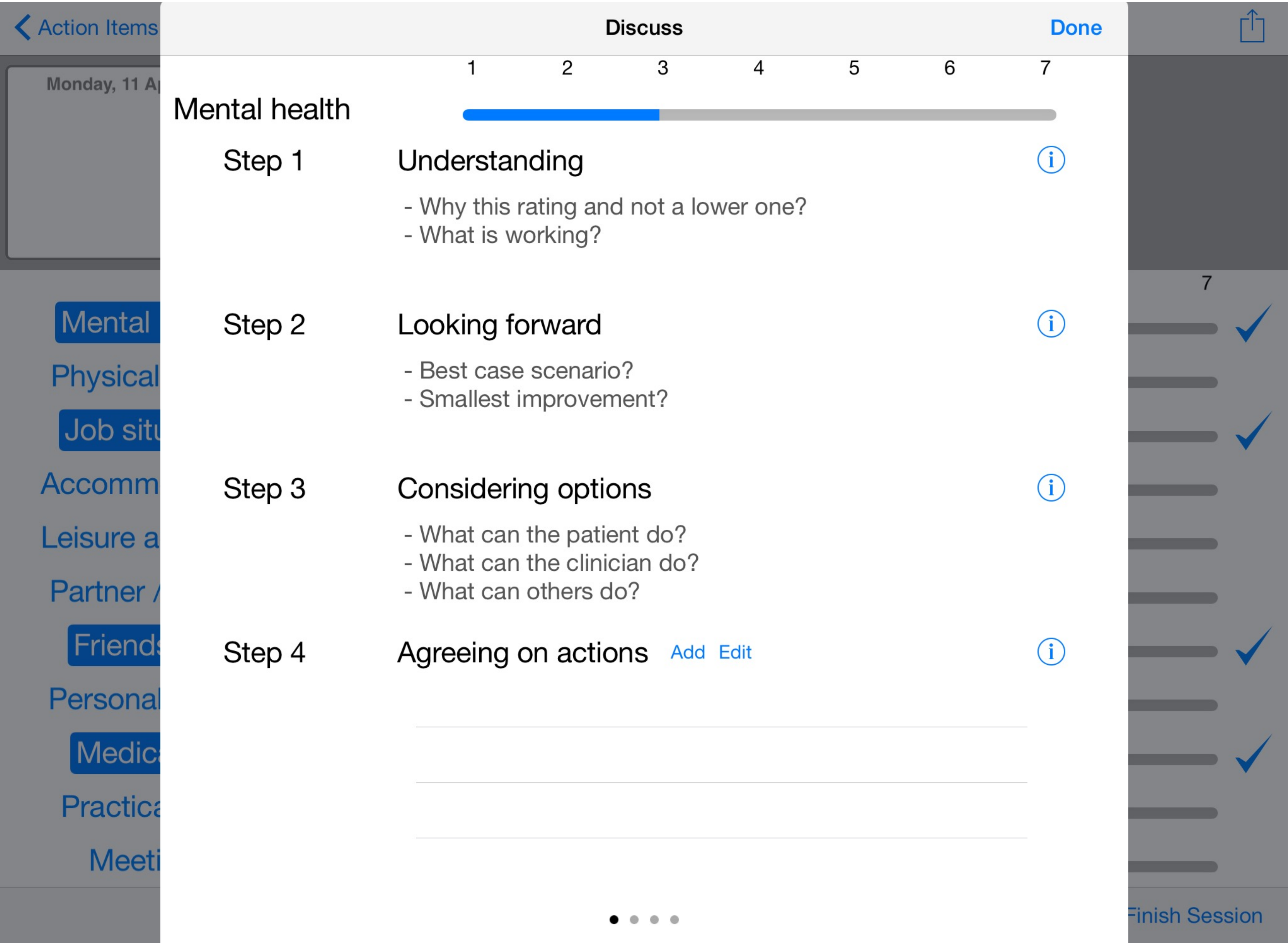
Personal safety

Medication

Practical help

Meetings


Action Items
Assessment
Monday, 11 April 2016
Friday, 13 May 2016
Current Assessment
1
2
3
4
5
6
7
Mental health
Physical health
Job situation
Accommodation
Leisure activities
Partner / family
Friendships
Personal safety
Medication
Practical help
Meetings
Review
Select
Discuss
Action Items
Finish Session



Mental health

Step 1 Understanding

- Why this rating and not a lower one?
- What is working?

Step 2 Looking forward

- Best case scenario?
- Smallest improvement?

Step 3 Considering options

- What can the patient do?
- What can the clinician do?
- What can others do?

Step 4 Agreeing on actions Add Edit

Data is drawn from 2 studies

1) TACK

TACKLING CHRONIC DEPRESSION

2) **DIALOG+ for DIABETES**

Methods

- Exploratory semi-structured interviews
- Multi-disciplinary clinicians in primary care
  - GPs; Nurses; Primary Care Liaison Practitioners, HCA
- Analysed using deductive thematic analysis

Findings

- Three themes found in both studies

SERVICE STRUCTURE CONSTRAINTS

DIGITAL INTEGRATION

PROBLEM FOCUSED NATURE OF PRIMARY CARE

Service Structure Constraints

"*What we are grandmasters at in general practice is chunking things up in **10 minutes slots***." (GP3_Depression)

"*It's quite good but **quite time consuming** (…) We have diabetic clinics in maximum 15 minutes that's what we get for complicated diabetics.*" (GP7_Diabetes)

Digital Integration

*"It's just that increasingly we realise the **importance of having connectivity** between these apps or external systems and the systems you use every day because we have experienced a lot of difficulties connecting records."* (GP6_Diabetes)

"*it would only work if you **integrated into EMIS**, into our computer system, and so there is a difficulty there*." (GP1_Depression)

Problem focused nature of Primary Care

“It is less about using that [tablet] *and more about…fundamentally it is about* ***re-orienting staff*** *(…) people from general practice they are still there trying to come up with answers for patients rather than* ***helping patients to come up with the answers**.”* (GP3_Depression)

“we are so ***grounded in a problem way of understanding*** *(…) staying focused on a solution that the patient is suggesting not that we are suggesting- takes a lot of skill.”* (GP4_Diabetes)

Conclusions

- DIALOG+ , for chronic conditions in primary care, is feasible, but only for certain settings
  - **Requires digital integration as a priority**
  - **Development of processes, rather than content**
  - **Compatible with intermediary primary care services**

- DIALOG+ has potential to change culture to be more solution focused and holistic

- Ongoing work, looking at the service user experience of receiving DIALOG+ in primary care https://dialog.elft.nhs.uk

philip.mcnamee@nhs.net

🐦 @philipmcnamee

Virtual Reality: A Future for Group Therapy?

