

Mental Health Research in the NHS: The Bottom Line

By **Professor Peter Tyrer**,
Clinical Lead for the North London Hub,
Mental Health Research Network

The Mental Health Research Network was set up seven years ago to improve recruitment to research studies on mental health carried out in the NHS. One of the main problems with research in mental health is that volunteers to take part in research studies, especially clinical trials, tend to be much so much lower than in other medical specialties. The Mental Health Research Network was set up to try and counteract this and also exploit the great possibilities of research into better outcomes of mental disorder in NHS settings.

In the last year the number of projects we are supporting in East London has significantly increased and we would like to say a big thank you to all clinicians who have been instrumental in referring potentially eligible participants into these studies. However, there is still much room for improvement and this can only be achieved with your support.

Research is often seen as remote, but good health services research has to be carried out in ordinary NHS settings if it is going to lead to improved care. I hope all clinical staff will increasingly see that research is not a separate department, locked away in an ivory tower. Good health services research plays a pivotal role in answering questions asked by clinicians in their day to day work and has to be answered in NHS settings, not in laboratories or special centres.

The Network offers the opportunity for everybody working in the NHS to play a part in this. We have two clinical studies officers (CSOs), Helen Blake and Naomi Bateman, based in East London, who assist with recruitment into studies. Both Helen and Naomi will undertake much of the work associated with the research in order to alleviate any additional burden on clinical time (usually the most that will be asked of you would be to identify potentially eligible participants).

Projects currently recruiting in East London and needing your support include:

OASIS

This study is evaluating the short term safety of SeroquelTMXL as part of the Risk Management Plan for the product. It is to be carried out independently by the Drug Safety Research Unit in Southampton, funded by AstraZeneca. Professor Tony Hale is the Chief Investigator.

It is a prospective, naturalistic, observational cohort study that is questionnaire based. The study aims to

recruit 1500 patients started on SeroquelTMXL and a comparator group of patients started on quetiapine IR during the study period (750 patients in each arm) nationally over the four year study period. Each individual patient will only have the first 12 weeks of treatment monitored.

Any patient in England will be eligible for inclusion when a clinical decision has been made to prescribe either the IR or XL preparation as part of normal clinical practice for the licensed indications of schizophrenia and mania associated with bipolar disorder.

DPIM

This study is researching the genetics of bipolar affective disorder, schizophrenia and alcoholism. This research and others like it have already begun to pave



the way for new treatments and preventative strategies. These may be more personalised and also associated with fewer or absent side effects.

We are looking for patients over 18 years old with an ICD-10 or DSM IV diagnosis of bipolar disorder or schizophrenia. They must be of European ancestry with at least three British grandparents. This enables the study team to avoid confounding ancestral genetic differences from differences related to mental illness. This makes it easier to identify mutations in the most significant way.

CITIMPPA

Posttraumatic stress disorder (PTSD) is an anxiety disorder that can develop following exposure to trauma. It is characterised by symptoms of hyperarousal, reliving of the event and avoidance of reminders of the event. Central to the current understanding and treatment of PTSD is the notion that trauma survivors with PTSD have particular disruptions in their personal

remembering of the trauma event.

Research suggests, however, that whether a person comes from an individualistic culture (i.e. a culture that predominantly socializes members to view themselves as individuals) or a collectivistic culture (i.e. a culture that predominantly socializes members to view themselves as members of the larger group) has an influence on the personal remembering of everyday events. The question remains, however, are there cultural differences in the remembering of trauma and what does this mean for PTSD models and treatment?

Preliminary research has investigated cultural differences using trauma survivors living in Australia. However, ideally a study that investigates samples of people in their own original cultural setting is needed, as this will help separate cultural factors more clearly. The aim of this research is to explore cultural differences in the autobiographical memory of trauma and associated posttraumatic psychological adjustment using trauma survivors from an individualistic culture (Britain) and from a collectivistic culture (Iran). This will be investigated using a questionnaire booklet that includes memory tasks and measures of posttraumatic psychological adjustment.

In all of these projects we would welcome greater collaboration and support from all health professionals working in East London NHS Foundation Trust. All we need from you for these three studies is

to identify potentially eligible participants as all other work related to the research will be undertaken by the CSOs. Please make any referrals to Helen Blake (helen.blake5@nhs.net) or Naomi Bateman (naomi.bateman@nhs.net)

Taking part in good health services research makes you a better clinician, as it illustrates much of the uncertainty in current practice and this is where we need more evidence. It is also important to remember that research offers professional development and revenue generation possibilities in research-related work, not just with commercial partners but also through collaboration with other academic institutions and public funding bodies like the National Institute for Health Research (NIHR).

