

Participation in life in advanced older age

By [Dr Paul Sugarhood](#), Occupational Therapist,
Extended Primary Care Services

Occupational therapists in Community Health Newham work in various multidisciplinary teams, where the focus is on avoiding hospital admission, preventing or delaying the need for institutional care and maximising independence in activities of daily living. With the ageing population, we increasingly receive referrals for older people, and in particular 'older' older people aged in their 80s and 90s.

Several years ago we were searching for outcome measures that could be used to measure the contribution of occupational therapy. This made us think more deeply than usual and ask: what are we and our clients actually trying to achieve?

Several measures that seemed promising (e.g. *Impact on Participation and Autonomy*, *Australian Therapy Outcome Measures*) were based on the World Health Organisation's International Classification of Functioning, Disability and Health (ICF, see figure 1). The ICF conceptualises health as the outcome of a dynamic interaction between an individual and their environment. It proposes that the components of functioning and disability are 1) body structures and functions, 2) activity and 3) participation, representing functioning successively "at the level of body or body part, the whole person, and the whole person in a social context".

It has been argued that the participation level should be the ultimate goal of rehabilitation, and in particular occupational therapy. The concept is important for occupational therapy because of the profession's concern with improving health and wellbeing by enabling people to overcome barriers to participation in the occupations of everyday life.

However, the ICF provides only a very basic definition of participation – "involvement in a life situation" – and a list of nine classification domains (e.g. self-care, domestic life, work and education). When we tried ICF-based outcome measures with



moral or ethical beliefs of a person about what they perceived to be important, worthwhile, right or good.

It was through the enacting of values held by the person that he or she felt they were participating and being involved in life. Values provided the motivation for specific ways of participating, guided actions and behaviours, and were the means through which participation was interpreted. The greater

our patients in advanced older age, they scored very poorly, often because they completed fewer activities in a typical day or were no longer involved in paid employment or education. This was despite many reporting satisfaction with their involvement in life.

So, do very old people necessarily participate less in life? Or were we missing what participation might mean in advanced older age?

My doctoral thesis therefore asked the question: "What does participation mean from the perspectives of older people aged over 80 years who experience functional decline or disability?" Using grounded theory and ethnography, the study recruited participants aged 81 to 96 years from a wide variety of ethnic, cultural and social backgrounds, home situations, medical diagnoses and levels of functional impairment.

Participation as enacting values: an adaptive process

The main finding was that participation was not experienced as an objective list of daily activities or social roles, or as frequencies that such activities or roles were performed. Rather, participation was experienced through a set of values. Values were the

the congruence between the daily experiences of the person and their values, the greater the sense of participation.

Despite great heterogeneity, seven commonly held and enacted values were:

■ **Connecting with others.** Almost universally, this was what mattered most and was most highly valued. Feeling linked to other people could be achieved directly in a social situation, by jointly performing an activity with others, through belonging to a family or other social group, or simply by feeling a connection to the outside world (e.g. sitting by a window watching people walk past in the street).

■ **Maintaining autonomy.** There were two aspects to autonomy. First, the ability to act as one wished, to do the things one wanted to do. Second, the ability to make decisions for oneself without feeling overly constrained by external influences. Both types of autonomy were often referred to as being "independent".

■ **Affirming abilities.** Despite much discussion of physical and functional decline, and what could no longer be done or participated in, value was placed on affirming abilities that the person still had and ways

Continued on page 2



Participation in life in advanced older age

Continued from page 1

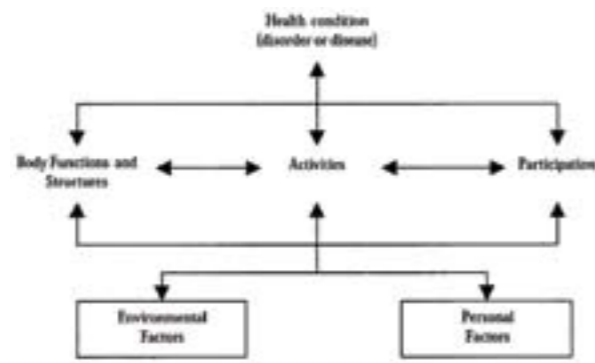
of participating in the here and now. What was valued was a sense of mastery and pride that one was still a capable and effective actor – at least in some ways and on some occasions – and not only a spectator or person requiring care and support.

