R&Dnewsletter

The political mission of psychiatry

Extract from an editorial published recently in *World Psychiatry*, in which **Prof Stefan Priebe** argues that psychiatry should advocate for the political changes needed to improve mental health

What contributes to poor mental health is well known (1): adverse childhood conditions; experience of war, persecution and torture (2); social isolation; unemployment and social exclusion; poverty, poor education and low socio-economic status; and social inequality.

In order to achieve substantial improvements in public mental health, we require societies to change and implement all those factors that promote mental health: societies should provide safe and supportive upbringing conditions; secure peace within and between countries; eradicate poverty; guarantee good education; strive for full employment; promote social cohesion and functional communities; and have little social inequality. These requirements are clear and unequivocal, no more research needed.

Yet, there is little evidence that we are currently making much progress towards such societies. How can this be changed and societies improved? Changing the rules and processes within societies is clearly a political task. Politicians get elected to take decisions about military activities, expenditure on education and social welfare, employment rules, taxation and other means of redistribution. Politicians are democratically legitimized and authorized, mental health experts are not. Perhaps, we should therefore just provide our expert view and leave it there? This appears to have been the dominating attitude of mental health professional bodies during the last three decades. One may conclude that such abstaining from political involvement has been a major mistake, both for people with mental disorders and the profession itself.

If there is a will to engage politically and call for

societal change on the basis of the evidence for public mental health, there are likely to be various and potentially strong allies, calling for similar changes based on expertise from other fields of medicine and social sciences. For example, social inequality is bad not only for mental health, but also for physical health and other social phenomena such as crime rates (Wilkinson & Pickett, *The Spirit Level*, 2009). Consequently, a World Health Organization European review of social health determinants (Marmot et al, Lancet, 2012) calls for action in the wider social and economic spheres, with less deprivation and a more balanced social gradient. Linking with such calls from experts in other fields may strengthen the impact of a political voice from mental health.

Political engagement of mental health professionals – even if aligned with experts from other fields as well as patient and carer groups –

might still not be successful. Other societal forces and interests might drive societies in opposite directions, e.g., towards military engagements and even greater social inequality. Politicians are unlikely to change the welfare system or stop wars just because they are told by experts that this would be better for public mental health.

Despite this, raising our professional voice in the political arena might still be important. How can we – as mental health academics or clinicians – know the central importance of societal factors for mental health and not call for the political action to improve them – loudly and clearly? Whether effective or not, political engagement appears a moral imperative for a credible profession with coherent values (Priebe et al, *Br J Psychiatry*, 2013). As a minimum, it can underline the societal relevance of psychiatry and help to link psychiatry and other important societal groups.

Clinicians' experiences of offering financial incentives to patients to increase their adherence to anti-psychotic medication

By **Katie Moran**, Research Assistant, Unit for Social and Community Psychiatry

People living with schizophrenia and other psychotic illnesses are often prescribed a 'depot' injection containing anti-psychotic medication. This helps to control symptoms and prevent relapse. Depots may be given to patients between once a week and once a month, at home or in a clinic, as an alternative to medication in tablet form. However, for various reasons, not all patients take all of their prescribed depots. This is called 'non-adherence.' As a result of non-adherence, patients' symptoms often worsen, resulting in risk to themselves or others. Past attempts to improve adherence to anti-psychotic medication have shown limited success. However, a recent research trial found that offering patients a financial incentive (money) to take their medication can be effective. Over one year, patients who were offered £15 for each depot showed improved adherence in comparison with patients who did not receive any incentives.

Offering financial incentives for adherence to depot medication is controversial. Following the trial, we wanted to learn more about how offering financial incentives worked in practice. We conducted interviews with clinicians (psychiatrists, depot clinic nurses, care coordinators and team managers) to find out:

1. How did patients spend the money?
Clinicians believed that around a quarter of patients spent the money on food, alcohol, or drugs. A smaller number of patients spent the money on household goods, hobbies or tobacco.

2. Did patients ask for more money, or more frequent depot injections?
A small number of patients were believed to have asked for the incentive to be increased to more than £15 and others asked to receive their depot more frequently to increase the amount of money received. In some instances, patients were reported to have turned up for their depot appointment earlier than arranged.

There appeared to be no negative consequences when these requests were refused.

3. Did other patients start asking to receive money for their depot injections, or become non-adherent to their depot to try and receive money?
Around 20 patients not involved in the trial asked to be paid for their depot or asked why they were not being paid. Two patients started to miss their depot as a result and one patient threatened to refuse taking their depot to receive the money. The problems that arose from this were quickly resolved and did not have any negative consequences.