If you would like to become involved in our work or would like any further information please do not hesitate to contact me (p.tyrer@imperial.ac.uk) or Sandra O'Sullivan, Hub Manager (s.o.sullivan@imperial.ac.uk).

Exploring the link between treatment satisfaction and symptoms

Previous research has shown a link between treatment satisfaction and symptoms in different groups of psychiatric in-patients. This study explored what specific symptoms are associated with treatment satisfaction and whether treatment satisfaction precedes or follows symptom change.

Involuntarily admitted patients to psychiatric wards and diagnosed with psychotic disorders (N = 232) were assessed one week and four weeks after admission. Higher treatment satisfaction was associated with lower scores on the manic excitement, anxiety-

depression and positive symptom sub-syndromes, while no significant association was found for negative symptoms. Treatment satisfaction predicted change in positive symptoms while symptom change did not predict treatment satisfaction.

The results underline the importance of patients' initial appraisal of in-patient treatment since a more positive appraisal predicts more subsequent symptom improvement.

For further reading, see Richardson, et al., in *Soc. Psychiatry Psychiatr Epidemiol*, 46(8):695-702.

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.

■ Adamson J, Warfa N & Bhui K. (2011) *A case study of organisational cultural competence in mental healthcare.* **BMC Health Serv. Res.** 11(1):218.

■ Bache RA, Bhui KS, Dein S & Korszun A. (2011) *African and Black Caribbean origin cancer survivors: a qualitative study of the narratives of causes, coping and care experiences.* **Ethn. Health.** [Epub ahead of print]

■ Bhugra D, Easter A, Mallaris Y, Gupta S. (2011) *Clinical decision making in psychiatry by psychiatrists.* **Acta Psychiatr Scand.** 124:403-411.

■ Bhui K & Dinos S. (2011) *Preventive psychiatry: a paradigm to improve population mental health and well-being.* **Br J Psychiatry.** 198:417-419.

■ Bhui KS, Dinos S & McKenzie K. (2011) *Ethnicity and its influence on suicide rates and risk.* **Ethn. Health.** [Epub ahead of print]

■ Breen G, Webb BT, Butler AW, van den Oord EJ, Tozzi F, Craddock N, Gill M, Korszun A, Maier W, Middleton L, Mors O, Owen MJ, Cohen-Woods S, Perry J, Galwey NW, Upmannu R, Craig I, Lewis CM, Ng M, Brewster S, Preisig M, Rietschel M, Jones L, Knight J, Rice J, Muglia P, Farmer AE & McGuffin P. (2011) *A Genome-Wide Significant Linkage for Severe Depression on Chromosome 3: The Depression Network Study.* **Am.J.Psychiatry.** 168(8):840-847.

■ Ceccherini-Nelli A & Priebe S. (2011) *Economic factors and suicide rates: associations over time in four countries.* **Soc. Psychiatry Psychiatr Epidemiol.** 46(10):975-982.

■ Clark C, Goodwin L, Stansfeld SA, Hotopf M & White PD. (2011) *Premorbid risk markers for chronic fatigue syndrome in the 1958 British birth cohort.* **Br J Psychiatry.** 199:323-329.

■ Clark C. (2011) *Childhood psychopathology at age 8 predicts antidepressant use by age 24.* **Evid. Based. Ment. Health.** 14(4):97.

■ Coid J, Yang M, Ullrich S, Zhang TQ, Aizmur S, Farrington D & Rogers R. (2011) *Most items in structured risk assessment instruments do not predict violence.* **J Forensic Psychiatry & Psychology.** 22(1):3-21.

■ Compta Y, Parkkinen L, O'Sullivan SS, Vandrovicova J, Holton JL, Collins C, Lashley T, Kallis C, Williams DR, de SR, Lees AJ & Revesz T. (2011) *Levy- and Alzheimer-type pathologies in Parkinson's disease dementia: which is more important?* **Brain.** 134(Pt 5):1493-1505

■ Crawford MJ, Thana L, Methuen C, Ghosh P, Stanley SV, Ross J, Gordon F, Blair G, Bajaj P. (2011) *Impact of screening for risk: randomised controlled trial.* **Br J Psychiatry.** 198, 379-384.

