

Are some clinicians just better than others?

By [Kirsten Barnicot](#),
Early Career Research Fellow

Our research shows that mental health clinicians who are consistently rated as empathic and genuine by their patients get better results. The finding was based on a study in 157 patients being treated for depression by clinicians in the United States.

It's been known for a while that some clinicians consistently achieve better results with their patients than others. However, why this was the case was not clear. At the same time, we know that if a patient feels that their clinician likes them and is genuine and empathic, the patient does better. Most people know what "empathy" means – it means making a person feel that you understand their emotions and perspective on a situation. Being "genuine" is less often discussed. It means coming across as your true self, not putting on a front, not being false and not just telling a person what you think they want to hear.

What isn't clear is whether this is really due to something about the patient, rather than anything to do with the clinician. For instance, it could be that patients who perceive their clinician positively are better at forming social relationships generally or have a more positive outlook – and that's why they're doing better in treatment. If it all really just comes down to the perspective of the individual patient, then saying that more genuine and empathic clinicians get better results could be a red herring. After all, one patient may perceive their clinician very differently than another. On the other hand, it could be that some clinicians are generally better able than others to show empathy and to come across as genuine, and that it is this that produces positive results. If this was the case, it could have important implications for



■ Do some clinicians seem to be generally better than others at making their patients feel liked?

clinician selection and training.

To investigate this, we used a dataset from the National Institute for Mental Health Treatment for Depression Collaborative Research Program. This involved 157 patients being treated by 27 clinicians. Because the same clinician was treating multiple patients, this enabled us to see if some clinicians really were consistently able to be more genuine and empathic than others – and whether this was important for good results. After their second treatment session, each patient rated whether they felt liked by their clinician and how genuine and empathic their clinician came across. We then averaged the scores across different patients being treated by the same clinician, to get an average score for each clinician. We found that patients who had been treated by clinicians with high average ratings of genuineness and empathy had less severe depression during and at the end of their treatment.

Finally, we calculated for each patient how different their perception of their clinician was from how the clinician's other patients perceived them. We found that, even after taking this into account, patients treated by clinicians with high average ratings of genuineness and empathy did better. This means that, even if an individual patient does not think their clinician is very genuine or empathic, if the clinician is someone who is generally able to come across as genuine or empathic, the patient is more likely to do well. The full methods and results of this piece of research have been published in the *Journal of Affective Disorders*, volume 167, pages 112-177.

The results suggest that some clinicians seem to be generally better than others at making their patients feel liked, and at coming across as genuine and empathic – and that this is important for enabling patients to benefit from treatment. The next question

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is – can these abilities be trained, or are some clinicians just naturally better at being genuine and empathic than others? Should people who want to be mental health clinicians be selected based on how good they are at showing genuineness and empathy? Should we try to develop training to boost clinicians' empathy and genuineness – or is this a waste of time with clinicians who do not already possess these abilities innately? A central premise of many therapy models is that people can and do change. So it could be argued that, if clinicians expect their patients to be able to change their behaviour, surely clinicians too can change their own behaviour? Perhaps the key is to remember that becoming a better clinician is a lifelong process, with a constant need to look to our own behaviour with patients and strive for improvement.

How do clinicians in ELFT respond to the findings of this research? "Having read about this research has reignited my commitment to be genuinely engaged in my clinical work", says Luka Hadrych, psychotherapist at Newham Specialist Personality Disorder Service. "For me this is about not hiding behind a façade of being a professional, or an expert, but simply being my patients' honest companion on their road to change, growth and acceptance."

Psychiatric and psychosocial morbidity before and after surgical treatment for refractory epilepsy

By **Dr Maurice Clancy**,
Speciality Trainee

Epilepsy is a common disease affecting 0.5-1% of the population. There is a high prevalence of mental illness associated with it, approximately 35%. In patients with severe epilepsy which is resistant to treatment with medication, surgery may be an option if an identified aberrant piece of brain tissue is found to be the cause of the epilepsy, this usually occurs in a type of epilepsy called temporal lobe epilepsy. Surgical intervention can reduce the number of seizures or stop seizures completely. However, surgery can have undesirable effects on mental health. Older research papers on this topic state that there is increased risk of psychosis, depression, anxiety and suicide after patients have epilepsy surgery. More recent papers have not found this. The contradictory findings in the existing literature is because many of the studies use small cross sectional studies with limited follow up, they do not use formal assessment instruments and the patient groups are heterogenous.

Bearing these limitations of the literature in mind, I conducted a prospective cohort study looking at rates and severity of mental illness in patients before surgery for epilepsy and looked at the same group of patients one year after surgery to see whether there was any difference following surgery.