4. What effect did the incentive have on patients' interaction with the mental health team?
Clinicians talked about whether the incentive had a positive or negative impact on patients' interaction with them and the mental health team. The majority talked about how the incentive made it easier to manage patients' care, and how patients' attendance to depot injections improved. Some also said that patients made more of an effort to ensure that they received their depot on time; ringing the team to check when their appointment was due, for example.

Clinicians also stated that they spent less time chasing patients for missed depots, that they were able to monitor their patients' health better, and that patients engaged well with the team and other services.

About one third of clinicians interviewed felt that relationships with patients improved because of the incentives, mainly through greater trust and better communication. This may have been the result of patients' increased contact with clinicians through attending depot appointments more often.

Whilst the majority of clinicians felt the incentives helped in some way, around one third of clinicians felt that they hindered their ability to manage patients' care, mainly because providing them took more time and effort out of their day. A small number of clinicians felt the incentives made it more difficult to manage patients' care, as the patient spent the money on drugs and/or alcohol and became more disengaged.

Some clinicians also talked about how the incentives had a negative impact on their relationship with patients, such that the relationship became more about the money. They said a minority of patients became aggressive if the incentive was not there for their appointment, which also affected the relationship.

5. Did patient's health improve as a result of the incentive?
Around a third of clinicians interviewed felt that incentives had a positive effect on their patients' health. Through turning up to their depot appointments and receiving their medication on time, patients showed improvements in their mental health and a reduction in using drugs and/or alcohol. Other clinicians found that their patients began to understand the benefits of their medication for their mental health. Moreover, clinicians also felt that their patients showed improvements socially, as the regular medication and contact helped them have more stable relationships with others.

On the other hand, around a fifth of clinicians felt that the incentives had a negative effect on their patients' health. This was largely to do with patients spending the money on drugs and/or alcohol, which impacted negatively on their mental health. In a minority of cases, clinicians reported that some of their patients had become dependent on the money, secretive about the money, or were at risk of being taken advantage of by others who knew about them receiving the incentives. The overall experience of clinicians was positive, with the majority feeling that offering financial incentives had a positive effect on their patients in a number of ways. However, clinicians for a third of patients did find offering the incentives to have a negative impact on the patient or their relationship with them. This seems to suggest that the use of incentives may not be suitable for everyone, and this must be taken into account when deciding whether to use them routinely in mental health care.

Correction
The Winter 2015 *R&D Newsletter* incorrectly identified Adrian Mundt, Dr. med. habil., as a Research Assistant in the Unit for Social & Community Psychiatry whereas he is a Research Fellow in the Unit.

ENRICH peer support for discharge NIHR research programme

ENRICH is a £1.95 million, five year programme of applied research commissioned by the National Institute for Health Research (NIHR) to develop, pilot and trial a Peer Worker intervention to enhance discharge from inpatient to community mental health care.

The programme started in March 2015 and builds on the pilot trial of peer support conducted in ELFT between 2009 and 2012. Professor Alan Simpson at City University London, who led the initial pilot and Professor Stefan Priebe are collaborators in the new programme of research which is being led by Dr Steve Gillard at St George's, University of London. The programme is underpinned by high levels of service user researcher involvement.

Approximately one third of people discharged from inpatient mental health care in England are readmitted within one year; the majority in the first three months post-discharge. The period following discharge is also a particularly risky time with 15% of all suicides nationally taking place following discharge from mental hospitals, the majority of those in the first week.

A recent systematic review in the British Journal of Psychiatry indicated that transitional interventions in support of discharge are likely to be clinically and cost effective (by reducing readmissions), and these may include peer support interventions. Studies have shown that where peer workers replace or do similar work to other mental health workers they are as effective, with no adverse effects. Studies have also suggested wider benefits to individual service user recovery, peer worker wellbeing and changed patterns of service use, especially where interventions focus on the unique contribution of peer support.

ENRICH is the most robust international trial to date of a peer support intervention that will target a high need population at a vulnerable transition in the care pathway. The study is designed to maximise the unique qualities of peer support, alongside existing services, to bring about change in a focused set of individual recovery, service use and cost outcomes. The key aim of ENRICH is to significantly reduce readmissions in the year post-discharge and the total cost of services used, while improving individual wellbeing and recovery.

The intervention will be fully developed over 2015 with the involvement of expert panels including service users and peer workers in each of the participating NHS Trusts. This trial will then be piloted for a year in two Trusts, including ELFT, before the full cluster trial is rolled out across six NHS sites in various parts of England. The study will include a detailed exploration of the impact of being a peer worker of the peer supporters themselves.