■ Crombie R, Clark C & Stansfeld SA. (2011) *Environmental noise exposure, early biological risk and mental health in nine to ten year old children: a cross-sectional field study.* **Environ. Health.** 10:39.

■ Das-Munshi J, Leavey G, Stansfeld SA & Prince MJ. (2011) *Migration, social mobility and common mental disorders: critical review of the literature and meta-analysis.* **Ethn. Health.** [Epub ahead of print]

■ Deville W, Greacen T, Bogic M, Dauvirin M, Dias S, Gaddini A, Koitzsch JN, Karamanidou C, Kluge U, Mertaniemi R, Puigpinos IR, Sarvary A, Soares JJ, Stankunas M, Straszmayr C, Welbel M & Priebe S. (2011) *Health care for immigrants in Europe: is there still consensus among country experts about principles of good practice? A Delphi study.* **BMC Public Health.** 11(1):699.

■ Dewan P, Miller J, Musters C, Taylor RE & Bewley AP. (2011) *Delusional infestation with unusual pathogens: a report of three cases.* **Clinical and Experimental**

Dermatology. 36:745-748.

■ Fisher HL, Cohen-Woods S, Hosang GM, Uher R, Powell-Smith G, Keers R, Tropeano M, Korszun A, Jones L, Jones I, Owen M, Craddock N, Craig IW, Farmer AE & McGuffin P. (2011) *Stressful life events and the serotonin transporter gene (5-HTT) in recurrent clinical depression.* **J Affect. Disord.** 136:189-193.

■ Hamill M, Smith L & Röhrich F. (2011). *'Dancing down memory lane': Circle dancing as a psychotherapeutic intervention in dementia—a pilot study.* **Dementia.** [Epub doi:10.1177/1471301211420509]

■ Jankovic J, Yeeles K, Katsakou C, Amos T, Morriss R, Rose D, Nichol P, McCabe R & Priebe S. (2011) *Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study.* **PLoS One.** 6(10):e25425.

■ Jensen NK, Norredam M, Draebel T, Bogic M, Priebe S & Krasnik A. (2011) *Providing Medical Care for Undocumented Migrants in Denmark: What Are the Challenges for Health Professionals?* **BMC Health Serv. Res.** 11(1):154.

■ Kallert TW, Katsakou C, Adamowski T, Dembinskas A, Fiorillo A, Kjellin L, Mastrogianni A, Nawka P, Onchev G, Raboch J, Schützwohl M, Solomon Z, Torres-Gonzalez F, Brenner S & Priebe S. (2011) *Coerced hospital admission*



and symptom change – a prospective observational multi-centre study. **PLoS One.** 6(11): e28191.

■ Keers R, Uher R, Huezo-Diaz P, Smith R, Jaffee S, Rietschel M, Henigsberg N, Kozel D, Mors O, Maier W, Zobel A, Hauser J, Souery D, Piacentino A, Larsen ER, Dmitrak-Wegiarz M, Gupta B, Hoda F, Craig I, McGuffin P, Farmer AE & Aitchison KJ. (2011) *Interaction between serotonin transporter gene variants and life events predicts response to antidepressants in the GENDEP project.* **Pharmacogenomics J.** 11(2):138-145.

■ Lydall GJ, Bass NJ, McQuillin A, Lawrence J, Anjorin A, Kandaswamy R, Pereira A, Guerrini I, Curtis D, Vine AE, Sklar P, Purcell SM & Gurling HM. (2011) *Confirmation of prior evidence of genetic susceptibility to alcoholism in a genome-wide association study of comorbid alcoholism and bipolar disorder.* **Psychiatr Genet.** 21(6):294-306.

■ McCrone P, Seed PT, Dowson AJ, Clark LV, Goldstein LH, Morgan M & Ridsdale L. (2011) *Service use and costs for people with headache: a UK primary care study.* **J Headache Pain.** 12(6): 617-623.

■ Odenwald M, Klein A & Warfa N. (2011) *Khat use in Europe: implications for European policy.* **Drugs in focus.** 1-4.

■ Owiti JA & Bowers L. (2011) *A narrative review of studies of refusal of psychotropic medication in acute inpatient psychiatric care.* **J Psychiatr Ment. Health Nurs.** 18(7):637-647.