The study was carried out in the National Centre for Neurology and Neurosurgery in Beaumont Hospital, Dublin Ireland. All patients who were possible going to have surgery for their severe epilepsy in the future were

enrolled in the study. The objective psychiatric rating scale used pre and post-operatively was the SCID I (Structured Clinical Instrument for the DSM IV Axis I disorders). The subjective scales which the patients filled in were the HADS (Hospital Anxiety and Depression Scale) and the QOLIE-89 (Quality of Life in Epilepsy 89 item scale). Patients filled in this scales before and after surgery. Ethical approval was sought and obtained before conducting the study.

138 patients were assessed pre-



operatively and 48 patients proceeded to surgery and had follow up 1 year later. I had a 100% follow rate in terms of patients who had surgery. 20 male and 28 female patients were followed up and the average age was 35. Most of the patient had operations on their amygdalas, hippocampuses or temporal lobes. 88% of the sample had a reduced number of seizures or no seizures following surgery ie there was a good surgical outcome.

Twenty-four patients (50%) had a psychiatric diagnosis before surgery but this fell to fourteen following surgery

(29.2). This result was statistically significant ($p=0.021$). There was no increase in the numbers of patients with depression or anxiety following surgery. This result was not significant. There was a dramatic reduction in the number of psychotic type symptoms following surgery ($p=0.004$). This was because epilepsy auras which are warning signs that a seizure may happen had stopped as there were fewer seizures post-operatively. Auras can be psychotic type symptoms such as olfactory (smell) hallucinations, gustatory (taste)

hallucinations, visual, auditory, tactile (feelings on the skin) or somatic (feelings inside the body) hallucinations.

There was no significant change in patients HADS scores pre-operatively versus post operatively. There was an improvement in Quality of Life following surgery with the average QOLIE-89 score increasing from

70 to 75 following surgery ($p=0.02$).

In conclusion, my study demonstrated that there are high rates of mental illness associated with severe epilepsy. Undergoing surgery had a neutral impact on mental health with no increased rates of depression and anxiety following surgery. Quality of life improved after surgery. There were very low rates of new onset psychiatric illness following surgery. Clinicians and patients should be reassured that having a mental illness does not mean patients with severe epilepsy should not have surgery for their epilepsy.

What can facilitate (or hinder) family involvement in mental health care?

By **Domenico Giacco**,
Senior Research Fellow and
Aysegul Dirik, Research Assistant

Relatives or friends of patients in mental health treatment often provide unpaid help and support. Terms such as "carer" acknowledge this important, even if "non-professional", role. Calls to involve families in patients' treatment can be found in national mental health policies and are supported by decades of research evidence.

Family members or friends can encourage patient engagement with treatment plans, recognise and respond to early warning signs of relapse and assist patients in accessing services during acute mental health crises. As a result, their involvement in treatment can lead to better outcomes from psychological therapies and pharmacological treatments, fewer inpatient admissions, shorter inpatient stays, and better quality of life reports by patients.

Despite these demonstrated benefits, evidence suggests that patients' families and friends are often not involved in routine mental health care.

Why is family involvement in treatment under-applied?

A recent systematic review (Eassom et al., *BMJ Open*) of the available evidence in the scientific literature was carried out at the Unit for Social and Community Psychiatry in order to answer this question.

We searched all of the studies that collected data about family involvement in mental health treatment. We then targeted the studies that discussed the factors which were shown to be helpful or unhelpful when trying to work with families in clinical settings. A search on scientific databases initially identified more than 15000 papers. Excluding studies that were not relevant resulted in 43 papers (from 16 countries) being included in the final review.

After analysing the data from the reviewed papers, we identified the following main themes:

a) There needs to be a whole team approach

If only a few professionals in a clinical team are trained to do family work and the

other staff members do not participate, the practical burdens of family work (such as the extra time it takes) can be too difficult for individual staff members to overcome. This can result in the work not happening at all, or not being carried out in the best possible way. Aside from developing specialist family interventions, there also needs to be a general focus on finding ways to enable family work within existing work routines. For example, allowing staff to have flexible working hours may help to address the needs of families who are only able to attend evening meetings. Powerful initiatives that can happen at an organisational level include writing family work into business plans, policies and the job descriptions of all staff.



b) Staff need training and ongoing supervision

The absence of adequate training and supervision for staff carrying out family work was often reported as a major barrier. As traditional clinical practices are focused on one-to-one encounters with patients, mental health staff may lack the skills or confidence to work with families. For example, they might need to learn how to manage group meetings where there are differences of opinion. Allowing staff to access supervision and ongoing support can help to increase their confidence in working with families.