The ENRICH intervention will see Peer Workers based in a small stand-alone team in the community supervised and supported by a named Peer Worker Coordinator. A dedicated training programme will be a key component of the intervention and Peer Workers will provide in-reach onto wards to begin working with service users two to three weeks before discharge. Peer Workers will continue to meet service users for four months post-discharge, initially weekly and then fortnightly and will deliver a combination of peer support, coaching and navigation. Peer Workers will have access to their own peer support as part of the intervention.

The ENRICH team's previous research shows that peer workers bring about change by building strong, therapeutic relationships based on shared lived experience; role modelling recovery, working, and living well in the community; and engaging service users with mental health services and the wider community.

Individual service user outcomes of receiving support from a peer worker include increased levels of hope in the future and personal empowerment; decreased experience of stigma within services and in the community; increased levels of social functioning and stronger social networks; and improved engagement with services.

ENRICH also aims to significantly reduce the cost to the Trust of providing a service to this population in the year post-discharge by reducing overall readmission, changing the overall pattern of service use and improving individual recovery and wellbeing.

Discussions with local partners are already taking place and will develop over the rest of the year.

OTHER NEWS

'JOIN DEMENTIA RESEARCH' LAUNCHES AS A NATIONWIDE SERVICE
'Join dementia research' delivers new opportunities for people to play their part in beating dementia, connecting researchers with people who want to participate in studies. For details and to find out how you can take part in the initiative, please go to the 'Join dementia research' website at www.joindementiaresearch.nihr.ac.uk

BENEFITS ADVICE SERVICE FOR RESEARCH INVOLVEMENT
A new confidential service has been launched which offers personal advice and support on how payment of fees and expenses for public involvement might affect people in receipt of state benefits. The service will be provided on behalf of the NIHR by Bedford Citizens Advice Bureau, initially as a pilot for one year, and offers a confidential service to members of the public involved with NIHR organisations or NIHR funded research projects and staff within NIHR organisations who are supporting members of the public to get involved. Visit www.invo.org.uk/resource-centre/benefits-advice-service/

SOCIAL MEDIA USAGE GUIDANCE
INVOLVE have published new guidance on the use of social media to actively involve the public in research. This guidance provides examples of ways in which different types of social media are currently being used to involve the public in research, the benefits, challenges, risks and ethics of using social media for involvement, and some top tips and things to think about. To download the guidance visit the INVOLVE website at www.invo.org.uk/posttypepublication/guidance-on-the-use-of-social-media/

HEALTH RESEARCH AUTHORITY PROTOCOL TEMPLATES
In response to feedback from researchers, sponsors and regulators, the Health Research Authority (HRA) is developing a suite of templates and guidance for writing protocols. A multidisciplinary group of individuals from research-active organisations and regulators provided expertise to this project. The group has produced detailed guidance and a template in line with international SPIRIT guidelines. The guidance and template clearly define the expected components of a protocol and help ensure researchers cover all the elements required by sponsors, Research Ethics Committees, the Medicines Healthcare Regulatory Authority (MHRA), and NHS sites.

RDS LONDON PPI LEAFLET
RDS London have produced a new PPI leaflet which summarises the services the PPI team offer to help investigators develop, refine and integrate PPI into research projects. Visit: www.rds-london.nihr.ac.uk/Patient-Public-Involvement/PPI-the-Role-of-RDS-London.aspx

Continuity across inpatient and outpatient mental health care or specialisation of teams?

By **Serif Omer**, Research Assistant, Unit for Social and Community Psychiatry

There is ongoing debate in mental health policy regarding the best system for organising secondary mental health care services. A central area of this debate is whether there should be continuous treatment teams across inpatient and outpatient settings or separate specialised teams within each of the two settings. These two types of system can be referred to as continuity systems and specialisation systems of care.

In the United Kingdom we have traditionally adopted a continuity system, in which the same consultant psychiatrist provides care for a patient in both inpatient and outpatient settings. However, following the Royal College of Psychiatrists report on the *New Ways of Working for Psychiatrists*, the NHS is moving toward adopting a specialisation system with separate consultants providing inpatient and outpatient care. Interestingly, this contrasts with reforms taking place elsewhere. In Germany, for example, there are initiatives to move from a specialisation system toward a continuity system of care.

These conflicting reforms are occurring throughout the world and are based on little or no evidence regarding their effects on patient care. As a result, we conducted a systematic review recently published in European Psychiatry to identify previous research on the topic and synthesize the findings. We searched 5 bibliographic databases using a comprehensive combination of search terms, contacted key researchers in the field, and tracked citations of relevant articles. We then analysed the included papers using narrative synthesis, a systematic method to draw conclusions from a range of different studies.