■ Doing the best you can. Great value was placed on doing one's best to participate and be involved in life. There were two main aspects. First, trying or working hard to participate, which involved putting in effort (often physical or mental) to overcome obstacles or adversity and so perform valued activities. Second, participants tried to make the best of a difficult or bad situation. This involved accepting that current participation might not be ideal, and so one just had to get on with life the best one could.

■ Being useful. Participants wanted to be useful, to have a sense of importance by adding something to society, both within and outside their family and local community. While this was often difficult when faced with poor health or functional decline, the desire to be useful remained important. Enacting the value of being useful was achieved by doing things for or helping others, giving something in return for help received, taking responsibility for something, or being a figure of respect.

■ Maintaining self-identity. The need for a sense of continuity with the past was frequently evident, with an orientation backwards to the past rather than forwards to the future. Value was placed on maintaining self-identity, on ways of participating in life that preserved a sense of who the person had been and still was. This could be achieved by continuing to pursue the same interests or fulfil the same life roles as in the past (even if in an altered way), using skills and experience from the past in the present and, perhaps most commonly, interpreting the present through reflection on the past.

■ Pursuing interests. Interests were activities or ways of spending time that the person found stimulating, enjoyable, satisfying or fulfilling. A very wide range of interests were mentioned, relating



■ Figure 1: The components of ICF

to hobbies or leisure activities, work and career, family or community roles and cultural or religious affiliations.

Participation in advanced older age was not, however, simply a continued enacting of values in the same way as had happened earlier in life. Rather, it was often challenged by deteriorating health, losses (e.g. of people, life roles) and environmental influences.

The research participants adapted (or not) to overcome these challenges by 1) interpreting their situation and thinking about things in a different way, and 2) selecting which forms of participation to engage in and how they were performed. For example, there was a tendency to move from pursuing more physically demanding forms of participation out of the home to those which were mentally stimulating, contemplative, sedentary and based in the home.

Implications for practice

To address participation, values must be considered. The patient-professional encounter should include dialogue through which an individual's values and preferences are discovered. Interventions to promote participation might be most effective if based on these values and aimed at enabling the person to enact them in some way.

■ The seven values described above could act as

a sensitising guide when working with very old people.

■ Connecting with others appears to be what matters most and is most highly valued. It might be that most attention should be paid to feelings of connection and belonging, interpersonal relationships and the social environment.

■ It is possible to gain access to a patient's values – what matters to them. Values relate to particular events, people and objects and stem from reasoned responses to the

challenges of everyday living. Discussion of events, people and objects therefore can enable identification of the values which, for each individual, motivate participation.

■ Health and social care professionals might be facilitated in gaining access to values given that 1) values tend to be recognised and articulated most commonly when challenged in some way, and 2) clinical encounters with very old people most often occur during such periods of change and challenge.

■ There is a tendency in current occupational therapy and rehabilitation practice with very old people to focus on improving performance of activities, of optimising abilities and compensating for deficits. Less attention is paid to interpretive processes of accepting and coming to terms with challenges to participation. Rather than focusing only on changing the reality of participation for patients, might there also be a role for clinicians in helping patients to re-define their expectations?

Finally, although promoting participation might not be the stated objective of services for very old people, many do already address the issue. For example, occupational therapy interventions frequently take place in patients' own homes and involve in-depth discussion of a person's priorities. Such practices should be validated and encouraged if participation is to be addressed and the goal of patients being optimally involved in life achieved.

