

East London Connects to the World

Unit for Social and Community Psychiatry named WHO Collaborating Centre

On Monday 25 March 2013, Professor Dame Sally C. Davies, Chief Medical Officer & Chief Scientific Adviser at the Department of Health, formally opened the Unit for Social and Community Psychiatry (Queen Mary, University of London) as a World Health Organisation Collaborating Centre for Mental Health Services Development. At the event, attended by senior management of the Trust and Queen Mary, local commissioners, politicians, and key collaborators from both academia and other NHS research organisations, the researchers shared some of their work and ideas.

The Unit for Social and Community Psychiatry is a joint venture, co-funded and supported by the Trust and Queen Mary. It was established in 1997, and is based at the Newham Centre for Mental Health. This new designation makes it one of just 18 WHO Collaborating Centres in the field of mental health in Europe and the only one in the world specifically focused on mental health services development. The Unit now forms part of a small network of selected centres that are involved in supporting the European Mental Health Action Plan. The status



■ The research team at the Unit for Social and Community Psychiatry.

links research and service development in East London with the WHO which is intended to be of mutual benefit.

Professor Stefan Priebe, Director of the Unit for Social and Community Psychiatry, said: "This is an important development for the centre, and a welcome recognition for the international expertise we have built up since we started from scratch in 1997. This designation will increase our opportunity to influence mental health policies in Europe, and will benefit mental health

services in East London through research-driven innovation and internationally leading expertise."

Over time, the Unit for Social and Community Psychiatry has built up close collaborations with local clinical services and has strong international links. Its research focuses on concepts, methods and practice of social and community psychiatry. This includes historical and epidemiological aspects, evaluation of care in naturalistic and experimental studies, the development and testing of

innovative treatment methods, and specific studies on communication and therapeutic relationships.

The proximity of the Unit to clinical services in Newham has brought about benefits for service development. This included the establishment of novel services and treatments such as a model day hospital, body psychotherapy, computer-mediated approaches for clinicians to communicate with patients in the community, and training modules for psychiatrists about how to

engage with patients with psychosis.

The Trust's Chair, Marie Gabriel, said: "East London NHS Foundation Trust along with Queen Mary, University of London, are delighted to be embarking on this partnership for the ultimate benefit of people with mental health disorders in East London. This is an exciting and unique development and we look forward to sharing knowledge and expertise to improve outcomes for people in our care."



Social relationships in schizo

By [Dr. Mary Lavelle](#)

Background

The ability to interact socially with others is an essential part of everyday life, from a quick chat over coffee with a friend, to a discussion with your doctor. Some patients with schizophrenia find it difficult to interact with others.

This can make many aspects of their lives more challenging, such as maintaining relationships with friends and family and gaining employment.

Patients with schizophrenia are at high risk of social isolation and it is possible that their difficulties experienced interacting with others may contribute to this. The reason for patients' difficulty is unclear. Patients' negative symptoms, such as feeling a lack of motivation or a desire to withdraw from social situations, may play a part in this.

However, research also suggests that schizophrenia patients may have difficulty interpreting the behaviour of others during social interaction, such as voice intonation, facial expressions, body posture, or hand and head gestures. This has only been found using 'social cognitive' tests that ask patients to watch a video of actors having a conversation and answer questions about the thoughts and feelings of the actors.

The skills used by patients to complete these tests may be different to the skills needed to interact with others during a fast paced conversation.

Research aim

The overarching aims of these studies were to investigate patients' social



■ Three-way interaction with participants in motion capture suits.

deficits as they manifest during their actual interactions, and explore the links with patients' symptoms and their social relationships.

Major studies so far

The Unit for Social and Community Psychiatry has coordinated three major studies so far to address this research aim:

Friendship study:

Multi-centre investigation of the relationship between patients' symptoms and friendships. The multi-centre investigation of friendship was the largest study to date to investigate the link between patients' specific symptoms and their friendships. Overall the findings revealed that many patients did not have

someone they would call a close friend. Patients with more negative symptoms had less contact with friends and fewer close friendships. However, the most "stigmatized" positive symptoms such as sensory hallucinations (i.e. seeing or hearing things that are not there) delusional beliefs or disordered thinking were not associated with patients' friendships. Therefore, the findings of this study suggest that targeting patients' negative symptoms may improve patients' friendships.

Clinical interaction study:

Observational investigation of patients' nonverbal behaviour during routine clinical interactions. During routine psychiatric consultations, patients with schizophrenia displayed more avoidant nonverbal behaviour, such as looking away and crouching, than patients with depression. Patients who were more unwell displayed even more avoidant behaviour, although this was not specific to any type of symptom (i.e. positive or negative). Overall, the findings of this

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 Husnara Khanom at husnara.khanom@eastlondon.nhs.uk

Date	Title
3 April	<i>Unilevel Regression</i>
17 April	<i>Patient Reported Outcomes</i>
1 May	<i>Conducting Research in the NHS: IRAS, Ethics, CSP and the alphabet soup of research governance</i>
15 May	<i>To be confirmed</i>
5 June	<i>Brief Psychiatric Rating Scale (BPRS)</i>
19 June	<i>Longitudinal Models</i>

Presented by
Kirsten Barnicot
Stefan Priebe
Karin Albani

Domenico Giacco
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phrenia

study suggest that avoidance of pro-social nonverbal behaviour is specific to schizophrenia and associated with the severity of patients' symptoms.

Motion capture study:

Experimental 3-D motion capture analysis of nonverbal communication and interpersonal rapport between patients and two unfamiliar partners who were unaware they were interacting with a patient. This was the first study to employ 3-D motion capture techniques to investigate nonverbal communication during patients' interactions with others. Nonverbal communication was disrupted between all partners in the patients' interaction.