Our systematic search identified 17 unique research studies relevant to our research question. This included 13 comparative studies that investigated outcomes in continuity and specialisation systems of mental health care and 4 qualitative studies that investigated the detailed views of patients and staff members.

Our narrative synthesis of the studies found the following:

■ Continuity systems are associated with shorter lengths of patient stay in hospital.

■ There are mixed findings on the number of hospital admissions. However, when restricting our analysis to only those studies that were deemed of higher quality, continuity systems were associated with lower hospital admissions.

■ Continuity systems are associated with faster and more flexible transitions between inpatient and outpatient services.

■ Patients and staff members have identified advantages and disadvantages of both types of system, but they seem to prefer a continuity system of care.

We also found that the quality of the previous studies was poor. Only two studies would meet the quality criteria for an acceptable level of evidence set by the Cochrane Effective Practice and Organisation of Care Group. Many of the studies failed to control for potential confounders and included only one site per intervention group, which could bias the findings. There was also a tendency for the novel system (i.e. the more recently introduced system of care) to have more intensive treatment and better outcomes, regardless of whether it was a continuity or specialisation system.

The findings of our systematic review suggest that a continuity system, whereby the same clinicians provide care for a patient across inpatient and outpatient settings, is associated with better outcomes and is preferred by patients and staff members. This could be due to improved communication between services which ensures smoother transitions between settings. Having the same clinicians across settings could also be beneficial as clinicians can develop a better therapeutic relationship with patients, which is of crucial importance in mental health care, and a better knowledge of their patient.

However, the quality of the available evidence is currently very poor and we should be careful when interpreting the findings. Even so, there are a large number of reforms taking place throughout the world which can be costly both financially and in terms of staff morale. At the very least, this review should raise questions regarding the appropriateness of reforms where a continuity system is being replaced by a specialisation system of care, as is the case in the United Kingdom. There is an urgent need for further, high quality research that overcomes the limitations identified in our review. The COFI study (Comparing Functional and Integrated Systems of Mental Health Care), coordinated by the Unit for Social and Community Psychiatry in East London, is currently being carried out across 5 European countries over 5 years. The study aims to answer some of these important questions.

The Research Forum

The Research Forum is a monthly peer-support and networking meeting for staff from all disciplines either involved in research or those wishing to get involved in a research project in the forensic service. We also publicise and promote research across the service.

Since we started meeting in December 2014, we have developed a service-wide Research Register that nicely demonstrates the breadth of interesting research activity going on here. Topics currently under investigation include:

■ Risk assessment ■ Work and Recovery ■ Reflective Practice
■ Longer-stay patients ■ Returns to prison

The Research Forum takes place every 2nd Wednesday of the month from 3.15 – 4.15pm at the John Howard Centre – Group Room B (but please check the venue to avoid disappointment); all are welcome. For more information contact Warren.dunn@eastlondon.nhs.uk or Jeremy.berman@eastlondon.nhs.uk

---

Can online social networking help patients to increase their social contacts?

By **Domenico Giacco**, Research Fellow, Unit for Social and Community Psychiatry

The internet has changed our life in many ways. In particular, online social networking tools (chat-rooms, forums, Facebook, etc.) can help people establish new social relations. This may be particularly important for people with psychosis. They are often socially isolated and may find it difficult to establish new social relations because of their psychological difficulties.

Relationships through online social networks do not require the immediate responses that are necessary in face-to-face interactions; this may reduce the difficulties related to lack of concentration and psychological distress. Also, the stigma towards mental illness which may highly impact on face-to-face interactions is less likely to negatively influence online social contacts.

On the other hand, there have been concerns that online social networking use may lead to potentially negative consequences, such as the development of "Internet addiction" and less drive to maintain real-world social contacts. The risk of negative consequences may particularly apply to individuals who at some point of their life may be vulnerable because of psychological distress.

In a paper recently published in the *International Journal of Social Psychiatry*, we explored the mental health literature to answer the following two questions:

1. Is there any difference in the use of online social networking between people with a diagnosis of psychosis and other clinical/non-clinical populations?

2. Has any risk related to the use of online social networking been reported for people with psychosis?

We selected the papers which explored the use of online social networking by people with a diagnosis of schizophrenia or bipolar disorder. Any type of online social networking (defined as any social interaction occurring online) was considered, with the exception of interactions between participants and mental health professionals. We excluded contacts between patients and professionals as we were interested in online social relations rather than in health care interventions delivered online.