c) Building trusting relationships is key

Some studies found that families themselves can refuse involvement or not take part fully, such as by not attending meetings. This can be for many reasons, including having negative experiences with services in the past or

because they do not see the benefits in their involvement. Involving families in treatment as soon as possible (after the patient's first contact with services) and presenting the approach enthusiastically seems helpful to establish good relationships between families and professionals.

d) Patients, carers and staff need to work together as active partners

It is highly important for patients, carers and staff to have a respectful, equal partnership, which is enriched but not dominated by professional skills and experience. When the expertise of each person is valued and respected, all members can communicate on a more equal level. Working in ways that are not genuinely collaborative often results in families feeling patronised or not understood. Factors helping to overcome this included professionals having the confidence to "let go" and not take too much control. This allowed for more shared decisions to be made and for solutions to be jointly found.

e) Structure is important, but there needs to be flexibility

Approaches to family involvement were sometimes described as rigid and even culturally insensitive. If staff tried to stick too closely to the "guidebook" they sometimes failed to meet the needs of particular groups. Whilst both staff and families valued having a clear structure for family involvement, it was helpful if staff sometimes changed things to accommodate the needs of individual families. For example, some families preferred to receive information face to face, as they found written materials too difficult to understand.

In summary, involving families and friends in patients' mental health care requires support and changes in existing ways of working. Whilst management and organisational level support is very important, it is not enough on its own. There also needs to be support within teams – involving families should not be seen as the responsibility of just a few members of staff.

■ If you would like further information, please contact us on d.giacco@qmul.ac.uk or a.dirik@qmul.ac.uk

OTHER NEWS

ANNUAL EAST LONDON RESEARCH PRESENTATION DAY

The Trust's 12th Annual East London Mental Health Research Presentation Day took place on 1 October 2014 in the Robin Brooks Centre at Barts Hospital; the event was open to all Trust staff and was well attended by staff, trainees, and representatives from the Governors Council. The format of the day was a series of very brief presentations on a wide range of research projects being conducted in the Trust. Attendees were able to get information about 14 different projects, ranging from epidemiological studies to clinical trials and qualitative work.

Feedback from the day was overwhelmingly positive: It was "very informative and useful to hear about the ongoing research projects taking place across East London". There were "Some really interesting things covered" by a "variety of presentations" that were "very interesting and insightful". The format "encourages concise and snappy presentations" leading to a "very enjoyable" and "very well organised" event. We hope to see you next year on 7 October 2015.

SPECIALIST TRAINEE WINS PRIZE

The Royal College of Psychiatrists Faculty of Neuropsychiatry (FoN) has established annual awards for trainees in order to promote the highest standards of critical thinking and communication by psychiatry trainees in the field of neuropsychiatry. The awards are given for the best original research, audit, literature review or clinically focused essay in the field of neuropsychiatry. Dr Maurice Clancy, an ST6 in General Adult Community Psychiatry working in Bethnal Green and Globetown CMHT and Globe and Lea wards in Mile End Hospital, was this year's winner for his oral presentation. This is the third prize Dr Clancy has been awarded for his work on mental illness in patients with epilepsy.

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 Hana Pavlickova by email at Hana.Pavlickova@eastlondon.nhs.uk

Date	Title	Presented by
8 October	Digital storytelling	Rose Thompson
29 October	Developing a protocol	Vicky Bird
12 November	Searching and Assessing Eligibility	Vicky Bird
3 December	Thematic Analysis	Sima Sandhu
14 January	Brief Psychiatric Rating Scale	Domenico Giacco
4 Feb '15	Meta-Synthesis	Vicky Bird

A sweet future of patient & public involvement in research ensured

A component of independent research commissioned by the National Institute for Health Research (NIHR) in 2009, the long-term future of SUGAR (Service User and Carer Group Advising on Research) has been

ensured through a partnership agreement established between City University London and the East London NHS Foundation Trust.

Professors Alan Simpson and Len Bowers, and their colleagues in mental health nursing research at the School of Health Sciences, were keen to further develop service user and carer involvement across

their programme of research and build long-term collaborative research relationships with members of local communities in east London. They wanted to ensure that a range of voices from those with lived experience of mental health services was heard in a systematic way by those conducting research into mental health nursing and services.

Inspired by the motto 'Nothing

about us, without us', SUGAR was created. The group currently consists of 13 service users and carers and meets with various mental health researchers once a month. Training and development is provided and meetings are

public engagement by universities. They hope to inspire other researchers to follow their lead and add SUGAR to their work.

SUGAR's services are available to researchers working within East London NHS Foundation Trust,

City University London, and those collaborating on projects with City University London academics, subject to prior discussion and arrangement with Prof Alan Simpson.

To present at a SUGAR meeting, please contact the SUGAR administrator, Alex Thornton Alexandra. Thornton.1@city.ac.uk to request a suitable date/time. Note: as

facilitated by members of the research team.