Compared to control interactions, people in the patient group showed less coordinated movements and patients' partners invested more nonverbal effort when communicating with the patient, such as gesturing more when speaking. These patterns were worsened by patients' symptoms and associated with others experiencing poorer rapport with the patient. Overall, nonverbal communication is disrupted between everyone in patients' social interactions; this is influenced by patients' symptoms and may contribute to patients' exclusion by others.

Current activities

The Unit for Social and Community Psychiatry is conducting several attempts to improve methods of assessing social networks of patients with psychosis. A systematic review on studies and instruments measuring social networks of people with schizophrenia has been conducted. Furthermore, given the increased role of online technologies (e.g. internet, facebook, etc.) in social relationships, a review of the available evidence on the use of these technologies by patients with psychosis is also being conducted. On the basis of the findings of these reviews, a new comprehensive assessment tool will be devised, the Social Contact Assessment (SCA). Future studies will employ complementary experimental and naturalistic research to investigate the relationship between patients' nonverbal deficits, their performance on 'off-line' social cognitive assessments and their real world social relationships.



Patient-clinician communication

By [Lauren Kelley](#),
Research Assistant

Background

Communication and the therapeutic relationship between a patient and a clinician play central roles in psychiatry. Evidence suggests that a more positive therapeutic relationship is associated with more favourable outcomes and the role of good communication in achieving good therapeutic relationships has been highlighted. Psychiatrists need to be able to effectively communicate with patients with psychosis to ensure patient engagement and to diagnose and deliver treatment effectively. This may feel especially difficult when communicating with patients with psychosis whose contributions may appear to be inappropriate both in their content and placement in the interaction. A focus of positive communication throughout healthcare is patient-centeredness, with shared decision making is a component of this.

Research has found patients with schizophrenia to have a slightly stronger preference for shared decision making in comparison to primary care patients. There is no specific theory of what constitutes good communication in psychiatry and understanding how the communication process influences patient outcome is a challenge.

Moreover, psychiatrists are currently not specifically trained in how to communicate with individuals with psychosis, and there are no evidence-based guidelines on how psychiatrists should communicate about psychotic symptoms and no evidence-based interventions to achieve a better

therapeutic relationship in community mental health care.

Research Aim

The aim of our research in this area was to improve patient-clinician communication in psychiatry in order to achieve better engagement and better outcomes for individuals with psychosis.

Major Studies so far

Firstly, we have carried out conceptual work and reviews on good communication in psychiatry and positive therapeutic relationships. These have identified that principles of positive therapeutic relationships and good communication in psychiatry have generic and specific aspects. A review identified five guiding principles for how clinicians should communicate with patients; focus on patient's concern, positive regard and personal respect, appropriate involvement of patients in decision making, genuineness with a personal touch and using a psychological model. These principles are proposed to help achieve the clinical objectives of patient-clinician communication and to provide a flexible framework to utilise different individual skills, resources and strengths of clinicians in their communication. Such principles can also guide training and supervision enabling clinicians to develop and improve their personal strengths and communicate effectively.

A major study we have conducted in this area was a cluster randomised controlled trial testing a new computer mediated intervention (DIALOG) to make patient clinician communication more patient centred and effective in 6 European

countries (Germany, Spain, Sweden, Switzerland, The Netherlands, UK). This was the first method to structure patient-clinician interaction in community mental healthcare, which focused on patients' quality of life and needs for care. After 12 months, the intervention led to better quality of life, fewer needs and higher treatment satisfaction, with a particularly large effect in East London. These positive treatment outcomes were achieved despite the fact that the symptom levels of the patients did not change.

We have also conducted in-depth analyses of actual communication between patient and clinicians, which aimed to identify how psychiatrists engage with patients and how they communicate about psychotic symptoms in routine consultations. We found that clinicians experience difficulties when required to discuss psychotic experiences with their patients. Psychiatrists were reluctant to engage with patients' concerns about their psychotic symptoms, despite patients repeatedly attempting to talk about the content of these symptoms, as indicated by hesitation and avoidance of answering patients' questions. Instead, psychiatrists focused on the frequency and severity of the symptoms in order to adjust medication. There was a wide variation in whether psychotic symptoms are discussed or not in outpatient consultations, with psychiatrists' behaviour being influenced by patients' symptoms. For instance, psychotic symptoms were more likely to be discussed when patients had higher levels of negative and general symptoms. These findings may reflect the lack of

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Mental health care foll

By [Aleksandra Matanov](#),
Research Assistant

Background

Systematic studies on mental health in war-affected communities are rare. Although Post-Traumatic Stress Disorder (PTSD) has been recognised as a frequent consequence of traumatic war experiences, little is known about its long-term course, treatment outcomes and factors associated with improvement. Most of the existing evidence comes from studies on war veterans rather than civilians, despite modern warfare affecting more civilians than soldiers. Research has been mostly carried out in Western countries and it is questionable whether results are transferable to post-conflict regions.

Following the period of political instability and conflict during the 1990s, the countries of South-Eastern Europe (SEE) embarked on a path of profound socio-economic change. In 1999 the European Union initiated the Stability Pact for South Eastern Europe, the framework for the regional stability and cooperation. The aim of the SEE Mental Health Project, its first public health project, was to establish pilot community mental health centres, train mental health professionals and modernise policies in nine countries of the region. The project was supported by the WHO Regional Office for Europe and the Council of Europe, and represented the first substantial step in the transition toward community based models of mental health care in the participating countries. As not much was known about the outcomes of mental health reforms in post-communist countries, an evaluation study was an integral part of this project.