Merve Dilgil

Group Therapy

Non-attendance

Impact of non-attendance

1. Non-attending patient

2. The attending patients

3. Financial ramifications for service providers

Facilitators	Barriers
Opportunity for autonomy	Concerns about social interactions
Self-acknowledging need	Not being sufficiently informed
Safe environment	Limited accessibility
Interest in content and enjoyment	Negative group dynamics
Actual and expected benefits of attendance	

The Light-bulb Moment

VR in Mental Health

Exposure Therapy

Cue-exposure

Avatar Therapy

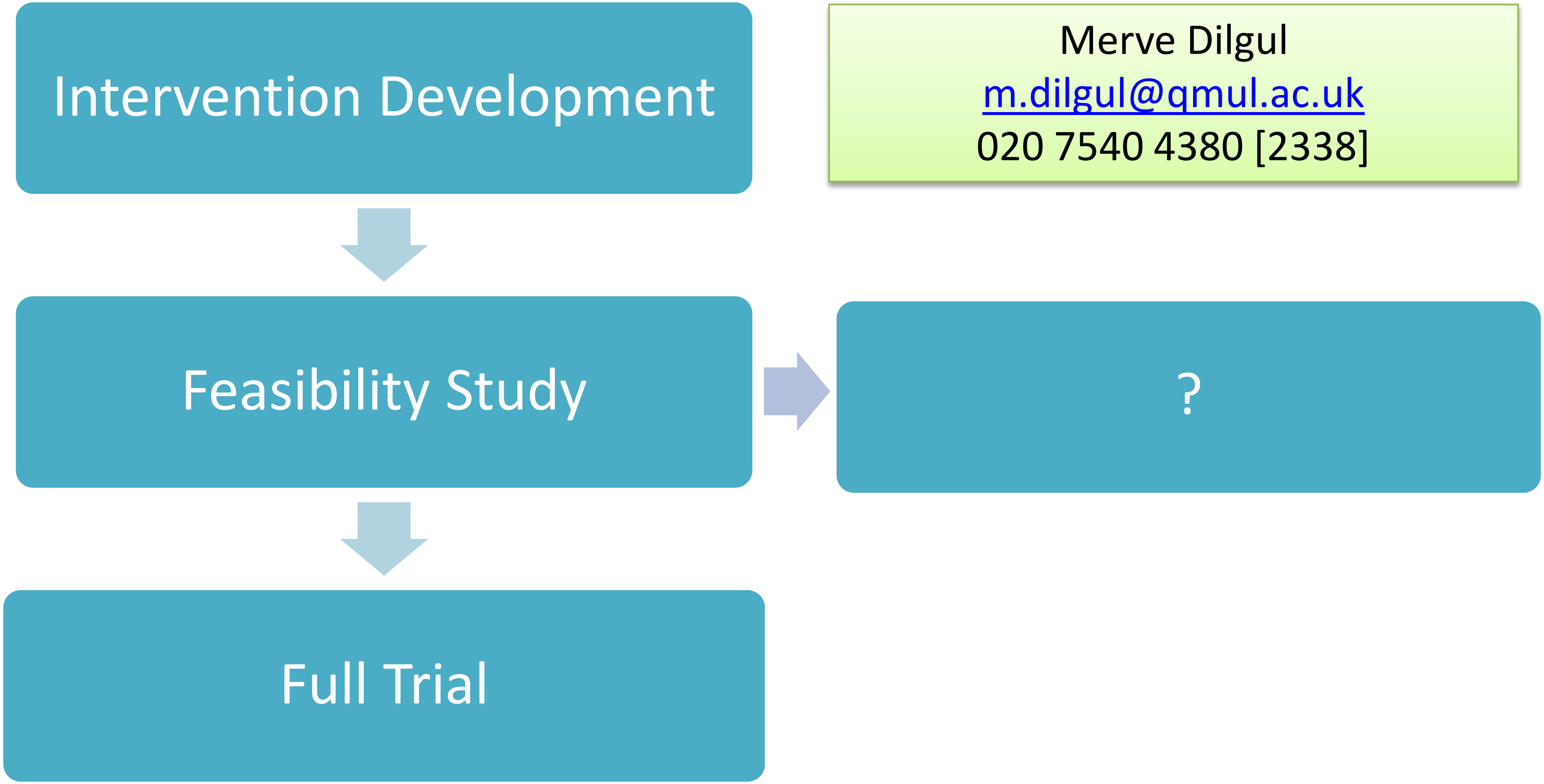
Virtual coach

VR Groups

Facilitators	Barriers
Opportunity for autonomy	Concerns about social interactions
Self-acknowledging need	Not being sufficiently informed
Safe environment	Limited accessibility
Interest in content and enjoyment	Negative group dynamics
Actual and expected benefits of attendance	

VR Groups

What next?



Intervention Development

Feasibility Study

?

Full Trial

Merve Dilgul
m.dilgul@qmul.ac.uk
020 7540 4380 [2338]

The COFI study – Episode IV

Final results and implications

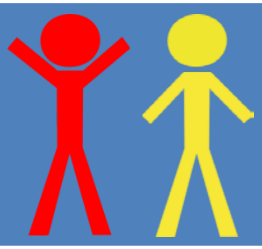
Victoria Bird

Continuity or Specialisation in COFI

Continuity

- Same mental health staff

Specialisation



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

Participants

- Patients approached within two days of hospital admission and followed up for **1 year**

- Baseline: 7302
- Follow up sample: 6369 (87%)

- Qualitative interviews: 188 patients / 63 clinicians

- Making COFI ***the*** definitive study to help settle the continuity vs. specialisation debate

Main Findings

- Inpatient satisfaction: CONTINUITY
- Re-admission: X
- Length of stay: X
- Involuntary admission: X
- Untoward events: X

Length of index hospital stay

- No difference between personal continuity and specialisation
- But: huge differences between countries

	Total	Belgium	England	Germany	Italy	Poland
Days, **mean** (SD)	**39.4** (49.7)	**55.1** (62.4)	**46.2** (63.0)	**37.0** (29.2)	**17.9** (16.6)	**33.4** (28.1)

- These were not explained by patient characteristics

Experience of care

Strengths and weaknesses of the system mirrored each other both patients and clinicians:

Specialisation

"There should be an inpatient psychiatrist and an outpatient psychiatrist because the inpatient psychiatrist sees you when you're unwell… I like the fact my psychiatrist met me when I'm well in the community because she doesn't have that previous picture of me"

Continuity:

"Patients like me feel better with a clinician who they know and who knows them. Then it's easier to talk because the matters covered are rather sensitive"

Decision-making

- Assessed the match between decision-making style and actual experience
- Majority of patients wanted shared decision-making. But…..
- Only 25% of patients reported a match
- Furthermore…..access to psychological treatments most problematic