Study to investigate diabetes care in people with severe mental illness

Researchers and clinicians from City University London, East London NHS Foundation Trust (ELFT), the Blizzard Institute Centre for Primary Care and Public Health, and Queen Mary University London have been awarded nearly £30,000 from Barts Charity to investigate diabetes care in people with severe mental illness.

People with severe mental illness (SMI) are twice as likely to develop diabetes compared with the general population. As a result, the study will speak to service users and healthcare professionals to gain a greater understanding of the views of people with SMI regarding the management of their diabetes.

Developed in consultation with clinicians, people with diabetes and severe mental illness, and members of Service User and Carer Group Advisors in Research (SUGAR), the researchers aim to interview

15 service users with diabetes and SMI, and 15 health professionals from primary, secondary and community care. This will enable the team to explore:

- what aspect of their diabetes service users with SMI find most difficult to manage;
- the barriers and facilitators to enabling them to manage their diabetes; and
- healthcare professionals' views about how best to promote self-management among service users who have diabetes and SMI.

Initial work has begun with the bulk of interviews to be conducted in early 2015 and results are expected in July 2015.

Lead investigator Professor Alan Simpson, who heads the Centre for Mental Health Research at City University London, said: "Self-management of diabetes is complex and the demands of managing

diabetes when also living with mental illness present additional challenges for both service users and healthcare professionals.

"Increasingly, people with diabetes are being supported to self-manage their condition and treatment but very few studies include people who also have mental illness. In this study we hope that the work will inform the development of appropriate self-management education for people with diabetes and SMI. We need to better understand the difficulties people experience and what they find helpful as well as asking health professionals for their views about how best to deliver diabetes care for this population."

The team members involved in the study are Alan Simpson, Kathleen Mulligan, Hayley McBain, Mark Haddad, Chris Flood, Julia Jones, Noeleen Hilton, Jackie Chapman and Sally Hull.



Building on success – a new initiative for ELFT

By **Frank Röhrich**, Associate Medical Director Research & Innovation

In the NHS we are all aware of the approaches to learning from adverse incident. We regularly report these incidents, develop action plans and identify learning to avoid similar events happening in the future.

There is however no similar way of capturing the good practice that regularly happens apart from celebrating success in delivering statutory milestones and achieving performance targets. There are surprisingly few systematic learning methods in place that would allow us to share findings from successful clinical work related to individual patients, small groups or case series.

In research terms, those scenarios feature in the literature as case studies, often providing meaningful insights into successful and creative clinical procedures, processes, engagement, innovations and treatments. Those findings are often the building blocks for hypotheses based cohort and subsequently controlled clinical trials (research cycle).

Seriously Good Practice

A new initiative has been launched, aimed at sharing learning and good clinical practice across the Trust and to develop the skill base for writing about and publish case studies. All staff members are invited to share examples of good practice, clinical success stories and interesting case studies.

The aim is to share those case studies with fellow colleagues across the Trust and to encourage staff submitting their case studies for publication in peer-reviewed journals, given a renewed interest in case-based clinical research.

A cross-professional group meets now on a monthly basis in order to creatively encourage and support clinicians coming forward with their reports and to consider these case reports for a bi-annually newsletter and open learning events.

Some simple tools have been posted on the intranet in order to support structured case report writing and to ensure all submissions are consistent. Subject to approval by clinicians who submitted case reports these will be published on the intranet for every member of staff to read about and with contact details for clinical teams to obtain more detailed information. The tools can be accessed here: http://elftintranet/news/new_initiative.asp

In a second step we will invite some examples to be presented at a bi-annual Trust-wide 'Seriously Good Practice' learning events. These will be selected by a group of clinicians and service users.

I am going to secure support from academic staff so that clinicians or teams with unique, potentially generalisable findings can be supported to develop their case report into a full case study for possible publication to a peer-reviewed journal.