Research aim

The studies coordinated by the Unit for Social and Community Psychiatry assessed the mental health consequences of the Balkan wars (1991-2001) in both residents of post-conflict regions and refugees resettled in the West. We also provided support to reforms of mental health care in South-Eastern Europe by evaluating newly established community mental health services.

Main studies so far

One of our major studies in this area



was CONNECT (2004-2008), the largest ever study to assess the long term mental health outcomes of exposure to war using consistent methods in several countries. Large community samples of individuals who survived stressful events during the war in former Yugoslavia were interviewed (total sample >4000) in five Balkan countries (i.e. Bosnia-Herzegovina, Croatia, Kosovo, Macedonia, Serbia) and three Western European countries (i.e. Germany, Italy, United Kingdom). Mental health disorders, subjective quality of life and costs of care were assessed for all participants. Individuals with persistent symptoms of posttraumatic stress were re-interviewed after a one year period (sample >900). Additional in-depth interviews were also conducted with both Balkan residents and refugees. The study was funded by DG Research of the European Commission.

The prevalence rates of post-war mental disorders were generally high, with some variation across countries. In the Balkans countries the overall prevalence rate was 45 % (anxiety

disorders: 16 % to 42 %; mood disorders: 12.1 % to 48 %), while amongst refugees in the West it was 55 % (anxiety disorders: 30 % to 61 %; mood disorders: 30.0% to 57 %). The most frequent individual disorders were PTSD and major depression. Traumatic experiences during war were associated with increased rates of mood and anxiety disorders in both Balkan and refugee samples. However, socio-economic factors such as unemployment and post-migration stressors were also independently associated with higher rates of mental disorders.

Individuals with PTSD who were followed up over 1 year reported significant symptom improvement which might indicate a fluctuating course of illness over time. Co-morbidity with depression predicted less favourable outcomes in Balkan residents, while the use of mental health services within the follow up period appeared to be linked to the persistence of PTSD symptoms in refugees.

A second major study we conducted

was the STOP study (2002-2006), which explored the help seeking behaviour and prevalence of long-term PTSD in war-exposed individuals who reported posttraumatic stress but did not receive treatment (total sample >600) in three Balkan (i.e. Bosnia-Herzegovina, Croatia, Serbia) and two Western European countries (i.e. Germany, United Kingdom). Treatment outcomes of patients in specialised PTSD treatment centres (total sample > 500), and the associated costs of care, were assessed in the three Balkan countries (i.e. Bosnia-Herzegovina, Croatia, Serbia). The study was funded by DG Research of the European Commission.

The long-term outcomes of treatment in specialised PTSD centres were poor with 86% of patients still satisfying diagnostic criteria for PTSD after 12 months. The outcomes were particularly poor for war veterans. There was no difference in health care costs for those who still met criteria for PTSD after one year and those who did not. There were small but statistically significant improvements in the patients' subjective

owing war



pilot community mental health centres established in nine countries of South Eastern Europe within the Stability Pact: Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Macedonia, Moldova, Montenegro, Serbia and Romania. The aim was to provide data on clinical and socio-demographic characteristics of patients and their views about the treatment received (total sample > 300). Patients' subjective quality of life, treatment satisfaction and rating of the therapeutic relationship were also assessed. The study was supported by the WHO Regional Office for Europe.

Newly developed community mental health centres mostly targeted patients with persistent psychotic disorders. Treatment satisfaction and therapeutic relationships were rated favourably and the care offered was highly valued by the patients. However, patients' subjective quality of life was rather low, and they were particularly dissatisfied with their financial and employment situation. Being unemployed was the only factor associated with poor quality of life and lower treatment satisfaction, indicating a need to develop employment schemes for people with severe mental illness.

quality of life.

Most people with PTSD who did not receive mental health treatment following war did not actively seek help. Their reasons were varied and include negative personal attitudes towards treatment, different explanatory models of their psychological distress, and the existence of alternative successful ways of coping.

Finally, the SEE Study evaluated 10

Current activities

We are currently conducting a further follow-up study of the long-term outcomes of PTSD and major depression following the Balkan war, exploring the role of the mental health services offered. Further evaluations of mental health services in South Eastern Europe are currently being designed in conjunction with WHO.

Patient-clinician communication

Continued from page 3

guidance on best practice in this area. Research has shown that patient-centred skills (particularly when giving information and counselling) are related to increased treatment compliance, improved satisfaction, and both decreased emotional distress and decreased burden of symptoms. With this in mind, addressing patients' concerns about their psychotic symptoms might facilitate better engagement with services.

Finally, building on the above findings, researchers at the unit have developed the first communication skills training programme for psychiatrists, nationally and internationally, that is specific to psychosis. The programme has been developed with experts in the field and is based on findings from our research on communication and psychosis conducted over the course of ten years, our large database of video-recorded psychiatric consultations as well as service-user involvement. The programme consists of four consecutive weekly group sessions, plus one individual 'seeing yourself session' where the psychiatrists review their own consultations with their patients.

Training modules target both generic communication skills and themes of psychiatric treatment, relevant with people across different mental health disorders (e.g. active listening skills, shared decision making and dealing with disagreement), and skills specifically for communication with patients with psychosis (e.g. CBT- techniques for working with positive and negative symptoms of schizophrenia and explaining the illness to the patient). Preliminary findings suggest that psychiatrists feel more confident in communicating with patients with psychosis after the training programme,

which is a good indication that psychiatrists are likely to change their behaviour as a result of the training. As detailed below, further work is being conducted to evaluate whether this is indeed the case.