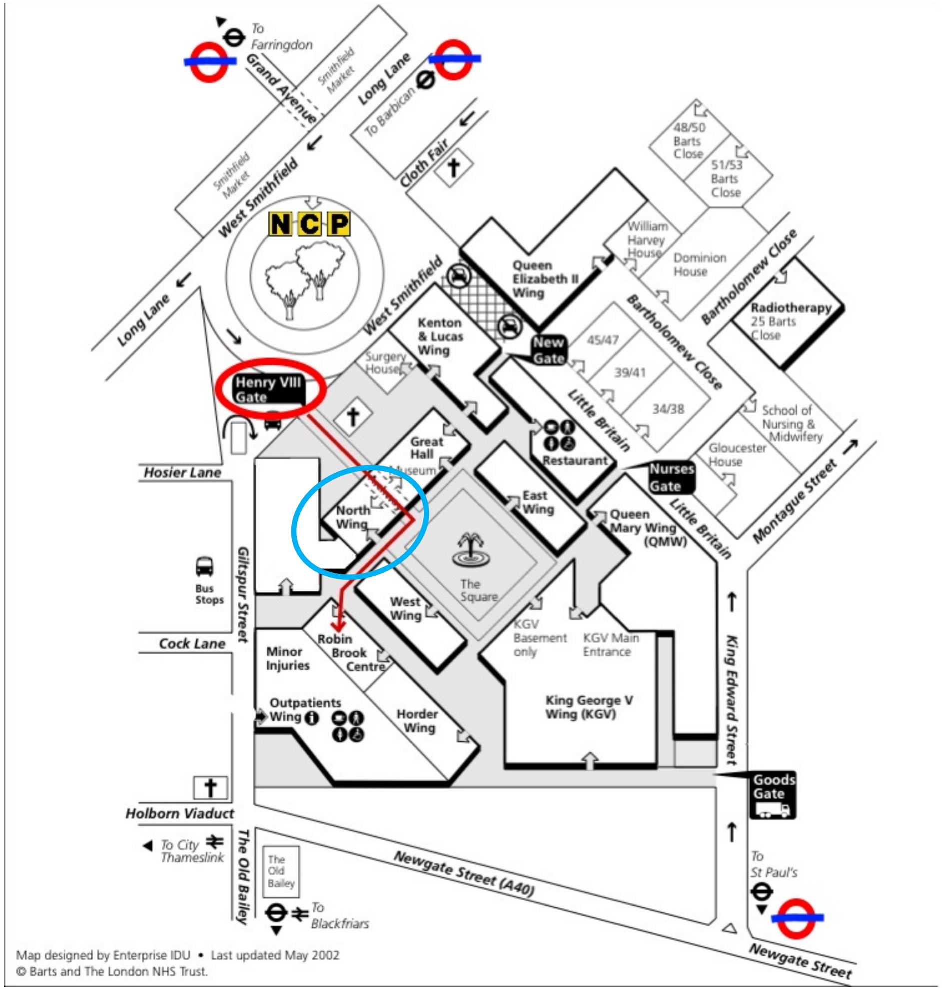
Discrimination

- All patients reported experiencing or anticipating discrimination
- Most pronounced for patients with anxiety disorders
- Yet focus is often on psychosis

Implications and Conclusions

- The system of care has little impact on any clinical outcome at one year.
- If the aim is to improve inpatient satisfaction continuity is favoured.
- Patient preferences are particularly important when there is a choice between the two systems, or when making clinical decisions.
- Should research, policy and practice focus on the content of care instead of the organisation of care????

Break



Map designed by Enterprise IDU • Last updated May 2002
© Barts and The London NHS Trust.

Communicating a Diagnosis of Dementia

Professor Rose McCabe, City University of London
Jemima Dooley, Nick Bass
And the Shared Project Team

NICE states “People should be told their diagnosis as clearly and honestly as possible. Without this knowledge, people cannot begin to make sense of what is happening, nor can they plan effectively for their future”

ShareD

Shared Decision Making in Dementia: The ShareD Project

The number of people with dementia in the UK is currently 820,000 and set to rise to 1,000,000 by 2021. Government policy advocates patient involvement in decision making, stating "no decision about me without me".

Find out more

DEVON
THREE CLINICS
ONE-STOP SHOP

LONDON
SIX CLINICS ACROSS
THREE TRUSTS

Data

- 21 doctors – psychiatrists and geriatricians
- **81 video-recorded diagnosis feedback meetings**
- 9 UK memory clinics
- **‘One stop shop’ & conventional pathway**
- 75% meeting patient for the first time
- 60% patient consent rate
- 46.5% people seen in memory clinic diagnosed with dementia

Stages of Dementia Diagnosis Delivery

Average meeting length: 28:07 (08:25 - 01:04:05)

Elicit Patient’s Orientation

Feed Back Test Results

Diagnosis Delivery

Diagnosis: 2 formats

- All doctors named dementia – no avoidance of diagnostic label suggested by previous research
- Average time spent on diagnosis discussion: 02:38 (00:20 – 10:10)
- **Indirect** delivery 59%
- **Direct** delivery 41%

Indirect Delivery

Indirect Delivery

Inference required
More sensitive

DR: um (0.4) so (.) I think (0.6) um (0.6) that that **what's**
causing this is the very very early stages of a
condition called Alzheimer's disea:se.
PT: °↑mm:°
(1.0)
DR: um (0.8) and I I'll tell you all the reasons for tha:t.
PT: °m: m°
DR: um (0.4) how does that sound to you:
(0.8)
PT: yea:h it's a bit ↑frightening
DR: I'm sure it i::s yea::h these things can be frigteni:ng,
PT: yea::h

Downplaying/
Softening language

Indirect delivery

1. present evidence of the patient’s problems (symptoms, test results, brain scan)
2. label them as dementia

- Requires patient inference that because they have those symptoms, and those symptoms are dementia, they have dementia
- In other settings, used to deliver diagnoses to avoid strong emotional or resistant responses

Direct delivery

DR: tch .hh so putting all that together (0.7) okay I think
your memory is more impaired than we would expect
for somebody of your age okay tch (0.4) um (1.1) are
you alright about me going ahead and saying what what
we think this is due to you know actually [giving you]
PT: [yes]
DR: a label for it are you okay with that?
PT: yes
(0.4)
DR: well I think what you've what you've got is
you've got Alzheimer's disease
PT: ah no (0.5) oh dear
PT: I have?
(1.7)
PT: I'm not very pleased about that

Interactionally more blunt
Enhances understanding?

Direct delivery

- “You have dementia”
- More blunt and thus likely to increase emotional or resistant responses
- Requires less patient inference to understand the diagnosis
- Used more often with people with **lower cognitive test scores**
- Aim may be to maximise understanding?

Prognosis

- Prognosis discussed directly in 62% meetings
  - 1/3 of prompted by patient or companion questions
- Discussed indirectly in context of medication in 25% meetings
- Not mentioned in 13% of meetings

Prognosis discussed directly

Prognosis

Explicit discussion of prognosis

DR: the nature of the condition itself is that it does
tend (0.4) tend to get worse over time
(0.8)

Qualifying language

DR: but (0.4) that time period isn’t (.) a matter of
weeks or months it’s over many years (.) normally
that we see (.) changes
(.)