If you are interested please contact me at frank.rohrich@eastlondon.nhs.uk

OTHER NEWS



RESEARCH ASSISTANT WINS POSTER PRIZE

William Harvey Day is the annual research day for Barts and the London School of Medicine and Dentistry, part of Queen Mary University of London. First started in 1990, it is an opportunity to celebrate innovation and expertise in research. As well as the lecture series, posters of work carried out within the School are shown on the day and there is a competition for internal contributions. Hana Pavlickova of the Unit for Social and Community Psychiatry presented a poster on the FIAT trial (Financial Incentives for Adherence to Treatment: does the effect disappear over time?) which won a prize for the 'Research Impact' category.

USCP JOINS TWITTER

Follow the latest research from the Unit for Social and Community Psychiatry, Newham Centre for Mental Health, a WHO collaborating centre for mental health services development on twitter [@SocialPsychQMUL](https://twitter.com/SocialPsychQMUL)

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
28 January	Brief Psychiatric Rating Scale	Domenico Giacco
18 February	Twitter within research	Rose Thompson
25 February	Psychological testing	Stefan Priebe
4 March	Meta-synthesis	Vicky Bird
11 March	Qualitative Interviewing	Winnie Chow
25 March	Conducting Research in the NHS	Karin Albani
15 April	Hamilton Depression Rating Scale	Adrian Mundt
29 April	Statistics refresher	Stavros Orfanos

Developing a positive psychology app for common mental health conditions

Sophie Walsh is a PhD student who has been funded by East London NHS Foundation Trust to develop a new intervention for people who experience anxiety and/or depression. This will use positive psychology which focuses on increasing life satisfaction and

happiness and aims to promote wellbeing rather than fixing problems. An example is the gratitude journal, a daily diary recording three things one is grateful for and why. This approach is quite different to symptom-focused treatments and therefore might appeal to those who do not take up current treatments. The intervention will

be delivered as a smartphone application (an 'app') for people in primary care seeking help for anxiety/ depression, so that many people can access it, perhaps whilst they wait for talking therapy.

The research intends to discover peoples' views and opinions of positive psychology, which patients could be targeted, and how to promote the treatment.

To do this, the research will work closely with people with depression and anxiety and healthcare professionals. Sophie is currently recruiting for members of a user reference group who will design an initial idea of the app, based on the existing evidence for



positive psychology. This will then be discussed in group interviews with 20 patients and 12 health professionals from primary care. An app will then be developed and ten people will try it to check it is user-friendly. Finally, a small study with 30 people in primary care will provide information on how acceptable and useful the app is. These small studies are important,

as they form the basis for future studies to test the effectiveness of the app on a larger scale. As this project is a PhD, it will be ongoing until September 2017.

Sophie, the PhD student said "I am very pleased to be working on a project which is going to try

a new way of treating anxiety and depression. It will be great to get people involved in thinking about ways to design the intervention and I am hoping this will result in a user-friendly, relevant intervention". Sophie is a student at Queen Mary University London and is being supervised by Professors Stefan Priebe, from the Unit for

Social and Community Psychiatry, and Stephanie Taylor, from the Centre for Primary care and Public Health.

If you are interested in finding out more about the project, such as how to get involved with the user-reference group, or would like any other details please contact Sophie on sophie.walsh@eastlondon.nhs.uk

Mental health care today in Immigration Removal Centres

By [Dr Hugh Grant-Peterkin](#),
General Adult Psychiatry

In 2011, following serious concerns in the media, and a letter written to the Royal College of Psychiatrists by concerned doctors (including myself), a 'working group on the mental health of asylum seekers' was created. I have a longstanding interest in Human Rights and supporting victims of torture. I applied to the President of the College and gained a place as a member of the group. In three years we have offered training days, responded to Government and European level enquiries relating to refugee rights, held focus groups and advocated to improve training and education in this area.

The most concerning area for the group was, and remains, mental health care in Immigration Removal Centres (IRCs). In November 2014 I was lead author on an editorial published in the British Medical Journal. We were prompted to write an editorial as, in late 2014, responsibility for healthcare in IRCs was transferred from the Home Office to the Department of Health. As a result there are now a different group of healthcare providers in IRCs, including one NHS Foundation trust.