SUGAR members discuss and contribute to various aspects of research projects and the research process and have also written journal papers and given conference workshops, presentations and posters.

SUGAR has hosted a number of international visitors and recently won a national award for

meetings take place once a month, advance notice is strongly advised. Confirmation of an agreed date and time will be sent by email.

If you would like to learn more about SUGAR, or are interested in working with us, please contact us or follow us on Twitter.

Email: sugareverything@gmail.com

Twitter: [@SugarSolution](https://twitter.com/SugarSolution)



OTHER NEWS

TRUST-EMPLOYED RESEARCH STAFF CAN ACCESS MEDICAL RECORDS TO IDENTIFY POTENTIAL PARTICIPANTS

The government wants to see the number of people enrolled in research studies increase. Allowing staff outside the clinical team to pre-screen patients' medical records prior to consent in order to identify patients suitable for recruitment to a research project (when full consent would be sought) is, therefore, desirable but must be managed within the principals of existing legislation protecting information.

Because assisting recruitment into national (e.g., NIHR Portfolio) studies is deemed necessary to the NHS, pre-screening of medical records prior to consent is permitted with following criteria/protections put in place:

- limited to research staff employed by the Trust, who therefore have an employment contract which includes a clause binding them to a duty of care

equivalent to that of a member of the clinical team;

- applies only to studies that have received both a favourable ethical opinion and NHS Permission;
- disclosure is kept to a minimum and is only on a 'need to know' basis; and
- it must not affect treatment decisions or cause damage or distress.

IRAS IT HELPDESK

The Health Research Authority is transferring the IRAS IT support to a new provider. This will result in a change of telephone number and email address for the IT helpdesk. The new IRAS Help Desk telephone number: 0207 0430734 and a new email address helpdesk@myresearchproject.org.uk will come into effect from the 14 September 2014.

This change in these details will be noted on the IRAS site. While the old contact details will still operate until 22 Sep 2014, HRA are seeking to have as many people use the new details as soon as possible.

European Federation of Psychiatric Trainees: a key stakeholder for psychiatric training in Europe

By [Domenico Giacco](#), Senior Research Fellow

A few weeks ago (from June 22nd to June 25th) the 22nd Forum of the European Federation of Psychiatric Trainees (EFPT) was held in London at the Royal College of Psychiatrists site.

The EFPT Forum has been organised once every year for the last 22 years and is one of the most important events for early career psychiatrists in Europe. During the Forum, psychiatric trainees from more than 35 European countries met to discuss about developments and issues in psychiatric training.

What is the EFPT?

The EFPT is a federation of national psychiatric trainees' association.

EFPT was founded in 1992 in London, based on a spontaneous initiative of a group of 16 trainees from 9 European countries. Other countries have joined in the following years and currently EFPT includes 35 member countries. The number of member countries is constantly increasing.

In 2010, EFPT became the first association of postgraduate medical trainees to become a recognized non-governmental organisation with headquarters in Brussels (Belgium).

The objectives of the EFPT are to:

- 1 promote the highest standards for psychiatric training and harmonisation of training programmes in Europe;
- 2 facilitate the exchange of information, collaboration and networking between trainees in different countries;
- 3 represent trainees in the international bodies which are responsible for defining and overseeing training curricula in Europe; and
- 4 support the establishment of national psychiatric trainees' associations in all European countries.

How is the EFPT organised?

Annual Forum

The central moment of EFPT activities is the Annual Forum, in which country delegations meet. It is organised by the sitting President in his/her country, therefore it takes place in a different country each year.

The Forum includes different sessions, each of them lasting for one day:

- a) Introduction day; the Board members welcome new members presenting on the history, organisation and activities of the EFPT;
- b) Academic day; scientific lectures are delivered by internationally renowned experts;

c) Working groups day; delegates meet in small groups that address specific aspects of training (e.g. training on psychotherapy, exchange programs or working conditions of trainees);

d) Assembly day; the General Assembly is the main governing body of the EFPT. Each country has one vote and participates with two delegates (ideally a trainee in Adult Psychiatry and a trainee in Child and Adolescent Psychiatry). During the General Assembly the main decisions on EFPT functioning are made.

EFPT Board of Directors

The EFPT Board of Directors is the executive body of the Federation and it is responsible for the management of its administrative and overall functioning. It includes seven members, elected each year among the delegates participating at the Forum: President, Immediate Past President, President Elect, General Secretary, Child and Adolescent Psychiatry Secretary, Information Technologies (IT Secretary) and Treasurer. Duration of the mandate for all Board members is one year, until the subsequent Annual Forum.