We identified 2275 potentially relevant papers. After our screening, we found that only 11 of them met our inclusion criteria. These 11 studies included overall 1,189 patients and had been carried out in a number of different countries, i.e. Austria, Brazil, Germany, Israel, Spain, Switzerland, Taiwan, United Kingdom, United States.

People with psychosis seem to use the Internet more frequently than control groups for the purposes of social networking, spending more time in chat rooms or online games, despite having fewer face-to-face social contacts.

The reasons why people with psychosis use online social networking are predominantly:

a) establishing new contacts (either resulting in face-to-face interactions or not);

b) re-connecting with people they had lost contact with; and

c) finding/providing peer support.

Some studies suggested that people with psychosis may find e-mails or Facebook less preferable than other online social networking tools. This may not be surprising given that e-mails and Facebook are mainly used to connect with an existing social network; and people with psychosis often have smaller social networks compared to other people.

We found little evidence on risks of the use of online social networking for people with psychosis. It needs to be mentioned, however, that risk related to online social networking was not the primary focus of any of the identified studies.

Only one study reported a correlation between less face-to-face social contacts and higher use of online social networking. However, the study was a cross-sectional one, providing a snapshot of current face-to-face and online social contacts of the interviewed patients. Therefore, it could not explore whether social networking use was a cause or a consequence of social isolation.

No studies found evidence of bullying or online harassment experienced or inflicted by patients; one reported few 'negative statements' encouraging non-compliance to treatment in online forum postings. This is in contrast with previous studies (case reports) in people who had not previously received a diagnosis of psychosis, which have shown stalking online behaviours and delusions about online social networking.

Our findings suggest that online forums or chat rooms have the potential to facilitate the establishment of new social relations for patients who are socially isolated.

Online social networking may be used alongside befriending schemes or other social interventions to enhance social support for these patients. However, the balance between risks and benefits needs to be more firmly established.

Key open questions are:

a) what is the ideal social networking tool to be used for people with psychosis in terms of benefits/risks profile and

b) whether (and which kind of) online social contacts can become supportive relationships.

Centre for Mental Health Research & the Joint Institute of Mental Health Nursing
Research Seminars 2015s

Venue – College Building, City University London, St John Street, London EC1V 4PB Time – 12:00 – 13:30 (Lunch will be provided from 12:00)
For further information please contact Julia Jones at J.Jones-4@city.ac.uk or 020 7040 5485

Date	Title	Presented by
20 April	*SUGAR in Everything: Mental health service users and carers' collaboration on mental health research*	Service User and Carer Group Advising on Research
18 May	*Results of the COCAPP study: Cross-national study of recovery-focused care planning and coordination*	Professor Alan Simpson & Dr Sally Barlow
15 June	*Reaching decisions about psychotropic medication during pregnancy in women with severe mental illness*	A user-led research study Dr Vanessa Pinfold & members of the research team

The inter-relationship between mood, self-esteem and response styles in adolescent offspring of bipolar parents

By **Hana Pavlickova**, Research Assistant, Unit for Social and Community Psychiatry

It has been well documented that children of parents with Bipolar Disorder (BD) have an increased risk of psychiatric disorders in comparison to offspring of parents without psychiatric problems; almost 30% of offspring of parents with BD have been found to meet diagnostic criteria for affective disorders, compared to less than 10% of children of well parents. However, little research has been carried out investigating whether children of bipolar parents already show some psychological and/or behavioural dysregulations similar to adults diagnosed with bipolar disorder. Identifying such psychological vulnerability mechanisms might have implications for theoretical models of the disorder as well as for early psychotherapeutic interventions for high-risk populations.

One way of addressing this question is by examining the core domains of psychological dysregulation in bipolar disorder that is instability of affect and intense shifts in self-concepts, within the context of response style theory (Nolem-Hoeksema, 1991). The response styles theory proposes that individuals differ in the way they respond to feelings of low mood, with serious consequences for the duration and severity of depressive or other kinds of dysphoric episodes. Three coping strategies have been described within this framework. First, **(i)** rumination has been defined as passively directing one's attention and thoughts to current depressive feelings, to its causes and effects. In contrast, **(ii)** active coping has been described as directing one's attention away from depressive symptoms by engaging in pleasant activities to relieve symptoms. Finally, **(iii)** Risk-taking, which is particularly important in the context of BD, involves engaging in dangerous behaviours without regard to the consequences.