Background to Immigration Removal Centres

The number of people held in IRCs in the UK has steadily increased over the last ten years, with a total of over 30,000 held in 2013. At any one time up to 3,000 people can be detained in one of thirteen IRCs. Although immigration detention is for administrative purposes (to process an asylum application or to facilitate removal from the UK), research has shown that detainees and staff both view it as punitive. The UK is one of the few countries in the world to have no time limit on the duration of detention, and detainees can remain in limbo for several years, not knowing their ultimate fate.

The standard of healthcare within centres in England is a serious cause for concern. Such evidence that exists indicates that immigration detention can be harmful to mental health, especially for people with pre-existing mental health problems such as post-traumatic stress disorder. A systematic review of 10 studies investigating the effect of immigration detention identified high levels of mental health problems among detainees. Time spent in detention was shown to be positively associated with the severity of mental health problems. This evidence is congruent with our collective experience as a group: we have seen detention precipitate mental health disorders, cause severe relapses, and substantially increase the risk of self-harm and suicide. Over the past five years official inspectorates,

international organisations, non-governmental organisations, and the law courts have repeatedly criticised both the immigration detention of mentally ill people and the conditions in which detainees are held. The needs of detainees are often not identified, and those in treatment often experience interruptions in care. No effective safeguards exist to prevent vulnerable people – for example, those who have been tortured – from being detained.

System Failures

A joint inspection report by Her Majesty's Inspectorate of Prisons and the independent inspector of borders and immigration in 2012 found "little evidence of the effectiveness of Detention Centre procedures, which are supposed to provide safeguards for vulnerable detainees, including those who have mental illnesses." This follows a report in 2011 raising concerns at Harmondsworth IRC that "Mental health needs were under identified and the inpatients department was described by staff themselves as a



'forgotten world.'

In 2013 the UN Committee Against Torture expressed concern about "instances where persons with serious mental disability were detained while their asylum cases were decided" and urged a review of the relevant safeguards. Furthermore, care has been so poor as to warrant multiple legal proceedings. In 2014 a jury found that neglect had contributed to the death of an American tourist with schizophrenia, who died in the segregation unit of Colnbrook IRC. A few months earlier the High Court found that a severely mentally ill man detained in Harmondsworth IRC was held in conditions amounting to "inhuman and degrading treatment" that breached Article 3 of the European Convention on Human

Rights (the prohibition of torture). The court described the failures of the centre to apply and comply with the applicable policies "as wilful and grossly negligent."

There have now been six breaches of Article 3 in less than three years, all related to the provision of mental healthcare. This means that the provision of mental healthcare in detention centres has been found to, not merely be poor but to constitute inhuman and degrading treatment – an unprecedented finding for any UK institution. In addition to these established cases of serious neglect and violation of human rights many former detainees have alleged physical or verbal abuse by staff. Allegations of endemic sexual abuse and exploitation of vulnerable women are currently under investigation.

Transfer of care

With the imminent transfer from the Home Office to the Department of Health a joint statement issued in November 2013 by NHS England and the Home

Office gave an assurance that NHS England would "actively promote the rights and standards guaranteed by the NHS Constitution."

As a working group we called on NHS England to ensure that detainees are screened for mental health problems and that all facilities under its umbrella maintain the

standards of care expected of the NHS. Asylum seekers are often highly vulnerable, particularly if they have mental health disorders; we have a professional duty of care to ensure that their needs are appropriately met. The evidence is overwhelming from across the globe: immigration detention can be highly deleterious to both physical and mental health. Many alternatives to immigration detention exist, and these should be explored before vulnerable people are placed in such facilities. Given an increasingly inflammatory media debate about immigration and asylum seekers the medical profession must ensure that it does not become complicit in a system that prioritises deterrence over protection of refugees and asylum seekers.