■ Parkkinen L, O'Sullivan SS, Kuoppamaki M, Collins C, Kallis C, Holton JL, Williams DR, Revesz T & Lees AJ. (2011) *Does levodopa accelerate the pathologic process in Parkinson disease brain?* **Neurology.** 77(15):1420-1426.

■ Pejuskovic B, Lecic-Tosevski D, Priebe S & Toskovic O. (2011) *Burnout syndrome among physicians - the role of personality dimensions and coping strategies.* **Psychiatr Danub.** 23(4):389-395.

■ Priebe S, Barnicot K, McCabe R, Kiejna A, Nawka P, Raboch J, Schützwohl M & Kallert T. (2011) *Patients' subjective initial response and the outcome of inpatient and day hospital treatment.* **Eur. Psychiatry.** 26(7):408-413.

■ Priebe S, Dimic S, Wildgrube C, Jankovic J, Cushing A & McCabe R. (2011) *Good communication in psychiatry - a conceptual review.* **Eur. Psychiatry.** 26(7):403-407.

■ Priebe S, Katsakou C, Yeeles K, Amos T, Morriss R, Wang D & Wykes T. (2011) *Predictors of clinical and social outcomes following involuntary hospital admission: a prospective observational study.* **Eur. Arch. Psychiatry Clin. Neurosci.** 261(5):377-386.

■ Priebe S, McCabe R, Junghan U, Kallert T, Ruggeri M, Slade M & Reininghaus U. (2011) *Association between symptoms and quality of life in patients with schizophrenia: a pooled analysis of changes over time.* **Schizophr. Res.** 133(1-3):17-21.

■ Röhrich F, Papadopoulos N, Dip PG, Holden S, Clarke T & Priebe S (2011) *Therapeutic processes and clinical outcomes of body psychotherapy in chronic schizophrenia – An open clinical trial.* **The Arts in Psychotherapy.** 38:196- 203.

■ Röhrich F. (2011) *Body Memory and Body-Ego: Two Central Reference Points for disorder Specific Body Oriented Psychotherapy, Psychologie in Österreich* 4:239-248.

■ Rucker JJ, Breen G, Pinto D, Pedroso I, Lewis CM, Cohen-Woods S, Uher R, Schosser A, Rivera M, Aitchison KJ, Craddock N, Owen MJ, Jones L, Jones I, Korszun A, Muglia P, Barnes MR, Preisig M, Mors O, Gill M, Maier W, Rice J, Rietschel M, Holsboer F, Farmer AE, Craig IW, Scherer SW & McGuffin P. (2011) *Genome-wide association analysis of copy number variation in recurrent depressive disorder.* **Mol. Psychiatry.** [Epub ahead of print]

■ Schosser A, Butler AW, Ising M, Perroud N, Uher R, et al. (2011) *Genomewide Association Scan of Suicidal Thoughts and Behaviour in Major Depression.* **PLoS One.** 6(7): e20690.

■ Sharma S, Bandopadhyay R, Lashley T, Renton AE, Kingsbury AE, Kumaran R, Kallis C, Vilarino-Guell C, O'Sullivan SS, Lees AJ, Revesz T, Wood NW & Holton JL. (2011) *LRRK2 expression in idiopathic and G2019S positive Parkinson's disease subjects: a morphological and quantitative study.* **Neuropathol. Appl. Neurobiol.** 37(7):777-790.

■ Smith NR, Kelly YJ & Nazroo JY. (2011) *The effects of acculturation on obesity rates in ethnic minorities in England: evidence from the Health Survey for England.* **Eur. J Public Health.** [Epub ahead of print]

■ Stansfeld S. (2011) *Socioeconomic disadvantage affects course and recurrence of psychiatric disability.* **Occup. Environ. Med.** 68(11):789-790.

■ Stansfeld SA, Clark C, Rodgers B, Caldwell T & Power C. (2011) *Repeated exposure to socioeconomic disadvantage and health selection as life course pathways to mid-life depressive and anxiety disorders.* **Soc. Psychiatry Psychiatr Epidemiol.** 46(7):549-558.

■ Tuck A, Bhui K, Nanchahal K & McKenzie K (2011) *Suicide by burning in the South Asian origin population in England and Wales: a secondary analysis of a national data set.* **BMJ Open.** 1(2) e000326.

■ Ullrich S & Coid J. (2011) *Protective factors for violence among released prisoners-Effects over time and interactions with static risk.* **J Consult Clin. Psychol.** 79(3):381-390.