Current activities

Following the findings from the original DIALOG trial, the National Institute for Health Research (NIHR) has funded a programme to develop this intervention further both in terms of technology and linking it with a simple psychological intervention informed by principles of Solution Focussed Therapy (SFT). This new intervention is called DIALOG+ and the software runs on a tablet PC. An exploratory pragmatic cluster randomised controlled trial is currently on-going in ELFT to test the effectiveness and cost-effectiveness of this further developed and expanded intervention. Participating clinicians and their clients are using DIALOG+ for a period of 6 months. Clinicians and service users are participating across all 3 boroughs within the trust. The communication skills training programme is currently being piloted within a cluster randomized controlled trial in ELFT and NELFT.

Two consultations per clinician are being video-recorded to enable a comparison of the communication pre and post training. A variety of different outcome measures are being collected such as patient satisfaction with the communication, therapeutic relationship and patient adherence at 6 months follow-up.

The Unit is also continuing to investigate therapeutic relationships and patient-clinician communication through analyses of non-verbal behaviour and decision making processes in videotaped patient-psychiatrist consultations.

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 13:00-14:00 the fourth Friday 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	Presenter
22 March	<i>Early Detection of Psychosis and Mental Health Promotion: a case example of how to implement a MH promotion and mental illness prevention service for young people in a deprived borough of London</i>	Silvia Murguía
25 April	<i>To be confirmed</i>	
24 May	<i>An evaluation of Care Coordination in an Inner London Community Mental Health Team</i>	Rahaman Mohammed
28 June	<i>EPOS</i>	Eoin Golden

Present your own research? Email your presentation title, and preferred monthly slot, to: eleanor.tomlinson@eastlondon.nhs.uk or henrietta.mbeah-bankas@eastlondon.nhs.uk

Patient-reported outcomes and experiences

By [Dr. Kirsten Barnicot](#)

Background

The ultimate aim of mental health treatment and research is to improve patient outcomes. Arguably the most important source of information about whether mental health services succeed in improving patient outcomes is the patients themselves. Many measures have been developed which ask patients to rate their experiences of treatment, their mental health, their functioning and their quality of life. These are known as “patient-rated outcome measures”. In the UK, NHS providers are now required to use patient rated outcome measures to assess the quality of the care they provide. The World Health Organization recognises that patient-reported outcomes are playing an increasingly important role in health care delivery and in reforms in health service organisation, and therefore recommends that research on developing and optimising patient-reported outcome measure should be a priority for health service researchers.

Research Aims

The aims of the Unit’s work on patient-reported outcomes and experiences are: (i) to build a better understanding of patients’ own perspectives on their mental health, quality of life and experience of mental health services, (ii) to develop and refine improved patient-reported outcome measures, and (iii) to evaluate measures of patient-reported outcomes and assess the value of the information they provide.

Major studies so far

The first set of studies conducted so far have been qualitative interview studies. These types of studies aim to explore patients’ unique perspectives in depth and, unlike quantitative questionnaires, report responses in the patients’ own words so that the rich detail of individual experiences is captured. One study explored patients’ experiences of involuntary and voluntary hospital treatment, including whether they felt coerced into being hospitalised, whether they found being hospitalised helpful or unhelpful, and whether they thought the decision to hospitalise them was right. Another study explored how and why patients engage with Assertive Outreach teams, and what experiences lead them to sometimes disengage from these services. A further study explored how patients with personality disorder experience the specialist treatment Dialectical Behaviour Therapy, as well as how these patients define ‘recovery’, and whether they see recovery as a realistic goal for themselves. A finding common to all of these

studies was that patients value commitment and respect from staff, practical help, and interventions beyond medication.

The second set of studies were quantitative, and involved developing new and improved measures of patient-reported outcomes i.e. standardised questionnaires filled in by patients about their feelings and experiences, later used in statistical analyses. The new measures developed in the Unit include

they had been discharged long ago by that point. This is a testament to the importance of patients’ perspectives on their care and reinforces the value of ensuring that patients feel supported, listened to and appropriately treated in the often turbulent first few days of a hospital admission.

The third set of studies, also quantitative, involved evaluating what factors influence how patients fill out self-reported questionnaires, and how good existing questionnaires are at giving us specific information about the concept they intend to assess. It has been noted in our research that people seem to have a general tendency to give generally positive or negative ratings of their experiences across different measures which assess different concepts. For example, someone who rates their subjective quality of life as high is very likely also to rate their therapeutic alliance as positive, their needs for care as minimal, and their treatment satisfaction as high. This raised the question as to whether measures of these different concepts are really assessing different things, or whether they simply assess patients’ general tendency to give positive or negative ratings, providing minimal information about specific concepts. In Accordingly, the Unit conducted research using an innovative statistical technique, known as item response theory, to investigate this problem. Our research found that, although a general appraisal tendency amongst measures was apparent,

each measure was still able to yield useful information on the particular concept it has been designed to assess. From these findings, we were able to generate recommendations about how better patient-reported outcome measures could be developed in the future.

Current activities

Currently we are conducting in-depth qualitative studies of the experiences of patients and carers in different settings, including inpatients’ experiences of being on 1-to-1 constant observation, inpatients’ experiences of receiving music therapy, and outpatients’ experiences of body psychotherapy. Further qualitative research will involve interviewing patients, staff and carers about their experiences of carer involvement in inpatient admissions. Using quantitative methods, researchers are currently collecting and analysing patient-reported outcome data to assess the potential impact of various interventions, including the therapeutic alliance in outpatient psychiatrist consultations, quality of life in the receipt of financial incentives for depot injections, and treatment satisfaction in body psychotherapy as treatment for negative symptoms in schizophrenia.



two measures of patients’ subjective quality of life (Manchester Short Assessment of Quality of Life and DIALOG scale), two measures of patients’ perception of therapeutic relationships with mental health professionals (Helping Alliance Scale and Scale for Assessing Therapeutic Relationships) and two measures of patients’ satisfaction with their treatment (Client Assessment of Treatment Scale, DIALOG Scale). These measures were developed using classical test theory, with regular consultation with patients during the development to ensure that the questions were relevant to their lives and worded appropriately.