Emphasising slow progression

DR: um (0.4) so (1.2) it’s not so- (.) what I’m
not suggesting is that you’re going to see things
getting worse very quickly
CR: mm
DR: but it (.) still it’s quite useful for you and your
family to know that it it may be that over time (0.8)
things (0.4) you know things might change a little bit

Downplaying

Prognosis discussed indirectly in context of medication

Prognosis discussed indirectly

```
DR: I mean in terms of other (0.3) the other thing that
    we can do is to give you a tablet if you would like
PT: mm
DR: um (.) a memory table[t ]
PT:                      [ye]ah
DR: um which (.) um (1.4) what we find is on average
    people tend to what it does is it stabilises things
    for about twelve to eighteen months
PT: mhm
```

Non-specific language

No explicit discussion of prognosis

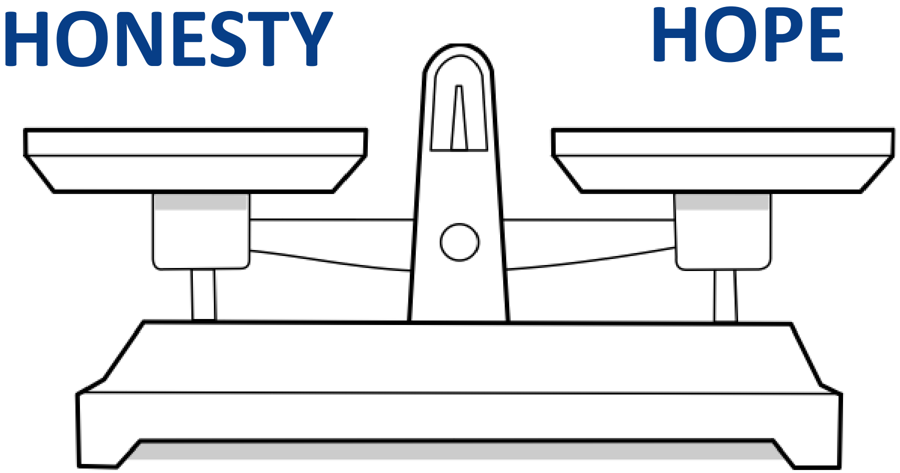
Findings

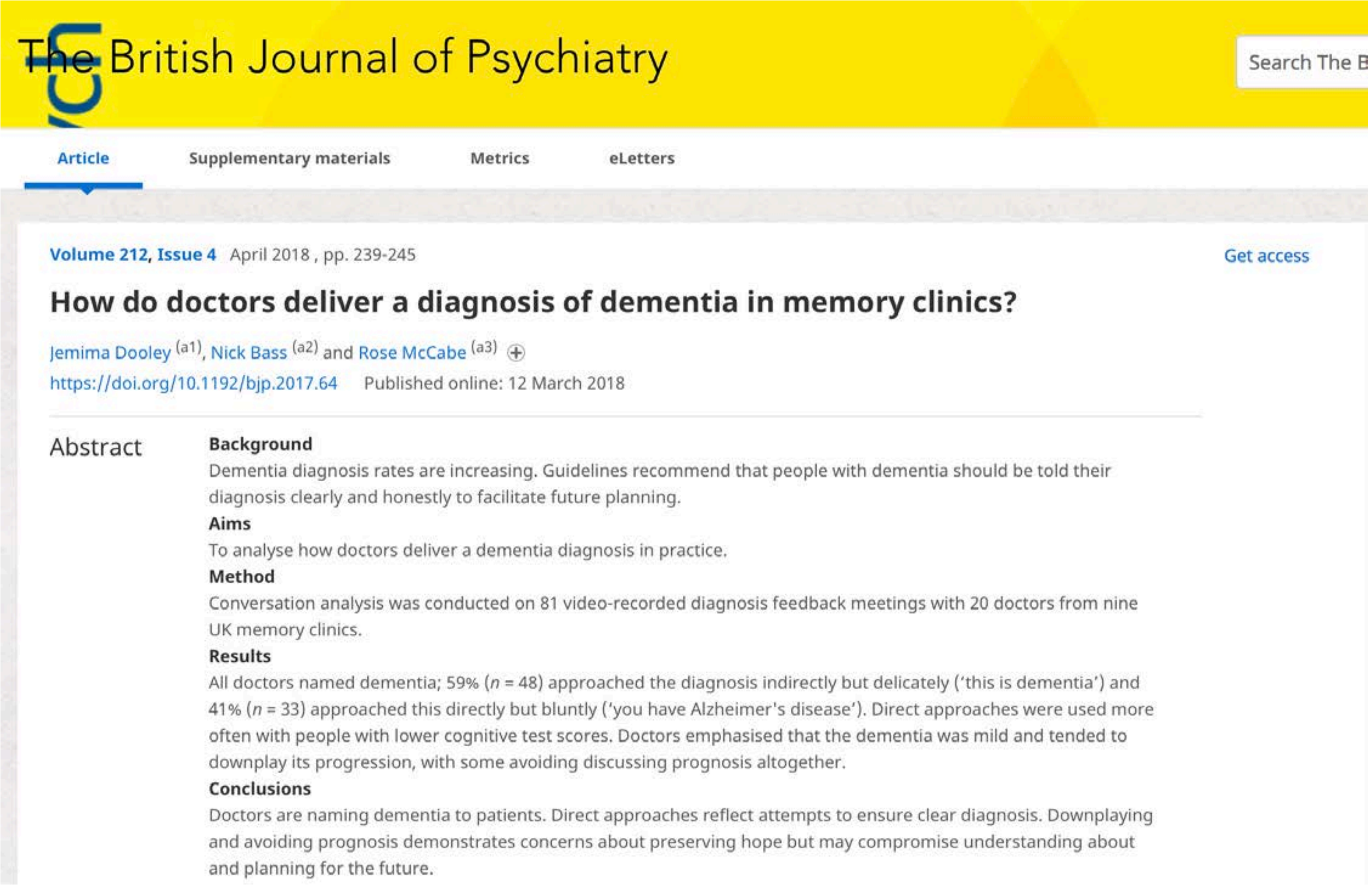
- No avoidance of the ‘D’ word
- **41% direct deliveries -** rare in other settings
- **Direct delivery** more likely to lead to patient resistance in other medical settings
- However, **indirect delivery** – need for inferential work by the person receiving diagnosis
- **Downplay severity** to preserve hope
- Some avoidance of prognosis

Focus groups with doctors – Bailey et al

- No ongoing relationship with patients
- Concerns about lack of pre-diagnostic counselling
- Emotionally overwhelming the patient
- Concerns about lack of post-diagnostic support & lack of personal follow-up
- Accuracy of diagnosis given pressures on memory clinics and increasing referrals
- Stigma of dementia

If diagnosis is (at least partly) to enable planning for the future, what is the optimal balance honesty and hope so people can benefit from diagnosis?





The British Journal of Psychiatry

Volume 212, Issue 4 April 2018 , pp. 239-245

How do doctors deliver a diagnosis of dementia in memory clinics?