Dr Catherine Carr awarded NIHR/HEE Clinical Lectureship

Music Therapist Catherine Carr has been awarded a National Institute for Health Research (NIHR) / Health Education England (HEE) Clinical Lectureship funded through the Clinical Academic Training (CAT) Programme. The CAT Programme, to be re-launched as the Integrated Clinical Academic (ICA) Programme in 2015, provides personal research training awards for non-medics/dentists who wish to develop careers that combine clinical research and research leadership with continued clinical practice and clinical development.

The HEE/NIHR Clinical Lectureship Scheme represents the early post-doctoral element of the Programme. A Clinical Lectureship enables the award holder to make a significant contribution to clinical practice whilst supporting their development as a clinical academic leader.

With the support of the East London NHS Foundation Trust and Queen Mary University of London, Dr Carr will develop, refine and test intensive group music therapy for acute adult psychiatric inpatients.

Music therapy can reduce mental illness symptoms and may be an important part of inpatient care. Hospital stays are short, so frequent sessions are needed to make a difference. Her previous research found how intensive group music therapy can be provided to appeal to patients and give positive experiences. To put these findings into practice, the next step will be to develop guidance for music therapists (a manual) and see if it is effective. This research will develop guidelines/training and run a small study to prepare for a larger effectiveness study. This will improve music therapy practice and care for inpatients.

OTHER NEWS



NIHR FUNDING OPPORTUNITIES BOOKLET – NEW ISSUE

This booklet has been revised and updated. It captures in a single publication the NIHR's research funding and career development opportunities available for researchers

based in the NHS, universities, industry and other organisations concerned with health, public health and social care. It is available on line at: <http://www.nihr.ac.uk/about/nihr-publications.htm>

21ST INTERNATIONAL NETWORK FOR PSYCHIATRIC NURSING RESEARCH (NPNR) CONFERENCE 2015

The next NPNR Conference will welcome colleagues from around the UK and further afield to the Manchester Conference Centre on 17-18 September 2015 to celebrate high quality research, education and practice development in mental health nursing. Supported

through the Royal College of Nursing and Mental Health Nurse Academics UK this conference will provide the opportunity to update yourself on the latest research in the mental health care field, learn of new developments in education, research and practice development and build new networks with colleagues from far and wide.

NEW FILMS ABOUT PATIENT AND PUBLIC INVOLVEMENT IN CLINICAL RESEARCH – FREE TO DOWNLOAD

Four new films are now available on Patient and Public Involvement (PPI) in clinical research. The films were made at the Medical Research Council (MRC) Clinical Trials Unit at University College London (UCL) and they aim to answer common questions about PPI and share patient experiences. The films explore PPI and the practicalities of what being a patient representative involves. They also shed some light why some patients want to get involved in clinical research and how they make a real difference to research. Watch or download the videos for free on the Vimeo channel at <https://vimeo.com/album/3139788>

Are psychiatric bed removals related to increasing prison population rates?

By **Adrian Mundt**, Research Assistant, Unit for Social & Community Psychiatry

The 75-year-old Penrose Hypothesis

The British psychiatrist, mathematician and geneticist Lionel Sharples Penrose (1898-1972) postulated for the first time an inverse relationship between psychiatric bed numbers and increasing prison population rates in 1939. Historical background was the following: numbers of beds in large psychiatric hospitals had reached a maximum around 1900. In the beginning of the 20th century, first psychiatric reform movements had led to the reductions of psychiatric bed numbers in Europe. Penrose analysed data of psychiatric bed numbers and prison population rates from 18 European countries. He argued that lower numbers of psychiatric beds could mean higher numbers of crime and prisoners.

The hypothesis was forgotten for many decades and only in the 1990's, increased interest and scientific reception had come up. Attempts had started to evaluate psychiatric reforms of the 1970's that had led to an acceleration of psychiatric bed removals. One of the main themes of those reforms was the intent to replace institutionalized care in psychiatry with community care. Psychiatric bed removals had then become a global paradigm for psychiatric service development promoted by the World Health Organization.