Not only have these measures been useful in evaluating the outcome of patients’ treatment, they have also been used to determine the influence that patients’ experiences early on in treatment have on their subsequent outcomes. For example, when the Client Assessment of Treatment scale was used to assess patients’ satisfaction with inpatient or day hospital treatment across the UK and 5 other European countries, additional research showed that patients who rated their satisfaction as high in the first few days after admission had better outcomes 12 months later – even though



OTHER NEWS

TENTH ANNUAL RESEARCH PRESENTATION DAY

The Trust's Tenth Annual East London Mental Health Research Presentation Day took place on 14 November in the Robin Brooks Centre at Barts Hospital; the event was open to all Trust staff and was well attended by our staff, academic collaborators, service users 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. Topics included: Violence and alcohol use; Results from a pilot trial of peer support; Love and work as predictors of wellbeing; Recovery after treatment for chronic fatigue syndrome; What do outpatients want to learn about their illness and how? and much more.

Informal feedback from the day was overwhelmingly positive. The presentations were widely seen as both informative and entertaining; and it's always a good opportunity to bring together so many different people associated with our Trust and its work.

If you missed it this year, don't worry. Just mark your calendar for Wednesday, 2 October 2013 and join us for the latest results from research in East London.

NIHR LAUNCHES NEW CLINICAL TRIALS TOOLKIT FOR RESEARCHERS

The NIHR has launched a new Clinical Trials (CT) Toolkit website designed to help researchers navigate through the complex landscape of setting up and managing clinical trials in line with regulatory requirements.

Based on the design of a tube map, the CT Toolkit uses an interactive colour-coded routemap to differentiate between legal and good practice requirements. This provides essential information at the 'stations' along the route and gives the users an idea of the critical path for trial set-up and delivery. The site signposts users to resources such as: the National Research Ethics Service (NRES), Health Research Authority (HRA) and Medicines and Healthcare products Regulatory Agency (MHRA) websites.

Although primarily aimed at those involved in publicly funded Clinical Trials of Investigational Medicinal Products (CTIMPs), the CT Toolkit will also benefit researchers and R&D staff working on trials in other areas, who will find useful information and guidance of relevance to the wider trials environment.

Visit the Clinical Trials Toolkit at www.ct-toolkit.ac.uk.

Trends in Institutionalised Psychiatric Care

By [Winnie S. Chow](#),
PhD Student

Background

In most Western and Central European countries, the large asylums and hospitals that historically dominated psychiatric care were established in the 19th century.

Since the 1950s, mental health care in Europe has undergone major reforms that have led to changes in the practice and organization of psychiatric care models. Probably the most significant change in provision of mental health care was the shift from institutional care to the establishment of services in the community beginning in the late 1950s, characterized as the deinstitutionalization movement. Deinstitutionalization led to closure and downsizing of many large hospitals and former asylums and the establishment of community-based psychiatric care models. The development of this movement varies greatly across countries in Europe. Much research has examined the deinstitutionalization movement over the years. Some have argued that the process of deinstitutionalization has an overall benefit for psychiatric patients while others have considered the process as a failure.

Research Aim

With this background in mind, the aim of this series of research was to understand trends in the provision of institutionalised mental health care and to better understand cross-country variations.

Major studies so far

Several major studies undertaken by the Unit indicate that there may be a new trend of 're-institutionalization' across Europe since 1990, the end of the post-war period. New forms of institutionalisation have possibly occurred in Western Europe in the guise of supported housing, forensic hospitals and mentally disordered individuals within prisons.

The first set of studies which examined trends across Western Europe suggested there have only been slight further reductions of conventional psychiatric hospital beds between 2002 and 2006 in most studied countries but a small increase in Germany and the Netherlands. However significant increases of forensic psychiatric beds, in the provision of supervised supported housing and prison population were found in most but not all of the nine studied countries. These could be considered as new forms of institutionalisation.

Another study identified comparable

main findings in twelve post-communist countries after the political changes in 1989. There has been a significant decrease in general psychiatric hospital beds in all countries but the number of forensic psychiatric bed and supported housing increased in most countries. The percentage decrease in general psychiatric beds ranged from 211% in Croatia to 251% in East Germany. The trends in the prison population ranged from a decrease of 258% in East Germany to an increase of 43% in Belarus and Poland. No relationships were found between the different forms of institutionalised mental health care. The findings do not support the Penrose hypothesis, in which Penrose argued for the first time in 1939 that there is an inverse relationship between the number of prison inmates and the number of psychiatric hospital beds in a population.

Although Israel has a distinctive history of psychiatric institutionalization compared to European countries, similar trends were observed in a study where changes in health care provision in Israel were analysed and compared with service provision data in Western Europe. Data from this study also indicates a consistent reduction of psychiatric hospital beds and a striking increase in supported housing places

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Trends in Institutionalised Psychiatric Care

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and psychiatric treatment in the prison population. Between 1991/2 and 2002/3, a substantial increase of 307% was noted in supported housing places, a rise of 61% in psychiatric treatments in the prison population and a fall of 42% of psychiatric hospital beds.

Different explanations have been put forward for this process. Economic factors were identified to be an important driver for the supply of hospital beds. The relationship between economic factors (consumer price index, real gross domestic product per capita, base discount rate, and rate of unemployment) and numbers of hospital psychiatric beds were explored in a study using a complex statistical technique known as time series analysis. The two regional data sets from the nineteenth century (North Carolina, USA; Berkshire, UK) and three national data sets in the twentieth century (US; UK; Italy), suggest there is an association between economic factors and psychiatric bed numbers, i.e. as one goes up, the other goes down. The consumer price index was found to be the strongest predictor of changes in psychiatric bed numbers.