Working groups

Every year new "working groups" are proposed and approved by the General Assembly on different topics related to psychiatric training. Participation in working groups is open to all Forum participants. Any trainee participating in the Annual Forum can propose a new working group on a topic of his/her special interest.

Within the groups, a coordinator is elected. The coordinator chairs the group and is responsible for keeping EFPT Board updated with periodic reports on activities and outputs of the working group.

Working groups start their activities during the Annual Forum and continue them in the subsequent

year via online means of communications (skype, e-mail groups, email) or face-to-face meetings.

What are the main EFPT outputs?

Statements

The policy of the EFPT is described in the EFPT "Statements". The Statements represent the official standpoint of European trainees on a wide range of training matters (e.g. psychotherapy training, working conditions of trainees, etc.).

They are proposed by Working groups, approved by the General Assembly of the EFPT and regularly revised (every three years as a minimum).

EFPT statements are accessible on the EFPT website (www.efpt.eu) and are divided in four main categories:

- guidelines for national psychiatric trainees' associations development;
- content of training in psychiatry;
- organisation and structural aspects of training;
- evaluation of training.

Country reports and research projects

All delegates of EFPT member countries present at the Annual Forum a brief description of psychiatric training in their country, the "country report", with a focus on main challenges and issues in the previous year.

The EFPT has also a specific Research Working Group with the aim of evaluating training needs and implementation of training in different European countries. Projects of the research working group have assessed preferences on medication prescribing of trainees, their relationships with pharmaceutical companies, their use of Information Technology tools for training, their attitudes about training and their views on the future of psychiatry. Reports from these studies have been published in major international journals such as *Lancet*, *World Psychiatry*, *European Psychiatry* and *BMC Psychiatry*.

Data from country reports and research project by the EFPT constitute a valuable source of information on improvements and problems for psychiatric training in different European countries. This evidence is used by EFPT Board members to advocate changes in training to the associations involved in definition of training standards at the European level and at national levels (e.g., European Union of Medical Specialists, European Psychiatric Association, and National Associations of Psychiatry).

Exchange Program

EFPT has created an international exchange program. Objectives of the programs are not only to increase professional knowledge and skills, but also to provide a platform to European trainees for exchanging

experiences and cultures. Internships are entirely organised by national coordinators (EFPT members) based on available opportunities at their Institutions.

The EFPT Exchange Programme has received support from the Lifelong Learning Programme of the European Commission. The next application period for internships is November-December 2014.

Influence on training standards at a European level

The EFPT is active member, with voting rights, of the European Union of Medical Specialists (UEMS) Board of Psychiatry and Child and Adolescent Psychiatry and, as such, contributed to the development of European guidelines for training and on the monitoring of training guidelines implementation.

Through EFPT, the opinions of psychiatric trainees have been incorporated in the main documents that set the standards in Europe for psychiatric training curricula. Two examples are:

- the "UEMS Framework for competencies in psychiatry", which lists the competencies that all European psychiatrists should have; and
- the "Charter for Medical Specialist training – Chapter for Psychiatry" that provides guidelines for national policies on psychiatric training.

Both documents are accessible on European Union of Medical Specialists – Section of Psychiatry website (uemspsi.org).

Promotion of networking and collaboration among European psychiatric trainees

The creation of a "community" among European trainees is very important in order to avoid professional isolation, facilitate exchange of positive (and negative) experiences and stimulate a debate on how to improve psychiatric training.

The Annual Forums are a great opportunity for networking with other colleagues from different countries. In the next year, the Annual EFPT Forum will be held in Lisbon, Portugal.

During the rest of the year the EFPT supports and contributes to educational activities organised by the European Psychiatric Association and the European College of Neuropsychopharmacology and also to national/local events organised by the national associations of psychiatrists and psychiatric trainees.

The information presented here is only intended to give "a flavour" of what EFPT is and of what this organisation has represented for psychiatric trainees around Europe in the last 22 years. For regularly updated information on the EFPT activities and if you want to get involved, please consult the EFPT website (www.efpt.eu).

Millfields Unit: The only quantitative evidence of efficacy to emerge from the DSPD programme?

By **Dr Celia Taylor**, Lead Clinician & Head of Service, and **Kim Wilson**, Research Assistant, Millfields Unit with **Mark Freestone**, Clinical Research Fellow, Violence Prevention Research Unit

Millfields Unit, the Trust's inpatient medium secure personality disorder (PD) unit, recently published the first quantitative evidence of the efficacy of its treatment model to emerge from the Dangerous and Severe Personality Disorder (DSPD) programme (Wilson et al., 2014). This was an initiative of the previous UK Government, and its aim was to address a lack of services for PD offenders through the development of a network of units for the assessment and treatment of an estimated 1,400 men in prisons and a further 400 in high and medium secure psychiatric hospitals. DSPD offenders were defined through a combination of DSM-IV diagnoses and psychopathic traits.