R&D newsletter

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East London 
NHS Foundation Trust

Evaluating body psychotherapy as a treatment for the negative symptoms of schizophrenia

Success of Newham exploratory trial leads to multi-site RCT 'NESS' Trial



By **Mark Savill**, NESS Trial Manager with **Prof. Stefan Priebe**, Social & Community Psychiatry

In schizophrenia, whilst the focus can often be on the positive symptoms of the disorder such as hallucinations and delusions, current evidence suggests that it is the negative symptoms of the disorder that are more disabling to individual in terms of social functioning and quality of life. Despite improvements in anti-psychotic treatment, the effectiveness of both Pharmacological and talking therapy treatments have been found to have a limited effect on reducing these symptoms. In a recent review by the NICE Guideline Development group it was

noted "Arts therapies [which include art, music, drama and dance movement therapies] are currently the only interventions (both psychological and pharmacological) to demonstrate consistent efficacy in the reduction of negative symptoms" (NICE, 2008, p199). Regarding evidence relating to efficacy of arts therapies however, it is recognised that there is only a small (albeit emerging) evidence base, and that larger-scale investigations are required. Relating to body psychotherapy specifically, earlier investigations have been noted to have serious methodological shortcomings, and more recent findings have been based upon small single-site trials without an active control.

Body psychotherapy itself refers back to a long tradition in psychiatry, with the first trial involving patients with schizophrenia being published back in 1965. In its current form, body psychotherapy comprises of components which focus on overcoming communication barriers through non-verbal techniques, focussing cognitive and emotional awareness towards the body, stimulating activity and emotional responsiveness, exploring physical potentials, focussing on the body as a source of creativity, pleasure and self-expression, modifying dysfunctional self-perceptions, and addressing body-related psychopathological features. Beyond the potential benefits of such an intervention potentially addressing a currently unmet therapeutic need, additional characteristics of the therapy such as it's relatively low cost, it's flexibility in terms of it being able to be combined with other treatments and the fact that such a different approach may appeal to patients who find it difficult to engage in more conventional methods makes this an important area for future research.

Following on from the success of an exploratory trial conducted here in the borough Newham, researchers at East London NHS Foundation Trust, together with Queen Mary University of London have recently been funded by the NIHR-HTA program to conduct the 'NESS' Trial, which is a multi-site RCT designed to assess the effectiveness and cost effectiveness of a manualised body psychotherapy in the treatment of negative symptoms in comparison to an active control. In addition to East London, the trial will also be run in three other NHS Trusts (South London & Maudsley NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust & Mersey Care NHS Trust) in collaboration with our partners at the Kings College-Institute of Psychiatry and the University of Liverpool.

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Evaluating body psychotherapy as a treatment for the negative symptoms of schizophrenia

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In East London, we are looking to recruit stable outpatients with a diagnosis of schizophrenia and a history of experiencing severe negative symptoms to get involved in the trial. Participants will be randomly assigned to either join a ten week, twenty session body manualised psychotherapy group geared specifically to treatment the negative symptoms of schizophrenia, or a physical activity class of the same duration. In order to assess the comparable effectiveness of the two interventions all participants will be assessed before, after and at six months follow-up. In addition to examining the severity of negative symptoms, we also intend to assess whether the interventions have any impact on a number of domains such as social functioning, general psychopathology, objective social situation and quality of life.

Patient experience – the ingredient missing from cost-effectiveness calculations

A recent paper by Prof. Dave Curtis in *Patient Preference and Adherence* claims that when the value of medical interventions is assessed some of the negative effects on patients are routinely ignored. Factors such as pain, indignity, inconvenience and time off work may not be considered. To illustrate this, an internet survey was carried out asking people how much money they would want to be paid in order to undergo some intervention if it was not of any clinical benefit to them. The sums named were significant – for example the median amount to be charged for having a single injection was £200 and that to spend a night on a psychiatric ward was £400. The paper addressed the issue of taking more account of such negative effects in the context of systematic cost-effectiveness evaluations. However it is hoped that through raising awareness of the subjective experience of the patient there may also be an impact on clinicians' behaviour, leading them to be more thoughtful and to try to consider things from the patient's point of view. The full text of this paper is freely available and can be viewed at: <http://www.dovepress.com/patient-experience-ndash-the-ingredient-missing-from-cost-effectiveness-peer-reviewed-article-PPA>