Other reasons for increased institutionalisation suggested by the aforementioned studies include a) an increase of psychiatric morbidity requiring more institutional care, b) decreased capacity to care for mentally ill family members as a result of increasing family fragmentation, c) an increased focus on risk containment could be influencing clinical decisions to refer to care in institutions and political funding decisions, and d) the interests of the provider organization to increase their income possibly leads to policies to expand mental health care institutions.

Current activities

Currently, research is being undertaken to update the analysis of current trends and exploratory study of potential drivers in Western Europe. For example, we are interviewing mental health professionals about the reasons for the changes in institutionalised mental health care over the last 20 years or so. In addition, we are also collecting service provision data including prevalence rates of mental disorders in prisons in South America.

Mental health care for

By **Dr Domenico Giacco**

Background

People from marginalised groups have a high likelihood of developing mental disorders. When compared with the general population, homeless people have higher prevalence rates of alcohol and drug dependence, psychosis and personality disorder; refugees are up to 10 times more likely to suffer from post-traumatic stress disorder; members of travelling communities have higher levels of anxiety, depression and likelihood of attempting suicide; and female sex workers and migrants have higher rates of mental disorders.

People from marginalised groups frequently experience problems accessing health services. At the same time, health services may struggle to reach people with mental disorders in such groups and engage them in care.

Therefore, the needs of these groups should be addressed in health policies in order to ensure an equitable distribution of health resources and the development of relevant programmes.

Research aims

The aim of the Unit's research in this area has been to understand and improve concepts and organisation of mental health care across Europe for marginalised groups, such as homeless, refugees, sex workers, travelling communities, migrants.

Major studies so far

The Unit for Social and Community Psychiatry coordinated two projects, funded by the European Commission Framework Programme 7, in order to assess and improve concepts and organisation of mental health care across Europe for marginalised groups. One was the EUGATE project ('Best Practice in Health Services for Immigrants in Europe'); which was conducted in 16 EU countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Poland, Portugal, Spain, Sweden and the United Kingdom. The other was the PROMO project ('Good Practice in Mental Health Care for Socially Marginalised People in Europe'), which was conducted in the two most deprived areas in the capital cities of the following 14 EU countries: Austria, Belgium, Czech



Republic, France, Italy, Germany, Hungary, Ireland, Netherlands, Poland, Portugal, Spain, Sweden, and the United Kingdom.

These two studies found that practice in mental health care for marginalised groups varies substantially across Europe. Clinicians across Europe tend to defy policies in order to provide humane and appropriate treatment to people who are often not legally entitled to receive health care services. Despite differences between European countries, common barriers to good care were identified. Some related specifically to the status of marginalisation, including limited entitlements to health care, lack of knowledge of health services, and language and cultural barriers; others related to the services, such as rigidity in the organisation, lack of ability to respond to complex needs, and negative attitudes amongst professionals.

Components of good practice were subsequently identified, based on what is already in place and is working, and on suggested improvements. They apply across health and social care systems in Europe, and may guide future policies to improve mental health care for socially marginalised groups

The four components of good practice that apply across all marginalised groups are: (i) establishing outreach programmes to identify, engage with and help individuals with mental health problems from marginalised groups; (ii) facilitating access to general health services that include expertise and treatment programmes for mental disorders (providing different aspects of health care in one service and reducing the need for further referrals); (iii) coordinating services for marginalised groups to strengthen their collaboration and facilitate sharing of expertise; and (iv) disseminating information on the health services available to marginalised groups, both to the groups themselves and to services.

Specific components of good practice for the provision of mental health care to migrants have been also identified: (i) organisational flexibility with sufficient time and resources, including longer consultation time and better allocation of resources; (ii) good interpreting services, including same-language therapists, bi-cultural workers as interpreters and professional interpreting services; (iii) working with families and social services,

marginalised groups



including collaboration with religious, community and refugee organisations; (iv) cultural awareness amongst staff, including promotion of cultural awareness through education and training of staff, and having multicultural staff to support the wider acquisition of acceptance and understanding of different cultures; (v) education programmes and information

material for immigrants, including translated material on health and the health care systems; (vi) positive and stable relationships with staff, with familiarity intended to improve staff-patient relationships; and (vii) clear guidelines on care entitlements of different groups of immigrants, with training of staff in immigrants'

entitlements.

In conclusion, there is wide variation in practices in mental health care for marginalised groups across Europe. Practices are often based on the personal initiative of clinicians and organisations that provide care to people who are faced with different legal and administrative barriers to receiving health care. In addition to sufficient resources, improved care requires the appropriate organisation of both individual services, and coordination and collaboration amongst these; training programmes for staff in different services; the provision of information materials; and positive attitudes of health and social care professionals towards socially marginalised groups.

Current activities

The Unit is currently designing further multi-centre studies in order to explore the provision of mental health care for vulnerable groups across Europe and to compare different mental health care systems with regard to their effectiveness and cost-effectiveness. As a World Health Organization Collaborating centre, the Unit is actively taking part in the collaborative work for the European Mental Health Plan, and leading on the evaluation of care for marginalised groups, the definition of quality indicators for mental health care, and the development of strategies to enhance patients' engagement with mental health services and to provide safe and effective care.