Despite the large sums invested in these services – in the order of £200 million between 2000 and 2010 (Tyrer et al., 2012) – independent evaluations were not favourable. The IMPALOX study of the assessment process for the high-secure prison units (Tyrer et al., 2007) found it to be too long, poor at selecting suitable prisoners, and frustrating for offenders who felt that their expectations were not being met; although some prisoners did report fundamental and positive changes in the way they were managed (Ramsay et al., 2009). Subsequent research into high secure prison and hospital DSPD programmes identified no positive change (Burns et al., 2011), and a lack of cost-effectiveness in the expensive hospital units (Barrett & Byford, 2012). In light of these findings, the DSPD unit at Broadmoor Hospital was decommissioned in 2012 – although both Broadmoor and Rampton hospitals will retain dedicated PD beds – and Government strategy has refocused on developing a pathway for PD offenders based largely in the criminal justice system (Joseph & Benefield, 2012).

Initial plans were made to decommission all medium secure PD beds too, although more recently these have been modified such that only those offenders whose needs cannot be met elsewhere may be transferred temporarily to these services for treatment. Despite this acknowledgement that inpatient mental health services form a key part of the pathway, there is a lack of research evidence as to the effectiveness of treatment for offenders with PD detained in hospital under the Mental Health Act.

Studies of therapeutic community (TC) treatments have shown the most promising results of any form of treatment for PD and/or offender populations (Reed, 1994; Lees, Manning, & Rawlings, 1999; Warren et al., 2003). The Millfields Unit, in ELFT's John Howard Centre, Hackney, which admitted its first patient in

2005, developed its model on this evidence base. Offenders referred to the service often present with complex needs – such as self-harm, mental illness or ambivalence about engaging with treatment – that are not well managed in a prison setting; a small number are on 'step-down' pathways from high-secure hospitals (for a breakdown, see Freestone et al., 2012). Treatment is delivered through a modified TC approach comprising community meetings three times a week, with a focus on interpersonal dynamics and community living; and twice weekly small psychotherapy groups, which allow for the processing of childhood trauma and attachment difficulties, and their relationship to risk and offending. Modifications to the core TC consist of the incorporation of Cognitive Behavioural Therapy approaches addressing specific criminogenic needs such as substance misuse and violence: Millfields is the first NHS service to run the accredited Self Change Programme for violence reduction (Offending Behaviour Programmes Unit, 2001). Psychodynamic interventions such as individual and art psychotherapy are also offered. Community leave is facilitated for those eligible, and is underpinned by research into factors that most support desistance from offending by building social capital (Farrall, 2005).

Millfields staff set out to examine the effectiveness of its modified TC approach by considering:

- Whether there was evidence of change in violence risk during treatment.
- Whether there was evidence of change in psychological distress during treatment.
- Whether there were significant individual or treatment-related factors that predicted successful outcome.

This was a retrospective panel study of patient progress. The service routinely collects progress monitoring and outcome data using measures of violence risk – the Historical Clinical Risk-20 (HCR-20; Webster et al., 1997) and the Violence Risk Scale (VRS; Wong & Gordon, 2001). These are scored at annual intervals by a multi-disciplinary team of clinical and research staff, to ensure triangulation of perspectives on risk and management. Annual assessments of psychological distress are also undertaken, using the Symptom Checklist 90 – Revised edition self-report instrument (SCL90-R;

Derogatis, 1994). Data analysis was performed on an 'intention-to-treat' (ITT) basis in which, if the patient was discharged (successfully or unsuccessfully) before the three-year mark, the final available value of the assessment was carried forward and used as a proxy for three-year outcomes.

The results showed evidence of reliable and clinically significant decreases in risk and psychological symptoms as patients progressed with treatment. VRS dynamic scores showed consistent statistically significant decreases each year from initial assessment, whilst SCL90-R Global Severity Index scores decreased significantly between initial assessment and the third year of treatment. Analysis of HCR-20 scores was not conclusive, with an initial improvement over two years of treatment followed by a non-significant increase in violence risk for patients in the third year of treatment. This result coincides with some individuals commencing community leave, which necessitates a change in scoring the HCR-2 and, by its very nature, the world outside the secure environment contains a multitude of unknown variables and therapeutic risks for patients, which remained untested prior to the point of scoring. Further, the now-accepted practice of 'dual-rating' HCR-20 assessments simultaneously for both inpatient and community settings was not introduced in the service until mid-2011 (five years into the study). Some support for this hypothesis is lent by the fact that VRS dynamic items – with one exception relating to 'Security level of accommodation on release' – are scored in the same manner throughout treatment.