Upcoming Events Tower Hamlets Research Forum

A multi-disciplinary research forum is running in Tower Hamlets exclusively for the support, dissemination, and discussion of local mental health research. Meetings, chaired by Prof. Dave Curtis, will typically comprise a 30-minute research presentation, with a 10-minute discussion, followed by a 20-minute workshop to provide education and support for new research, e.g. around issues such as funding, methodologies, recruitment, etc. Meetings take place from 12.30-1.30 on the fourth Monday of each month in the Multi-purpose room (1st floor), Tower Hamlets Centre for Mental Health, Mile End Hospital. All Trust staff are welcome; please feel free to bring your lunch along to the meetings.

Date	Title	Presented by
26 March	<i>Effectiveness of AOS in reducing bed usage</i>	Vicenzo Giordano
23 April	<i>Evaluating an inpatient psychology group based on principles of compassion and mindfulness</i>	Laura Markham
28 May	<i>Religiosity, shame and self-compassion in South Asian Muslim women</i>	Dr. Deba Choudhury-Peters
25 June	<i>Service users with a diagnosis of Personality Disorder and their experiences of working with a Home Treatment Team</i>	Naomi Nicholas
23 July	<i>What helps and hinders service users into employment</i>	Louise Blanks

If you would like to present your own research in 2012, please email the title of your presentation, and your preferred monthly slot, to: elaenor.tomlinson@eastlondon.nhs.uk or Henrietta.mbeah-banks@eastlondon.nhs.uk

Streamlining Research Ethics Review

From September 2011, a number of types of studies are now exempt from requiring REC review (however, the research will continue to require "R&D approval" from each Trust where participants are recruited), including:

- Research limited to NHS or social care staff recruited as research participants by virtue of their professional role. – where there is no involvement of service users, their data, family or carers, etc
- Research limited to secondary use of tissue or information previously collected in the course of normal care (without an intention to use it for research at the time of collection) is generally excluded from REC review, provided that the patients or service users are not identifiable to the research team in carrying out the research
- Identifiable data collected for clinical care can be used by the clinical team to conduct research without REC review.
- REC review is not required for research involving use of or access to a care organisation's premises or facilities, provided that review is not required under any other applicable legal

or policy requirement. For example, research undertaken by a university department on NHS premises, involving healthy volunteers not recruited as NHS patients and not subject to any legal requirements, would not require review by a REC. However, a Phase 1 clinical trial undertaken by a Contract Research Organisation on premises rented from a NHS Trust would legally require REC review under the Clinical Trials Regulations.- Healthcare market research conducted by professional market researchers in accordance with the Legal and Ethical Guidelines issued by the British Healthcare Business Intelligence Association (BHBA).

For details, please see 'Does my project require ethical review?' on the National Research Ethics Service (NRES) website at <http://www.nres.npsa.nhs.uk/applications/approval-requirements/ethical-review-requirements/>

There is a new filtering question in IRAS (Integration Research Application System) regarding whether REC review is required; when answering 'no' the dataset is significantly reduced.

Upcoming Events Spring/Summer 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 details, call Carolanne Ellis on 020 7540 4210.

Date	Title	Presented by
5 March	<i>Non-verbal aspects of communication in schizophrenia</i>	Mary Lavelle
12 March	<i>Quality of life in war affected populations</i>	Aleksandra Matanos
19 March	<i>DIALECT – Effectiveness of DBT for the treatment of personality disorder with self-harm</i>	Nyla Bhatti
26 March	<i>What do outpatients with schizophrenia and mood disorder want to know and learn about their illness?</i>	Claudia Dougall
2 April	<i>NESS – Body psychotherapy in the treatment of negative symptoms of schizophrenia</i>	Mark Savill & Stavros Orfanos
BANK HOLIDAY		
23 April	<i>FIAT – Financial incentives for adherence to medication in non-adherent patients</i>	Lauren Kelley & Nicola O'Connell
30 April	<i>DIALOG - Software to structure the communication between patients with psychosis and clinicians in CMHTs</i>	Eoin Golden
BANK HOLIDAY		
14 May	<i>Research programme on housing services for people with mental disorders</i>	Stefan Priebe
21 May	<i>Communication skills training for treating patients with psychosis</i>	Paula Hermann & Jemima Dooley
28 May	<i>Patient centredness and shared decision making in schizophrenia</i>	Husnara Khanom
BANK HOLIDAY		
11 June	<i>Communication in psychiatric outpatients</i>	Laura Thompson
18 June	<i>Social interaction in group arts therapies for negative symptoms of Schizophrenia'</i>	Stavros Orfanos
29 June	<i>Psychiatrist-patient communication</i>	Rose McCabe
2 July	<i>Process research in psychotherapy for BPD</i>	Kirsten Barnicot