Association of psychiatric bed removals with increasing prison populations in South America

Researchers from the Unit for Social & Community Psychiatry collaborated with scientists from South America to investigate whether the Penrose-

Bolivia, Brazil, Chile, Paraguay and Uruguay, psychiatric beds were removed and prison population rates massively increased at the same time. Psychiatric bed removals were significantly related with increasing prison population rates. When and where more beds were removed, the prison populations increased more. This relationship on the level of an association does not yet provide any evidence for a causal link. There may be further factors mediating this relationship.

We studied two such factors: the per capita Gross National Income GNI and the income distribution, the Gini-Index. Strong growth of the GNI was also associated with increasing prison population rates. The increase of the GNI explained in part but not fully the association between psychiatric bed removal and increasing prison population rates. The Gini-Index was unrelated. 75 years after the publication of the Penrose Hypothesis, this is the first study supporting this relationship in a longitudinal data set in South America.

The notion that chronically mentally ill may have been lost in mental health care institutions to criminal justice settings is worrying and raises human rights concerns.

Those findings together with recent research reporting very high prevalence rates of mental health and substance use disorders in prisoners indicate that mental health care systems may need to increase engagement of people at risk for involvement with the criminal justice system.

Hypothesis applied to South American during the past two decades (Mundt et al., *JAMA Psychiatry*, 2014 Dec 3; doi: 10.1001/jamapsychiatry.2014.2433). In the six countries included in the study, Argentina,



Nine out of ten people would be willing to take part in clinical research

A new survey conducted on behalf of the NIHR Clinical Research Network shows that 89% of people would be willing to take part in clinical research if they were diagnosed with a medical condition or disease – with an all-time-low figure of just 3% saying they would not consider it at all.

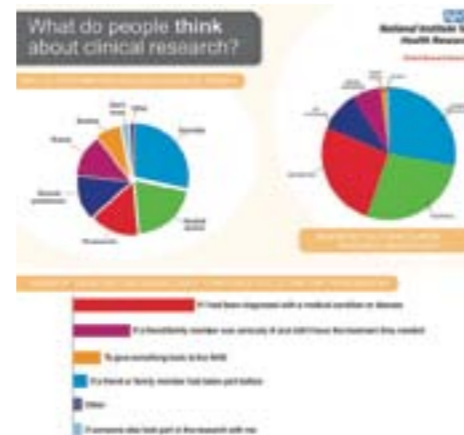
The survey also revealed that 95% of people said it was important to them that the NHS carries out clinical research.

Last year over 600,000 people took part in research which aims to improve diagnosis, treatment and care of patients in the NHS. The growing importance of clinical research to the general public and their increased willingness to take part suggests

that this number is set to rise.

When asked about motivating factors for taking part in clinical research, nearly half of the people surveyed said that receiving a diagnosis for a medical condition or disease would be a factor most likely to motivate them. One in five said that they would be motivated if a friend or family member was seriously ill and an appropriate treatment had not yet been developed.

Patients interested in research can visit the NIHR's Patients carers and the public webpages to find out more about taking part and see what research is happening in their local area. <http://www.crn.nihr.ac.uk/can-help/patients-carers-public/>