The high proportion of reliable and significant reduction in psychological distress is supportive of the effectiveness of the Millfields treatment programme in reducing symptoms, which otherwise have the potential to elevate violence risk and complicate management and treatment (Fyer et al., 1988).

In contrast to previous studies, this research was not limited by confounds that had the potential to impact upon follow-up assessments, because all measures were undertaken whilst patients were in the Unit. A further strength of this study lies in the multi-methods used to assess effectiveness of treatment, including both self-report and clinical assessment tools.

Millfields staff, in collaboration with the Violence Prevention Research Unit, plan to build on these findings by conducting an in-depth, qualitative exploration of patients' experiences of treatment.



Upcoming Events

Autumn/Winter 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 more information, call Carolanne Ellis on 020 7540 4210.

Date	Title	Presented by
6 October	EPOS – findings from the trial	Serif Omer
13 October	VOLUME – Existing volunteering schemes	Joyce Siette
20 October	FIAT – The follow-up on financial incentives for adherence to medication in non-adherent patients	Hana Pavlickova
27 October	Development of a mobile health intervention using positive psychology for common mental health disorders	Sophie Walsh
3 November	Recruitment to trials and mental health care	Paulina Szymczynska
10 November	Immediate social networks in people with psychosis	Domenico Giacco
17 November	Group processes in therapeutic groups	Stavros Orfanos
24 November	Built environment and mental health	Nikolina Jovanvic
1 December	Video clip study and treatment expectations	Gonca Bastug
8 December	QuEST – Quality and effectiveness of supported housing services for people with mental disorders	Sima Sandhu
15 December	Friendship in Befriending	Rose Thompson
22 December	FIAT – Financial incentives for adherence to medication in non-adherent patients experiences	Katie Moran
Holiday Intermission		
5 January	Comparing functional and integrated systems of mental health care – management of the COFI programme	Domenico Giacco
12 January	NESS – findings from the body psychotherapy for the treatment of negative symptoms trial	Mark Savill
19 January	EPOS – findings from the trial	Eoin Golden
26 January	Review on religious leaders involvement in mental health	Victoria Bird

Studies recruiting in your trust

DNA Polymorphisms in Mental Illness – DPIM

The DPIM research study...

Aims to identify the genetic cause of Mental Illnesses. In the East London Foundation Trust the study is recruiting patients who have a diagnosis of Schizophrenia, Bipolar Affective Disorder and alcohol dependence Syndrome. By exploring the genetics of people with these diagnoses the study aims to identify whether specific genetic markers correlate to certain characteristics of mental illness. With the understanding of genetic markers and mental illness, this will hopefully promote further understanding and better treatments for mental illnesses. The study is only recruiting people who are of white British ancestry; this is to enable the study team to identify genetic markers in a small population first. The study team hopes to recruit people with alternative ancestries, at a later stage.

Who can take part?

- Males or Females between the ages of 18-65
- Must be of White British Ancestry (parents and grandparents to be either white, English, Irish, Scottish or Welsh. One grandparent can be of other European descent).

- Diagnosis of Schizophrenia, Bipolar Affective Disorder and alcohol dependence Syndrome.
- Willing to give DNA sample.

What does it involve?

Once patients are referred by clinicians, it involves a DNA sample to be taken (either blood or saliva). Following this a short interview with the individual to ask questions regarding the symptoms they have experienced and their responses to medications they have taken. The researcher will complete the appointment at a time and venue that is convenient for the participant. Only one appointment is required for the study.

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

- Contact Kimberley Anderson, kimberley.anderson@eastlondon.nhs.uk
- Or by telephone at 020 7540 6755 x.2325
- The Chief Investigator is Dr Andrew McQuillin, University College London a.mcquillin@ucl.ac.uk
- Local Investigator in our Trust is Dr Nicholas Bass, Nicholas.Bass@eastlondon.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.

■ Barnicot K, Wampold B & Priebe S (2014) *The effect of core clinician interpersonal behaviours on depression*, **J Affect. Disord.**, 167C: 112-117 doi: 10.1016/j.jad.2014.05.064.

■ Bhui K (2014) *Preventing the tragedy of railway suicides*, **Ment Health Today**, 24-27.

■ Copeland J, Thornicroft G, Bird V, Bowis J & Slade M (2014) *Global priorities of civil society for mental health services: findings from a 53 country survey*, **World Psychiatry**, 13(2):198-200 doi: 10.1002/wps.20133

■ Doyle M, Coid J, Archer-Power L, Dewa L, Hunter-Didrichsen A, Stevenson R, Wainwright V, Kallis C, Ullrich S & Shaw J (2014) *Discharges to prison from medium secure psychiatric units in England and Wales*, **Br.J Psychiatry**, 205(3):177-182 doi: 10.1192/bjp.bp.113.136622.