Jemima Dooley (a1), Nick Bass (a2) and Rose McCabe (a3)

https://doi.org/10.1192/bjp.2017.64

Abstract

Background

Dementia diagnosis rates are increasing. Guidelines recommend that people with dementia should be told their diagnosis clearly and honestly to facilitate future planning.

Aims

To analyse how doctors deliver a dementia diagnosis in practice.

Method

Conversation analysis was conducted on 81 video-recorded diagnosis feedback meetings with 20 doctors from nine UK memory clinics.

Results

All doctors named dementia; 59% ($n = 48$) approached the diagnosis indirectly but delicately ('this is dementia') and 41% ($n = 33$) approached this directly but bluntly ('you have Alzheimer's disease'). Direct approaches were used more often with people with lower cognitive test scores. Doctors emphasised that the dementia was mild and tended to downplay its progression, with some avoiding discussing prognosis altogether.

Conclusions

Doctors are naming dementia to patients. Direct approaches reflect attempts to ensure clear diagnosis. Downplaying and avoiding prognosis demonstrates concerns about preserving hope but may compromise understanding about and planning for the future.

Thanks to …

- The clinicians, people with dementia & their companions who took part
- Devon Partnership NHS Trust
- Camden and Islington NHS Foundation Trust
- East London NHS Foundation Trust

This is a summary of independent research funded by the National Institute for Health Research (NIHR)'s Research for Patient Benefit Programme (Grant Reference Number PB-PG-1111-26063). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

NHS
National Institute for Health Research

Can psychosis change social identity?

Maev Conneely

Background

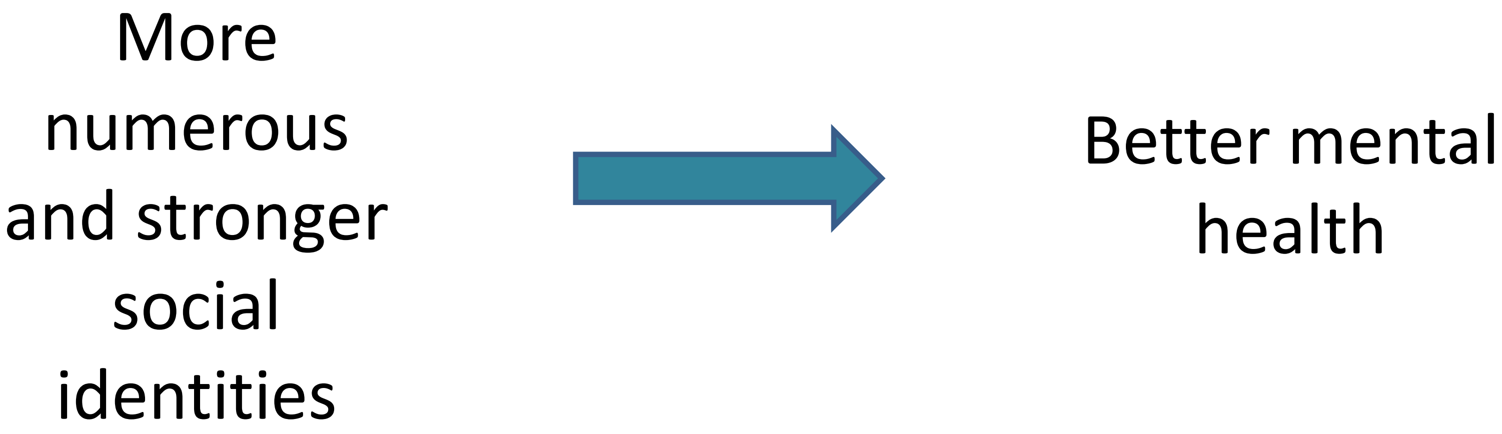
> “In each case there is a more or less clear splitting … the personality loses its unity”
>
> *Eugen Bleuler, 1911*

→ Interviews and first person accounts of psychosis also highlight the importance of identity *(Holt et al., 2014; Connell et al., 2015)*

Social Identity Approach

"Social identity is that part of an individual's self-concept which derives from their knowledge of their membership in a social group"

Henri Tajfel, 1981



More numerous and stronger social identities

Better mental health

Questions

- How has identity in psychosis been conceptualised?
- Can we measure social identity in people diagnosed with psychosis in a way that can be linked to symptoms?
- Can this measure of social identity be used as a tool to explore patients’ experiences of identity/and identity change?

Questions

- How has identity in psychosis been conceptualised?
- Can we measure social identity in people diagnosed with psychosis in a way that can be linked to symptoms?
- Can this measure of social identity be used as a tool to explore patients’ experiences of identity/and identity change?