Upcoming Events

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
5 January	<i>Comparing functional and integrated systems of mental health care – management of the COFI programme</i>	Domenico Giacco
12 January	<i>NESS – findings from the body psychotherapy for the treatment of negative symptoms trial</i>	Mark Savill
19 January	<i>EPOS – findings from the trial</i>	Eoin Golden
26 January	<i>Review on religious leaders involvement in mental health</i>	Victoria Bird
2 February	<i>QuEST – Quality and effectiveness of supported housing services for people with mental disorders</i>	Sima Sandhu
9 February	<i>Putting theory into practice: Developing, refining and testing intensive group music therapy for acute adult psychiatric inpatients</i>	Catherine Carr
16 February	<i>Immediate social networks for people with psychosis</i>	Domenico Giacco
23 February	<i>VOLUME – Preferences survey design and initial findings</i>	Claudia Gulea
2 March	<i>COFI – Comparing functional and integrated systems of mental health care</i>	Victoria Bird
9 March	<i>FIAT – Financial incentives for adherence to medication in non-adherent patients</i>	Katie Moran
16 March	<i>Carer involvement in the treatment of psychosis</i>	Aysegul Dirik
23 March	<i>Development of a mobile health intervention using positive psychology for common mental health disorders</i>	Sophie Walsh
30 March	<i>Recruitment to trials and mental health</i>	Paulina Szymczynska
13 April	<i>Group processes in therapeutic groups</i>	Stavros Orfanos
20 April	<i>Built environment and mental health</i>	Nikolina Jovanovic
27 April	<i>Intimacy and wellbeing in people with mental illness: ethical challenges</i>	Rose Thompson

Studies recruiting in your trust



The neuropsychological profile of early-onset Obsessive-Compulsive Disorder

The early-onset OCD study...

There is very little known about the differences between adolescent and adult Obsessive-Compulsive Disorder (OCD). The purpose of the present study is to establish a cognitive profile of adolescents with OCD by assessing a diversity of cognitive processes e.g. executive functioning, memory, decision-making, social reasoning in adolescents with OCD.

Who can take part?

- Adolescents aged 12-19
- Primary diagnosis of OCD with no additional psychiatric diagnosis
- Native or Fluent English-speaker
- Normal or corrected to normal vision
- No current or previous alcohol/drug dependence

What does it involve?

Firstly patients will have a short telephone interview with a psychiatrist. The researcher will arrange an appointment with the participant at a time and venue convenient to them. The appointment will take 4 hours and involves completing a few questionnaires and a few tasks on a touch screen computer which are like games or puzzles. Participants will be paid £40 for their time.

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

■ Contact the study team – Gonca Bastug (tel: 07984 278 878 or email gonca.bastug@eastlondon.nhs.uk) or Julia Gottwald (email jg687@cam.ac.uk)
The Local Investigator in our trust is Dr Graeme Lamb, Graeme.Lamb@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.

■ Abbott S, Campbell S & Simpson A (2014) *Young offenders with mental health problems: their views of how services help them*. **Journal of Mental Health Training, Education and Practice**, 9(4): 232-243.

■ Ajaz A, Owiti J & Bhui K (2014) *Using a cultural formulation for assessment of homicide in forensic psychiatry in the UK*, **Int Rev.Psychiatry**, 26(5):607-614.

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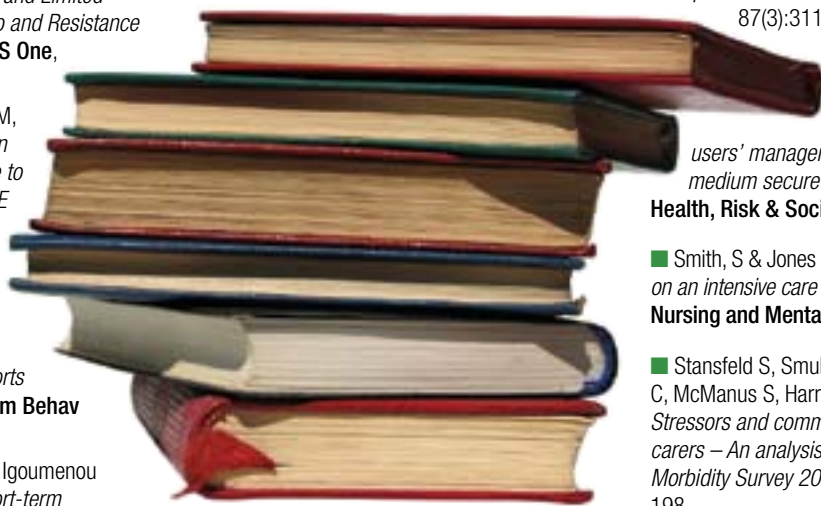
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