Health care for immigrants: good practice

Providing health care to immigrants is an increasing challenge across Europe. Some countries like the UK have a long tradition of immigration, whilst in other countries, in particular in Eastern Europe, large scale immigration is a relatively new phenomenon. Various people express opinions on how health care for immigrants should be provided and what constitutes good practice. However, is there a consensus on principles of good practice among experts in different European countries? The Unit for Social and Community Psychiatry coordinated a study exploring this. The study was funded by the European Commission and conducted in 16 European countries.

A total of 134 experts in 16 EU Member States participated in a so-called Delphi process to reach a consensus on good practice of health care for immigrants, i.e. health care in general, not just mental health care. The experts represented four different fields: academia, Non-Governmental Organisations, policy-making and health care practice. For each country, the process aimed to produce a national consensus list of the most important factors characterising good practice in health care for migrants. Ten to 16 factors were identified as the most important for each participating country. All 186 factors were aggregated into 9 themes: (1) easy and equal access to health care, (2) empowerment of migrants, (3) culturally sensitive health care services, (4) quality of care, (5) patient/health care provider communication, (6) respect towards migrants, (7) networking in and outside health services, (8) targeted outreach activities, and (9) availability of data about specificities in migrant health care and prevention. Although local political debate, level



of immigration and the nature of local health care systems influenced the selection and rating of factors within each country, there was a broad European consensus on most factors. Yet, discordance remained both within countries, e.g. on the need for prioritising cultural differences, and between countries, e.g. on the need for more consistent governance of health care services for immigrants.

One can conclude that experts across Europe asserted the right to culturally sensitive health care for all immigrants. There is a broad consensus about the major principles of good practice that need to be implemented across Europe. However, there also is some disagreement both within and between countries on specific issues that require further research and debate.

For further information, see Deville, et al., in *BMC Public Health*, 11(1):699.

OTHER NEWS

NINTH ANNUAL EAST LONDON RESEARCH PRESENTATION DAY

The Trust's Ninth Annual East London Mental Health Research Presentation Day took place on 2 November 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 pleasant to have many professionals coming together" for an event that was "very intellectually stimulating and helpful to improve clinical practice." There was a "good balance of more clinical and more academic research topics" and attendees felt "encouraged to evaluate practice." Overall it is "always a fun day with little opportunity for boredom" and we "look forward to next year."

FUNDING FOR LOCAL PROJECTS

Research projects sponsored by the East London NHS Foundation Trust and not funded by an external grant can apply for up to £3,000 to support the work. Requests will be assessed potential of the work develop into a successful award of an external grant. To apply, send an email specifying what funding is needed and how it will be used to achieve this goal to ResearchOffice@eastlondon.nhs.uk.



Dancing Down Memory Lane

By Dr. Michelle Hamill, Deputy Head of Clinical Psychology for Older Adults, Newham

Dementia is a progressive condition in which changes in cognition and emotion reduce a person's ability to function in everyday life and has significant implications for psychological well-being. People who have been given the diagnosis of dementia can face major issues of loss, especially as the illness progresses, which can result in anxiety and depression. Caring for someone with dementia can also be a complicated and lonely experience, and carers can face their own significant issues of loss and emotional pain.

With an increasing number of people being diagnosed with dementia there is a need to find meaningful and engaging psychotherapeutic interventions to improve patient's and carer's quality of life, facilitate emotional expression, stimulate cognition and work to prevent or manage the psychiatric and behavioural difficulties that often accompany the illness as it progresses.

A review by NICE-SCIE (2006) found that interventions involving the person with dementia alongside the carer appeared to have the most beneficial effects on both parties' psychological well-being. Taking into account the deterioration in verbal abilities, memory and abstract thinking, there is a need to develop alternative and effective interventions to work therapeutically with people with advancing dementia. Therapeutic approaches that utilise non-verbal, body-oriented interventions are worth studying in this context due to positive reports in the literature and with regard to neuropsychological considerations.