■ Eassom E, Giacco D, Dirik A, Priebe S (2014) *Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors*. **BMJ Open**.

■ Giacco D, Luciano M, Del VV, Sampogna G, Slade M, Clarke E, Nagy M, Egerhazi A, Munk-Jorgensen P, Bording MF, Kawohl W, Rossler W, Zentner N, Puschner B & Fiorillo A (2014) *Desire for information of people with severe mental illness*, **Soc Psychiatry Psychiatr Epidemiol**. [Epub ahead of print] doi: 1007/s00127-014-0901-5

■ Hale DR, Patalay P, Fitzgerald-Yau N, Hargreaves DS, Bond L, Gorzig A, Wolpert M, Stansfeld SA & Viner RM (2014) *School-level variation in health outcomes in adolescence: analysis of three longitudinal studies in England*, **Prev.Sci**, 15(4):600-610.

■ Hung CF, Rivera M, Craddock N, Owen MJ, Gill M, Korszun A, Maier W, Mors O, Preisig M, Rice JP, Rietschel M, Jones L, Middleton L, Aitchison KJ, Davis OS, Breen G, Lewis C, Farmer A & McGuffin P (2014) *Relationship between obesity and the risk of clinically significant depression: Mendelian randomisation study*, **Br.J Psychiatry**, 205(1):24-28. doi: 10.1192/bjp.bp.113.130419

■ Le BC, Slade M, Lawrence V, Bird VJ, Chandler R, Farkas M, Harding C, Larsen J, Oades LG, Roberts G, Shepherd G, Thornicroft G, Williams J & Leamy M (2014) *Competing Priorities: Staff Perspectives on Supporting Recovery*, **Adm Policy Ment Health**, Doi: 10.1007/s10488-014-0585-x



■ Mullins N, Perroud N, Uher R, Butler AW, Cohen-Woods S, Rivera M, Malki K, Euesden J, Power RA, Tansey KE, Jones L, Jones I, Craddock N, Owen MJ, Korszun A, Gill M, Mors O, Preisig M, Maier W, Rietschel M, Rice JP, Muller-Myhsok B, Binder EB, Lucae S, Ising M, Craig IW, Farmer AE, McGuffin P, Breen G & Lewis CM (2014) *Genetic relationships between suicide attempts, suicidal ideation and major psychiatric disorders: A genome-wide association and polygenic scoring study*, **Am J Med Genet B Neuropsychiatr**. Genet, 165(5):428-437 doi: 10.1002/ajmg.b.32247

■ Rukat A, Musisi S, Strohle A & Mundt AP (2014) *Prescription Patterns of Psychotropic Medications for the Treatment of Psychotic Disorders in the Largest Mental Health Institutions of Uganda*, **J Clin. Psychopharmacol**. [Epub ahead of print]

■ Shiraz F, Rahtz E, Bhui K, Hutchison I & Korszun A (2014) *Quality of life, psychological wellbeing and treatment needs of trauma and head and neck cancer patients*, **Br.J Oral Maxillofac.Surg.**, 52(6):513-517 doi: 10.1016/j.bjoms.2014.03.019

■ Slade M, Jordan H, Clarke E, Williams P, Kaliniecka H, Arnold K, Fiorillo A, Giacco D, Luciano M, Egerhazi A, Nagy M, Bording MK, Sorensen HO, Rossler W, Kawohl W & Puschner B (2014) *The development and evaluation of a five-language multi-perspective standardised measure: clinical decision-making involvement and satisfaction (CDIS)*, **BMC.Health Serv.Res.**, 14:323 doi: 10.1186/1472-6963-14-323

■ van der Werf M, Hanssen M, Kohler S, Verkaaik M, Verhey FR, RISE Investigators, van Winkel R, van Os J & Allardyce J (2014) *Systematic review and collaborative recalculation of 133,693 incident cases of schizophrenia*, **Psychol Med**, 44(1):9-16 doi:10.1017/S0033291712002796

■ Leamy M, Clarke E, Le BC, Bird V, Janosik M, Sabas K, Riley G, Williams J & Slade M (2014) *Implementing a Complex Intervention to disorder in primary care: a meta-analysis*, **Br.J Gen.Pract.**, 64(624):e408-e418 doi: 10.3399/bjgp14X680497

■ Zangrilli A, Ducci G, Bandinelli PL, Dooley J, McCabe R & Priebe S (2014) *How do psychiatrists address delusions in first meetings in acute care? A qualitative study*, **BMC. Psychiatry**, 14(1):178 doi:10.1186/1471-244X-14-178.