Using this theoretical framework, we asked 23 adolescent children (i.e. 13-19 years old) of parents diagnosed with bipolar disorder and 25 adolescent children of well parents with no psychiatric problems (further referred to as control children) to complete a diary for six day (this method is referred to as the Experience Sampling Method (ESM; Csikszentmihalyi and Larson, 1987)). Adolescents were asked to rate their mood, self-esteem, and response styles (i.e. rumination, active coping, risk-taking) 10 times a day at randomly periods throughout the day as reminded by a wristwatch they wore. This data allowed us to examine the way mood, self-esteem and response styles affect each other over time, and the differences

in these between offspring of bipolar and well parents. We expected that low mood would lead to greater engagement in rumination in the offspring of bipolar parents, whilst high mood would lead to a greater engagement in risk-taking. Second, we also expected that in children of bipolar parents rumination would lead to more pronounced decreases in mood and self-esteem, whilst risk-taking would lead to a greater increase in mood and self-esteem.

In contrast to our expectations, there were no differences in the magnitude of rumination each group displayed. Further, both groups showed improved mood as a consequence of risk-taking, and dampened self-esteem after engaging in rumination. However, whilst control children employed active coping strategies to cope with low mood, children of bipolar parents did not. Finally, we found that in children of bipolar parents low self-esteem triggered greater risk-taking at the subsequent time point.

Whilst our findings did not support the role of cognitive abnormalities (i.e. negative thinking) as a vulnerability factor for BD, they are in line with previous studies linking increased risk of mood and anxiety disorders with behavioural inhibition, and recent suggestions of a clinical staging in the development of bipolar disorder (Duffy et al., 2009; Duffy & Carlson, 2013).

Furthermore, our finding that rumination led

to decreases in self-esteem, rather than mood (although with no differences between groups) is contrasting our previous findings in patients with bipolar disorder, where rumination dampened affect, but was unrelated to self-esteem. It is possible that these findings reflect differential relationship between cognition and affect, changing as a function of the capacity of top-down emotion regulation, decreasing with severity of the illness.

Finally, while risk-taking increased positive mood in both groups, only offspring of bipolar parents showed an increased engagement in risk-taking in response to low self-esteem. This finding is in line with previous studies of manic patients, and have been previously explained in the context of the manic defence mechanism arguing that some individuals develop mania to cope with experiences that threaten self-esteem (Abraham, 1911/1927). Given that no bipolar offspring in the current sample met diagnostic criteria for BD, this finding might indicate early behavioural dysregulation specific for vulnerability for BD, with important implications for early psychological interventions. Although more research is needed to reliably inform our understanding of the development of bipolar disorder as well as early psychological interventions for high-risk individuals, the present findings have identified some areas that might be of relevance both theoretically and clinically.

Further reading

Duffy, A., & Carlson, G.A. (2013). How does a developmental perspective inform us about the early natural history of bipolar disorder? Journal of the Canadian
   Academy of Child and Adolescent Psychiatry, 22, 6-12. http://www.cacapacpea.org
   Duffy, A., Alda, M., Hajek, T., & Grof, P. (2009). Early course of bipolar disorder in high-risk offspring: prospective study. British Journal of Psychiatry, 195, 457-458. doi: 10.1192/bjp.bp.108.062810
   Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressed mood. Journal of Abnormal Psychology, 100, 569-582. doi: 10.1037/0021-843X.100.4.569
   Abraham, K., 1911/1927. Notes on the psychoanalytic investigation and treatment of manic depressive insanity, in: Jones, E. (Ed.), Selected papers of Karl Abraham. Hogarth, London, pp. 137-156.
   Csikszentmihalyi, M., Larson, R., 1987. Validity and reliability of the Experience Sampling Method. Journal of Nervous and Mental Disease 175, 526-536.

Studies recruiting in your trust

It's OK to ask about clinical research

Clinical research is the way in which we improve treatments in the NHS. Doctors use clinical research studies to compare current treatments with potentially better ones, so that we can keep improving the care we offer NHS patients. People who take part in studies often feel that they are taking an active part in their health care and helping others, by helping to identify the best treatments.

Who and what should you ask?
In many cases doctors will tell patients about research. But we also want to encourage patients and their carers across the country to ask their family doctor or consultant about clinical research, and whether it might be right for them or their loved one.

In a consumer poll, only 21% of patients and the public said that they would feel confident asking their doctor about research opportunities – a low number. That is why the National Institute for Health Research (NIHR) is promoting the fact that it's OK to ask about clinical research.

If you have a medical condition and are undergoing treatment, we would like you to ask your family doctor, nurse or consultant about clinical research, and whether it might be right for you.

Last year, more than half a million NHS patients chose to take part in nearly 3000 clinical research studies. Thanks to those patients, we are learning more all the time about how to deal with a whole range of medical conditions - and make some real breakthroughs that willl improve thousands of lives. This year, you could help us to do even more if you remember it's OK to ask.