OTHER NEWS

HOME OFFICE CHANGES PRE-ENGAGEMENT CHECK RULES

In September 2012 the Home Office changed the rules around Criminal Record Bureau checks that are necessary (or not now!) prior to the granting of access to patients and other types of vulnerable people. To a significant degree this is a liberalisation and fewer checks will be required (indeed HR Departments undertaking inappropriate checks could be breaking the law). However, as with many good things, there is a grey lining: In this case the administrative burden of deciding when CRB checks are appropriate has increased. It is not just a matter of patient access, it is about what researchers are actually going to be doing on site with NHS patients.

To help our researchers and staff the JRMO has created a simple NHS Access Arrangements Pathway diagram to take applicants through what is needed and what outcomes will be. For substantive NHS employees, Research Passports are unnecessary but local access arrangements, such as a Letter of Access, remain essential.

Further details about the Research Passport Process, including the diagram can be found on the JRMO website at <http://www.bartsandthelondon.nhs.uk/our-services/research-and-development/>

CLARIFICATION FROM NRES ON ANONYMISED DATA USAGE

GAfREC2 has clarified that research limited to secondary use of 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.

This exception also applies to research undertaken by staff within a care team using information previously collected in the course of care for their own patients or clients, provided that data are anonymised or pseudonymised in conducting the research. However, if there is an intention, at time of collection, to use the data for a specific research project, the project should be reviewed by a REC.

The exemption referred to only applies to the secondary use of anonymised data for research, previously collected for clinical purposes and where a specific research project was not envisaged at time of collection.

Spring 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
25 March	<i>QuEST – Quality and Effectiveness of housing services for people with mental disorders</i>	Sima Sandhu
8 April	<i>Acceptance of covert coercion in mental health care</i>	Ciara Banks
15 April	<i>FIAT – Financial incentives for adherence to medication in non-adherent patients</i>	Nicola O'Connell
22 April	<i>Nonverbal communication in schizophrenia</i>	Mary Lavelle
29 April	<i>Conceptual review of resource oriented treatment models in psychiatry</i>	Serif Omer
13 May	<i>Communication skills training for treating patients with psychosis</i>	Paula Hermann
20 May	<i>Recruitment in the EPOS trial</i>	Husnara Khanom
3 June	<i>Shared decision making in mild to moderate dementia</i>	Jemima Dooley
10 June	<i>The EPOS trial</i>	Lauren Kelley
17 June	<i>Group music therapy for acute adult psychiatric inpatients</i>	Catherine Carr
24 June	<i>Psychiatrist-patient communication in the treatment of schizophrenia</i>	Laura Thompson

NEW NIHR INTERACTIVE FLOWCHART

The new interactive flowchart helps guide researchers through the process of how to get their study included in NIHR Portfolio – the key to unlocking Clinical Research Network (CRN) support. Browse the flowchart at: http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_how/application_process/

HRA TAKES A ROLE IN RESEARCH ACCESS TO PATIENT DATA

National Governance Information Body (NIGB) functions will transfer to HRA when NIGB closes in March 2013. Future applications for access to patient data under section 251 of the NHS Act 2006 will be considered by HRA. Section 251 of the NHS Act 2006 allows access to patient data for research purposes without consent in some circumstances. The consideration of such decision will fall under the HRA following the closure of NIGB. Please see:

<http://www.hra.nhs.uk/hra-news-and-announcements/health-research-authority-to-take-role-in-research-access-to-patient-data/>

NEW GUIDANCE ON UK DATA PROTECTION IN PHARMACOVIGILANCE

The pharmacovigilance process can bring many challenges in ensuring patients' personal data is held and transmitted in line with data protection legislation. To support companies and promote consistent practice, the ABPI, the Pharmaceutical Information & Pharmacovigilance Association (PIPA) and plegal have collaborated to publish guidance on this topic. For further details, see: <http://www.abpi.org.uk/our-work/news/2013/Pages/120213.aspx>

FUNDING EXCESS TREATMENT COSTS FRAMEWORK – UPDATE FROM DH

The NHS reorganisation and demise of Primary Care Trusts means there are several research related activities that need realignment. From 1st April 2013 the Clinical Commissioning Groups (CCGs) have a duty to "ensure the treatment costs for patients who are taking part in research are covered". A recent message from DH highlights that a framework to fund Excess treatment costs is still being developed. For further information please see: <http://www.rdforum.nhs.uk/003a.asp?entryid=1064>

Developing novel non-verbal

By [Mark Savill](#),
NESS Trial Manager

Background

Non-verbal therapies, also known as 'arts therapies', refer to a number of different interventions that focus on promoting non-verbal expression and communication through use of an arts medium. Different types of non-verbal therapies include Music Therapy, Art Therapy, Dance Movement Psychotherapy, Body Psychotherapy and Drama Therapy. The focus has primarily been on group interventions, and on Music Therapy and Body Psychotherapy in particular. In the former, music is used to address the physical, emotional, cognitive and social needs of the individual through a combination of active music-making, listening and verbal reflection. In Body Psychotherapy, groups use a number of props such as balls, ropes, and instruments which facilitate communication between members of the group to challenge dysfunctional body perceptions and encourage creative play.

One area of non-verbal therapies that has received particular attention has been the treatment of negative symptoms in schizophrenia. The features of negative symptoms include blunted affect, social withdrawal, an inability to experience pleasure, and substantial motivation deficits. Despite positive symptoms often being the more recognisable features of the disorder (voices, hallucinations and other delusions), evidence suggests that it is the negative symptoms that have a greater impact on social functioning and quality of life.

Both pharmacological interventions and conventional talking therapies have been found to be ineffective in treating negative symptoms; however, there is a small evidence base to suggest that non-verbal therapies may be effective in treating these types of symptoms. NICE guidelines stating that "Arts therapies are currently the only intervention (both psychological and pharmacological) to demonstrate consistent efficacy in the reduction of negative symptoms", though recognising that larger full-scale trials are required to fully examine the effectiveness and cost-effectiveness of these interventions, and the processes by which these groups may facilitate change. Further, the process by which these groups may facilitate changes is not known.