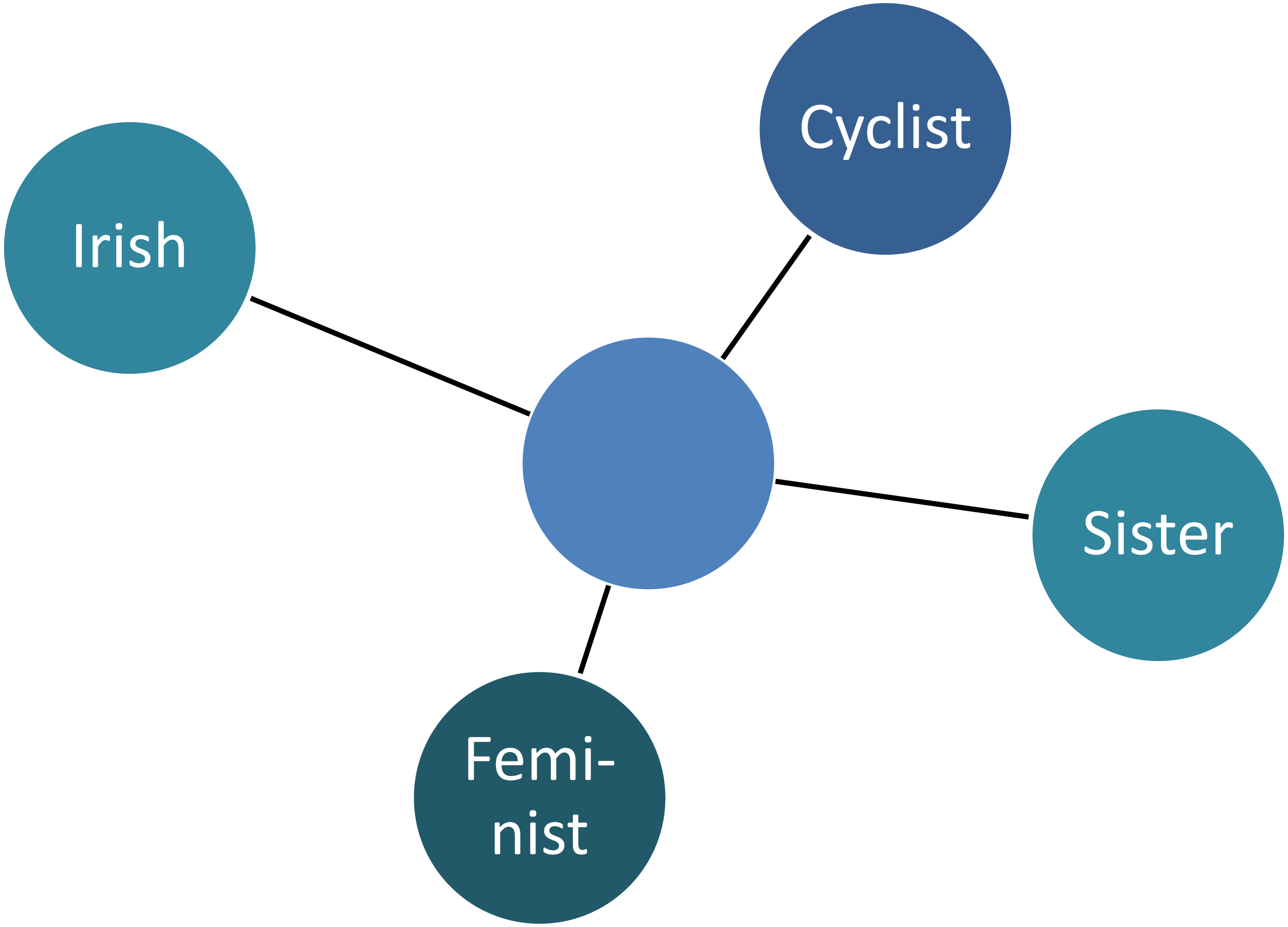
Questions

- How has identity in psychosis been conceptualised?

- Can we measure social identity in people diagnosed with psychosis in a way that can be linked to symptoms?

- Can this measure of social identity be used as a tool to explore patients’ experiences of identity/and identity change?

Social Identity Mapping



Survey

- N=200 participants who have received a diagnosis of a psychotic disorder (F20)

- Recruiting from:
  - Community Services
  - Early Intervention Services
  - Inpatient wards
  - Non-clinical settings

Patient Researcher Recruitment

- To work on the literature review: “How has identity in psychosis been conceptualised?”

→ Meeting on the **14th of November.**

Maev Conneely
☎ 020 7540 4380 x 2308
✉ m.conneelymcinerney@qmul.ac.uk
🐦_Maev_C

SCENE
Enhancing social networks,
improving quality of life

A social contact coach – testing a new intervention

Helena Tee

- Can we improve the quality of life of people with psychosis by increasing social contacts?

- Can this be achieved through a new targeted intervention to support patients to improve their social networks?

Background work - Survey

- **550 participants**
- East London
- Luton
- York & North East
- Devon
- Cornwall
- Oxford
- Somerset

Background work - Survey

- Average of 3 social contacts in the past week
- 63% had 3 or less
- 68% indicated that they would be interested in expanding their social networks

  – of those 53% said that they would not be confident in doing this

What is a social contacts coach?

- An NHS professional with experience working in mental health
- Work collaboratively with patients to increase their social contacts
- Support their patient in identifying and engaging in a social activity of their choice
- Regular meetings over 6 months
- Additional phone contacts if required

What happens during the intervention?

1) Introduction
2) Clarification of the remit of the intervention
3) Exploration of past and current activities
4) Motivation for change
5) Options for activities
6) Information
7) Consideration & decision
8) Agreeing on actions

Moving forward

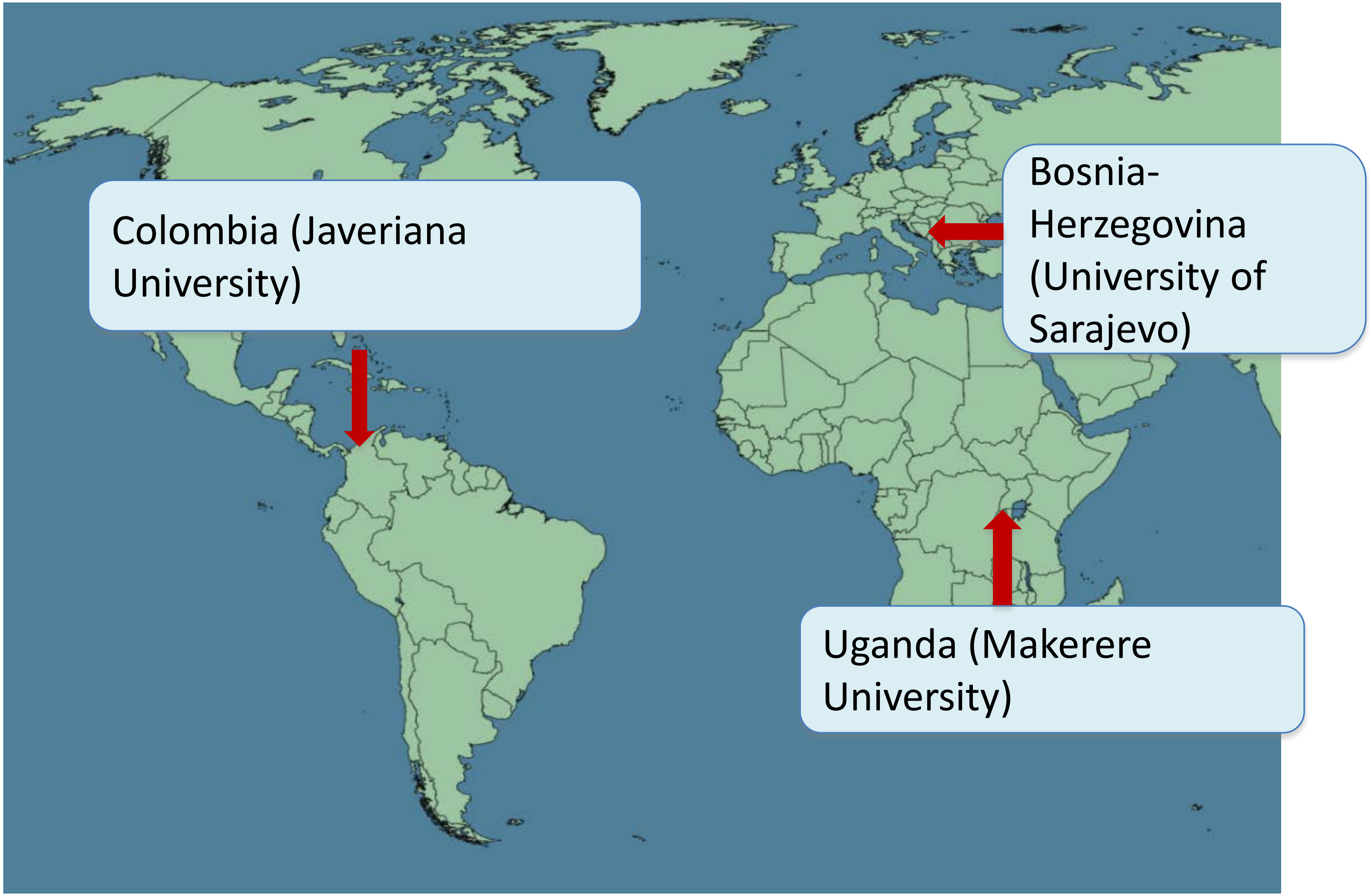
- Small scale testing has been done with 51 participants
- Randomised Controlled Trial (568 participants) – Nov’18

Anyone who is interested in being a coach….