A range of psychotherapeutic benefits have been associated with dance movement, including improvement of orientation, mood, self-expression, relationships and coordination, as well as facilitating reminiscence and understanding/accepting the illness. However, the evidence base has been criticized for being largely anecdotal. With this in mind, a paper written for *Dementia: International Journal of Social Research and Practice* (online prepublication version available Sep 2011) by Hamill, Smith and Rohricht (2011) describes a pilot trial, which was conducted to explore the psychological effects of a circle dance group therapy on people with dementia and their carers.

Method

People with moderate to advanced dementia (defined as MMSE score of <20), who were expressing emotional distress (social isolation, anxiety, agitation) and carers who experienced carer burden were identified as suitable for the group by mental health care professionals.

The intervention is integrative, incorporating influences from developmental psychology, body-oriented theory, dance therapy and neuropsychology. As an accessible form of dance for people of all ages and abilities, with the emphasis on participation, not performance, circle dancing was felt appropriate to use when working with people with dementia. It is delivered standing or seated, adapted for people with poor mobility and balance. Spontaneity is endorsed. Circle Dance provides an opportunity to move together as part of a group; promoting re-attachment and connection by overcoming communication difficulties through the use of non-verbal means and verbalisation of those experiences whenever possible and as required.

Results

The therapists noted many moments of warmth, social interaction, empathy, and the processing of a range of feelings in the group. Self-reports, therapist observations and weekly monitoring notes indicated benefits as follows: improved mood, concentration and interactions; participants valued meeting new people, and looked forward to attending the group sessions. From the outset there was a clear sense of group coherence. Everyone held hands without hesitation or discomfort. There was good engagement; acknowledgement of each other's needs; sharing of observations regarding past experiences and changes in participants' appearance and behaviour.

Two out of seven patients improved in their cognitive state during therapy and for five out of seven patients an improvement of quality of life scores was noted; the general health questionnaire score of carers did not change during group participation.

Some of the carers reported that the group helped them to acknowledge the reality of dementia diagnosis and process their feelings of grief and loss as well as see beyond the diagnosis to the person they cared for. They commented that before the group the burden of care often meant that they focused predominantly on the problems but that participation in the group helped them

to re-connect with their loved one's residual strengths and individual personalities.

Discussion

Whilst the impact of the findings is limited due to the exploratory and small scale pilot nature of the study, there are a number of observations worth considering for practitioners interested in providing and/or developing similar interventions.

People with advanced dementia can engage in and benefit from emotionally salient procedural based activities. Specific benefits of dance therapy for people with dementia on communication, emotional expression, communal spirit and acceptance. Music, dance and movement facilitate a (non-verbal) dialogue through which people with dementia and those around them can communicate and connect more effectively and whilst verbal communication becomes more difficult.

The group also appeared to help partners in re-connecting as husband and wife. When one partner takes the role of carer the relationship and affections can change, resulting in both parties experiencing loss. Dancing together appeared to enhance the relationship, whilst experiencing each other as individuals who have affections and also sexual feelings, which could still be expressed. The couples displayed many moments of affectionate tenderness over the weeks.

The familiar movements and rhythms helped people to re-connect with their own bodies thus accessing memories and facilitating emotional expression. The usefulness of body and movement based interventions for disorders with limited response to talking therapies are growing (see Rohricht, 2009). Sacks (2008) described how the response to music has been shown to be preserved into the advanced stages of the disease. The interventions seem to have stimulated procedural learning and enhanced concentration.

The format of the group offered a coherent structure repeated week by week. It may be speculated that this helped participants to regain confidence in their relationships, mobility and abilities. It gave carers the opportunity to meet others in similar circumstances to themselves and helped them with their understanding of the illness, grief and hope. In addition, reports from some care coordinators suggested that social interaction outside of the group improved. Although group psychotherapy for carers and people with dementia is still in its infancy, initial results using different sensory activities including music, dance and reminiscence are promising and show effects on improved quality of life for both parties. For both carers and therapists it can be a groundbreaking and encouraging experience to see how withdrawn and relatively unresponsive individuals move freely, sway, smile and re-connect in a group, emphasising that they can still experience emotions deeply.

We hope that this paper as part of the developing evidence base encourages other clinicians unfamiliar with such interventions to explore and integrate such methods into their practices with a view to improving the quality of life for people with dementia and their carers.

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