Why?
We would like those people that do ask to let us know that they did, along with what response they received and any other comments or suggestions

for improvements. By sharing your experiences to the OK to ask campaign we will be able to let clinicians know that patients are interested in research. It will also help us to see where we may be able to improve our response to patients who want to take part in research.

You can send us your responses by:
- *twitter: @OfficialNIHR #NIHRoktoask*
- *facebook: facebook.com/ NIHRoktoask*
- *oktoask@nihr.ac.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.

■ Agel M, Marcenes W, Stansfeld SA, Bernabe E (2014) *School bullying and traumatic dental injuries in East London adolescents*. **British Dental Journal**; 217(12): E26.

■ Ahmed H, Blakeway EA, Taylor RE, Bewley AP (2015) *Children with a Mother with Delusional Infestation-Implications for Child Protection and Management*. **Pediatric dermatology** (in print)

■ Auty KM, Farrington DP, Coid JW (2015) *Intergenerational transmission of psychopathy and mediation via psychosocial risk factors*. **The British journal of psychiatry: the journal of mental science**; 206(1): 26-31.

■ Bhui KS (2015) *Big data and meaning: methodological innovations*. **Epidemiology and psychiatric sciences**, 1-2.

■ Bien H, Bolte J, Zwitserlood P (2014) *Do syllables play a role in German speech perception? Behavioral and electrophysiological data from primed lexical decision*. **Frontiers in psychology**; 5: 1544.

■ Bourke JH, Langford RM, White PD (2015) *The common link between functional somatic syndromes may be central sensitisation*. **Journal of psychosomatic research** (in print)

■ Bui L, Farrington DP, Ueda M, Hill KG (2014) *Prevalence and risk factors for self-reported violence of Osaka and Seattle male youths*. **International journal of offender therapy and comparative criminology**; 58(12): 1540-57.

■ Chalder T, Goldsmith KA, White PD, Sharpe M, Pickles AR (2015) *Mediators of treatment outcome in the PACE trial of rehabilitative therapies for chronic fatigue syndrome*. **The Lancet Psychiatry**; 2: 141-152.

■ Coid JW, Yang M, Ullrich S, Hickey N, Kahtan N, Freestone M (2015) *Psychiatric diagnosis and differential risks of offending following discharge*. **International journal of law and psychiatry** (in print)
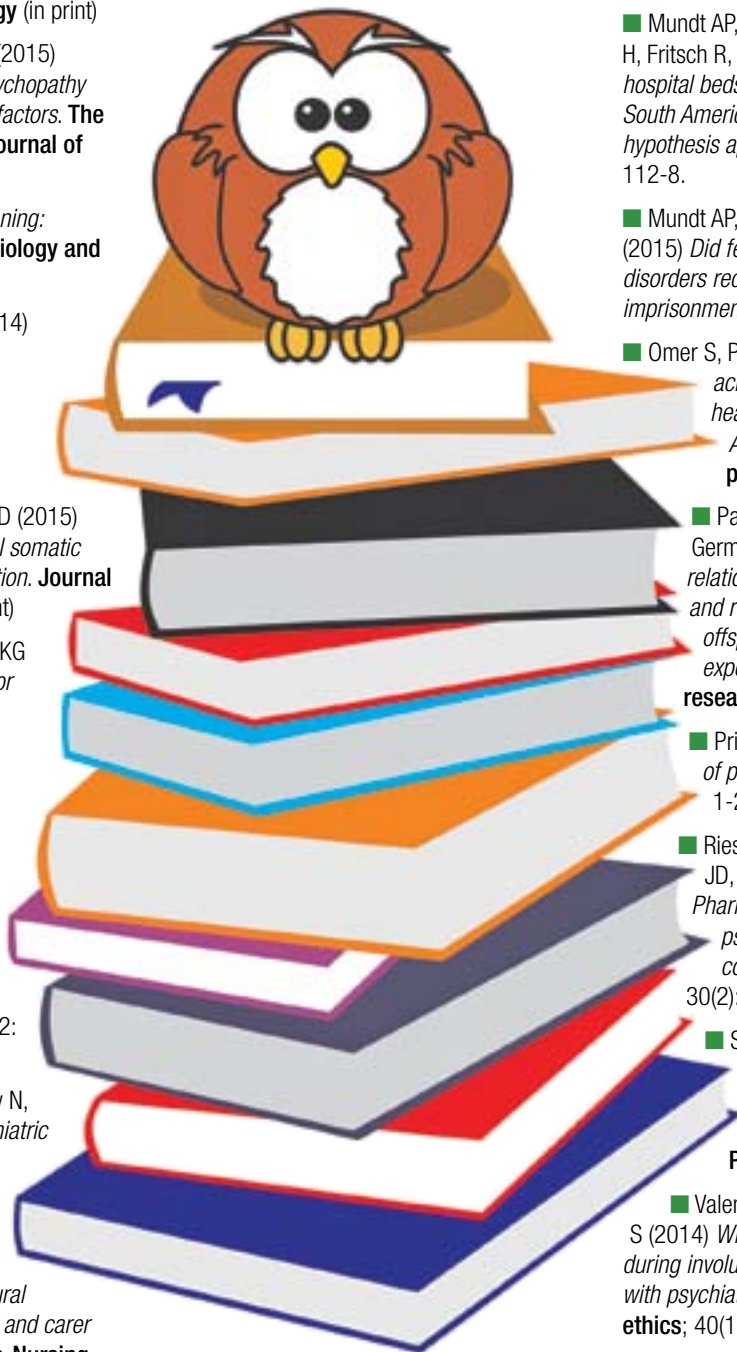
■ Cox LG & Simpson A (2015) *Cultural safety, diversity and the service user and carer movement in mental health research*. **Nursing Inquiry** [epub ahead of print doi: 10.1111/nin.12096]