Global Mental Health – our current research and future scenarios

Catherine Fung

NIHR Global Health Research Group (2017-2020)



Colombia (Javeriana University)

Bosnia-Herzegovina (University of Sarajevo)

Uganda (Makerere University)

Improving care for patients with severe mental disorders

- Three resource-oriented approaches:

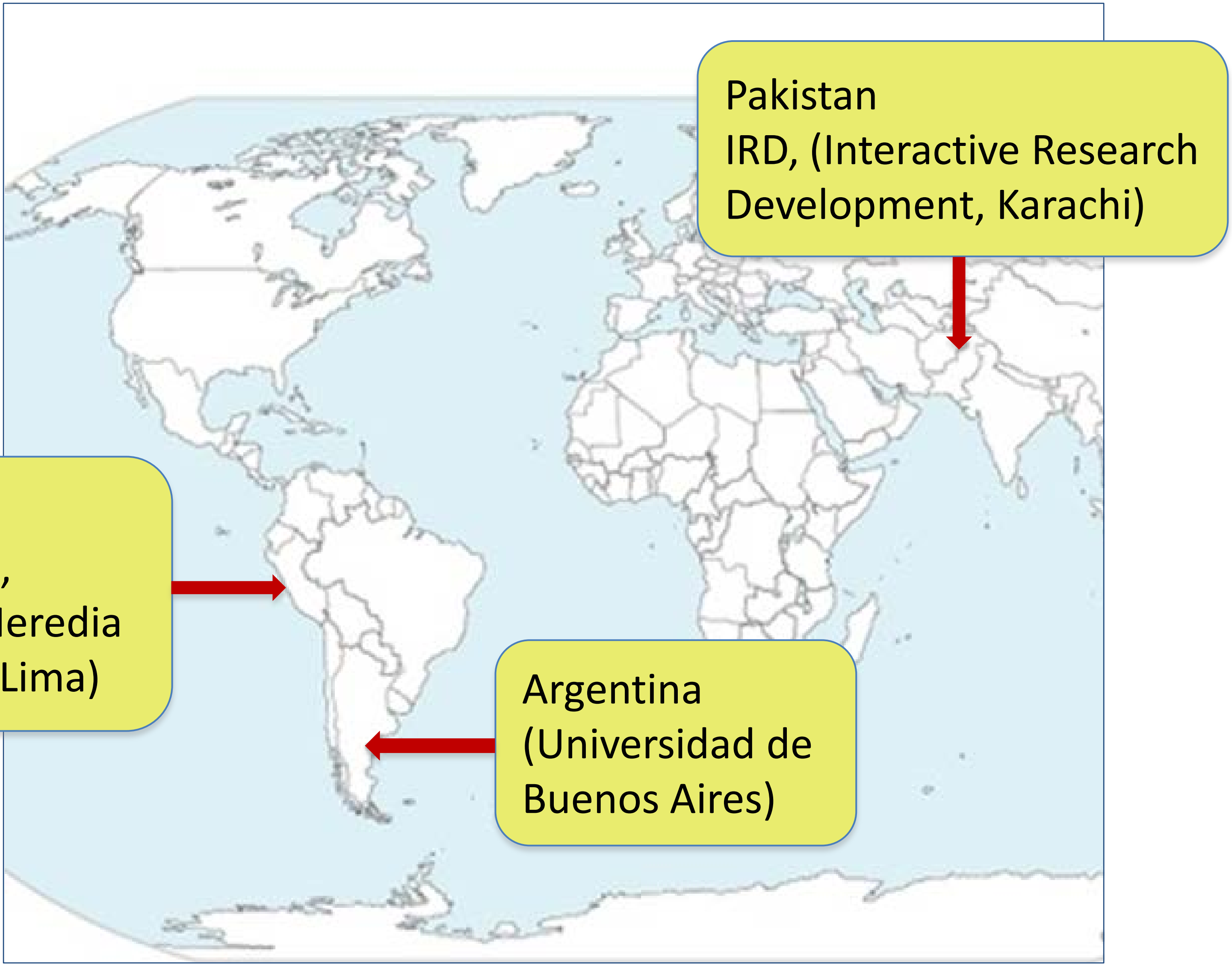
DIALOG+

Volunteer support

Family involvement

- To be tested in a range of RCTs and proof-of-concept studies across the different sites

Extending our network



Pakistan
IRD, (Interactive Research Development, Karachi)

Peru
(CRONICAS, Cayetano Heredia University, Lima)

Argentina
(Universidad de Buenos Aires)

What is the future of global mental health?

A scenario building workshop

10th and 11th April 2018

What did we do?

- Scenario planning methodology
- Arts-based facilitation
- 27 interviews and attendees from across the world

Future scenarios of global mental health

- Development of 6 distinct scenarios:

Universal standards for care

Worldwide coordination of research

Making use of diversity

Focus on social factors

Globalised care through technology

Mental health as a currency in global politics

SCENARIO 3

Making use of diversity

- Embracing and understanding differences
- Global exchange of knowledge and practice through repository accessible to all
- Promote multi-directional learning and flexible partnerships worldwide

SCENARIO 5

Globalised care through technology

- Remote delivery of mental health care to all across the world
- Any time, any place, low cost
- Reduced cultural differences

Conclusions

The 6 scenarios:

- Are speculations rather than predictions for the future
- May help to guide further discussions and decision-making
- The future: a multi-disciplinary approach?

Thank you!
Any questions?

Last words

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!

Finally, please note for next year:

East London
Mental Health Research
Presentation Day

When?

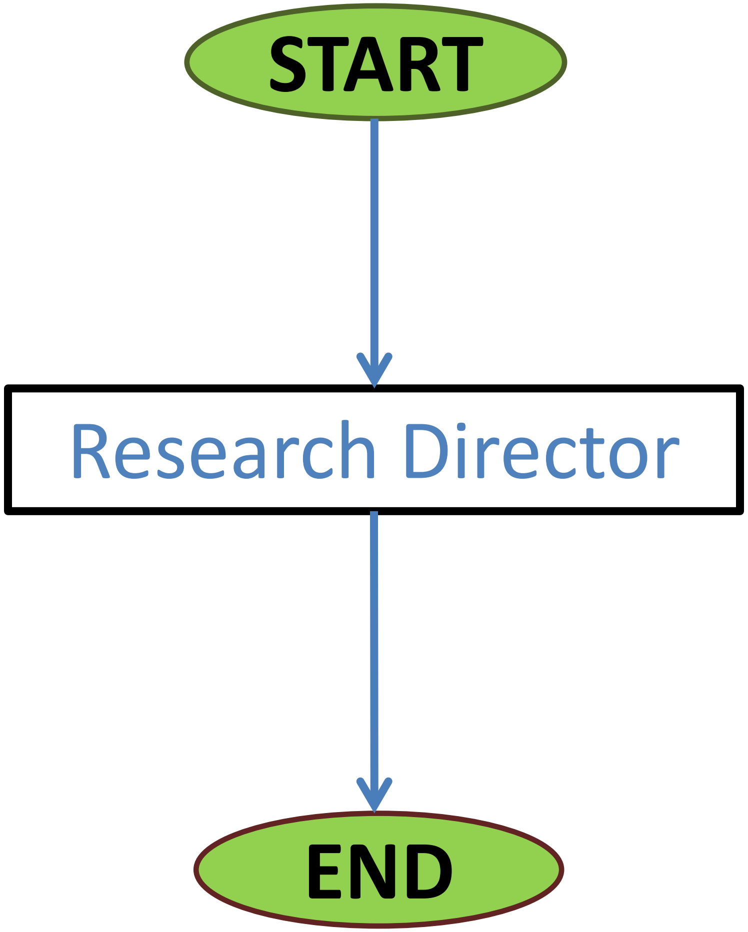
2nd October 2019!