■ Das-Munshi J, Leavey G, Stansfeld SA, Prince MJ (2014) *Does social disadvantage over the life-course account for alcohol and tobacco use in Irish people? Birth cohort study*. **European journal of public health**; 24(4): 594-9.

■ Del Vecchio V, Luciano M, Sampogna G, De Rosa C, Giacco D, Tarricone I, et al (2015) *The role of relatives in pathways to care of patients with a first episode of psychosis*. **The International journal of social psychiatry**, (in print).

■ Giebel CM, Zubair M, Jolley D, Bhui KS, Purandare N, Worden A, et al (2014) *South Asian older adults with memory impairment: improving assessment and access to dementia care*. **International journal of geriatric psychiatry**.

■ Highton-Williamson E, Priebe S, Giacco D (2015) *Online social networking in people with psychosis: A systematic review*. **The International journal of social psychiatry**; 61(1): 92-101.

■ Lavelle M, Dimic S, Wildgrube C, McCabe R, Priebe S (2014) *Non-verbal communication in meetings of psychiatrists and patients with schizophrenia*. **Acta psychiatrica Scandinavica**.

■ Le Boutillier C, Slade M, Lawrence V, Bird VJ, Chandler R, Farkas M, et al (2014) *Competing Priorities: Staff Perspectives on Supporting Recovery*. **Adm Policy Ment Health**.

■ Mundt AP, Chow WS, Arduino M, Barrionuevo H, Fritsch R, Girala N, et al (2015) *Psychiatric hospital beds and prison populations in South America since 1990: does the Penrose hypothesis apply?* **JAMA psychiatry**; 72(2): 112-8.

■ Mundt AP, Kastner S, Mir J, Priebe S (2015) *Did female prisoners with mental disorders receive psychiatric treatment before imprisonment?* **BMC psychiatry**; 15(1): 5.

■ Omer S, Priebe S, Giacco D (2015) *Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review*. **European psychiatry**; 30(2): 258-70.

■ Pavlickova H, Turnbull OH, Myin-Germeys I, Bentall RP (2015) *The inter-relationship between mood, self-esteem and response styles in adolescent offspring of bipolar parents: An experience sampling study*. **Psychiatry research**; 225(3): 563-70.

■ Priebe S (2015) *The political mission of psychiatry*. **World psychiatry**; 14(1): 1-2.

■ Riese F, Guloksuz S, Roventa C, Fair JD, Haravuori H, Rolko T, et al (2015) *Pharmaceutical industry interactions of psychiatric trainees from 20 European countries*. **European psychiatry**; 30(2): 284-90.

■ Savill M, Banks C, Khanom H, Priebe S (2014) *Do negative symptoms of schizophrenia change over time? A meta-analysis of longitudinal data*. **Psychological medicine**, 1-15.

■ Valenti E, Giacco D, Katasakou C, Priebe S (2014) *Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients*. **Journal of medical ethics**; 40(12): 832-6.

■ White PD, Chalder T, Sharpe M (2015) *The planning, implementation and publication of a complex intervention trial for chronic fatigue syndrome: the PACE trial*. **BJPsych Bulletin**; 39: 24-27.

■ Williams J, Leamy M, Bird V, Le Boutillier C, Norton S, Pesola F, et al (2014) *Development and evaluation of the INSPIRE measure of staff support for personal recovery*. **Soc Psychiatry Psychiatr Epidemiol** (in print).