Where?

Here!

Change:

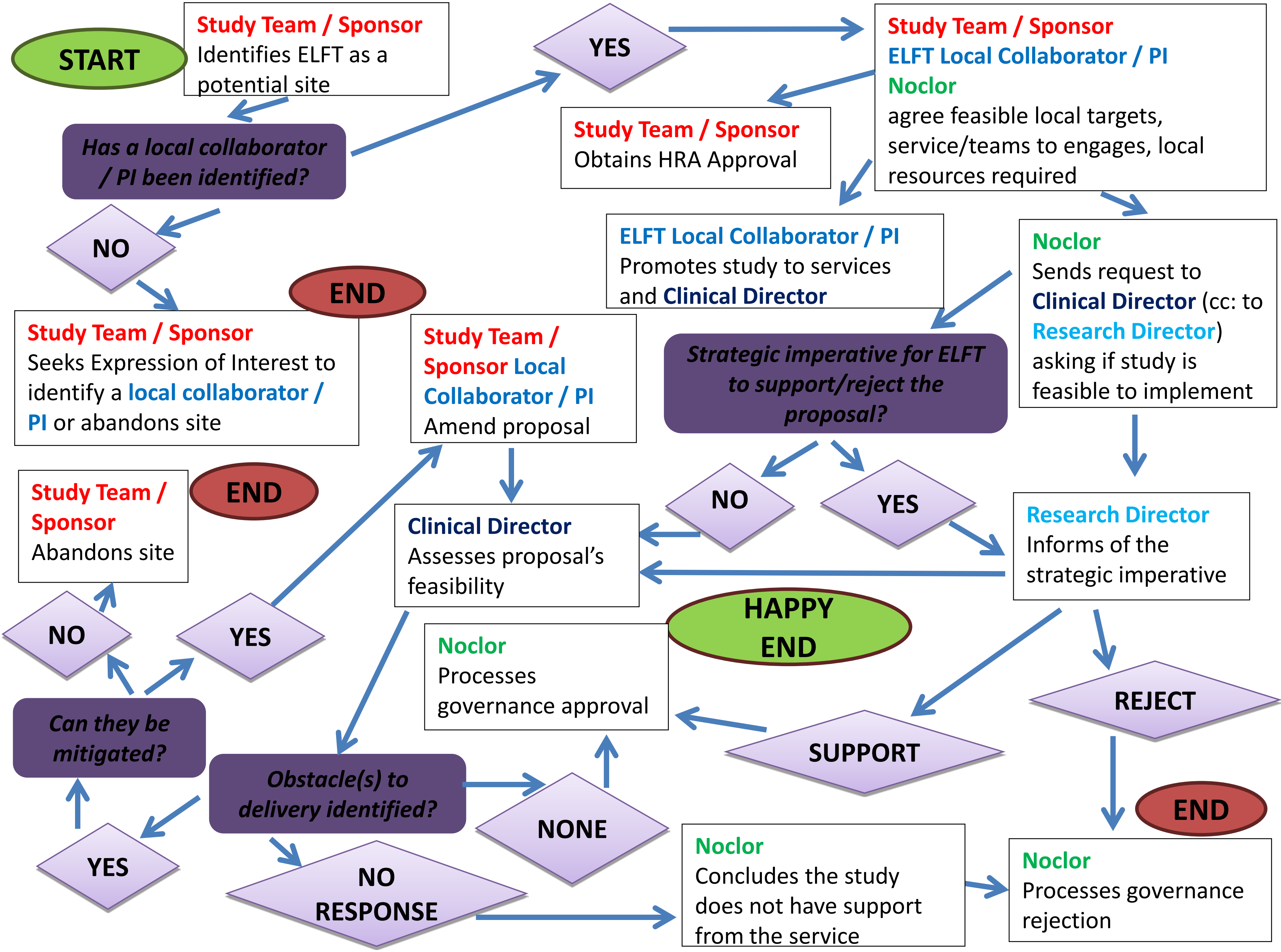
- Frank Röhricht in charge
- End of 19 years and 3 months fixed term contract
- No more R&D Director



START

Research Director

END



START

Study Team / Sponsor Identifies ELFT as a potential site

Has a local collaborator / PI been identified?

YES

NO

Study Team / Sponsor Seeks Expression of Interest to identify a **local collaborator / PI** or abandons site

END

Study Team / Sponsor ELFT Local Collaborator / PI Noclor agree feasible local targets, service/teams to engages, local resources required

Study Team / Sponsor Obtains HRA Approval

ELFT Local Collaborator / PI Promotes study to services and **Clinical Director**

Noclor Sends request to **Clinical Director** (cc: to **Research Director**) asking if study is feasible to implement

Strategic imperative for ELFT to support/reject the proposal?

NO

YES

Research Director Informs of the strategic imperative

Clinical Director Assesses proposal's feasibility

REJECT

SUPPORT

END

Noclor Processes governance approval

HAPPY END

Obstacle(s) to delivery identified?

NONE

NO RESPONSE

YES

Can they be mitigated?

NO

YES

Study Team / Sponsor Abandons site

END

Study Team / Sponsor Local Collaborator / PI Amend proposal

Noclor Concludes the study does not have support from the service

Noclor Processes governance rejection

Research in ELFT - past

- Always one of the leading Trusts in own mental health service research
- Unit for Social and Community Psychiatry – more or less self funded
- Research-led Trust?
- Varying importance of research for other activities in ELFT
- Research and Quality Improvement?

Research in ELFT - future

- Partnerships with academic institutions
- Focus and priorities
- Link with other activities in ELFT
- Supporting key researchers for ELFT

My wallpaper and I are fighting a duel to the death.
One or the other of us has to go.

Oscar Wilde

If this is dying,
I don’t think much of it.

Lytton Strachey

I did what I could.

Edward Abbey

I have no final statement.

Lawrence Russell Brewer

Thank you!!!