Against this background, treatments are increasingly being provided in various contexts for a range of disorders. In the East London NHS Trust in particular, one of the strategic aims is to increase non-verbal therapies provision in acute inpatient services. However, there is little research to guide how these interventions should be provided in short inpatient stays.

Research Aims

The aim of the Unit's research in this area is to evaluate the effectiveness of novel group non-verbal therapies and refine the provision of these therapies as treatment for various mental health disorders and symptoms.

Major studies so far

The Unit has thus far conducted three randomised controlled trials in the field of non-verbal group therapies. The first examined the effectiveness of manualised group body psychotherapy in the treatment of negative symptoms, in comparison to individual supportive counselling. In this study of 45 participants, it was found that body psychotherapy resulted in a significant reduction in negative symptoms compared to the supportive counselling group, and that this difference was

maintained at 4 months post-treatment.

The second trial examined the effectiveness of group music therapy in the treatment of chronic post-traumatic stress disorder (PTSD), in comparison to a waiting list group. A significant reduction in the symptoms of PTSD was detected in the music therapy group, with the group mean symptoms scores at the end of treatment being below the clinical threshold on the Impact of Events Scale (IES). This finding was particularly notable given that all participants had already received, but not responded to, CBT treatment, which is currently recognised as the primary treatment for this type of disorder.

The third randomised controlled trial examined the effectiveness of group body psychotherapy in the treatment of depression, in comparison to a waiting list control. Participants in the body psychotherapy group were found to have significantly lower symptom severity levels at end of treatment. A dose-response effect was detected, and evidence of group effectiveness was found after the participants attended at least 5 of the 20 sessions.

Current activities

Following on from the successful

therapies



exploratory trial of body psychotherapy in the treatment of negative symptoms of schizophrenia, the NIHR has recently funded a full-scale multi-site trial designed to examine the effectiveness and cost effectiveness of the intervention in comparison to an active control. In this study, 256 patients are to be recruited to take part in 32 groups, with outcomes compared at baseline, end of treatment and at 6 months follow-up. To date, 18 groups have been completed (6 in East London Foundation Trust), with results expected at the beginning of 2015. In an attempt to better understand the processes that are involved in the interventions, a PhD project has recently been funded to examine whether there are specific features of body psychotherapy that facilitate social interaction, with the long-term aim of refining the interventions currently being provided. In addition, a second PhD project funded by the NIHR is currently underway to examine how Music Therapy can best be delivered in acute care. This project will examine whether increased frequency of therapy is acceptable to inpatients, and attempt to identify which specific components of the groups are linked to improved outcomes and more positive patient appraisals.

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.

■ Ascoli, M., Palinski, A., Owiti, J. A., De, J. B., & Bhui, K. S. 2012, *The culture of care within psychiatric services: tackling inequalities and improving clinical and organisational capabilities*, **Philos.Ethics Humanit. Med.**, vol. 7, no. 1, p. 12.

■ Badrick, E., Hull, S., Mathur, R., Shajahan, S., Boomla, K., Bremner, S., & Robson, J. 2013, *Health equity audits in general practice: a strategy to reduce health inequalities*, **Prim.Health Care Res.Dev.** pp. 1-16.

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■ Cella, M., White, P. D., Sharpe, M., & Chalder, T. 2013, *Cognitions, behaviours and co-morbid psychiatric diagnoses in patients with chronic fatigue syndrome*, **Psychol.Med.**, vol. 43, no. 2, pp. 375-380.

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■ Curtis, D. 2012, *Thrombolysis in acute ischaemic stroke*, **Lancet**, vol. 380, no. 9847, pp. 1054-1055.

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■ Farrington D, Auty K, Coid J, & Turner R 2013, *Self-reported and official offending from age 10 to age 56.*, **European Journal on Criminal Policy and Research.**

■ Fisher, H. L., Cohen-Woods, S., Hosang, G. M., Korszun, A., Owen, M., Craddock, N., Craig, I. W., Farmer, A. E., McGuffin, P., & Uher, R. 2013, *Interaction between specific forms of childhood maltreatment and the serotonin transporter gene (5-HTT) in recurrent depressive disorder*, **J Affect.Disord.**, vol. 145, no. 1, pp. 136-141.

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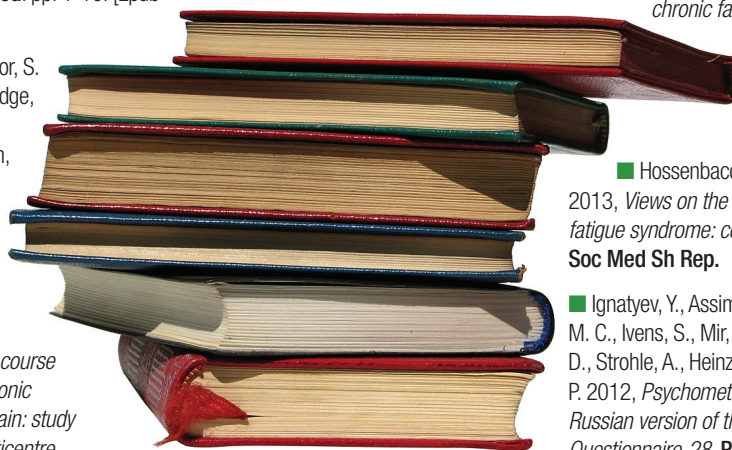
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■ Kalra, G., Bhui, K. S., & Bhugra, D. 2012, *Sikhism, spirituality and psychiatry*, **Asian J Psychiatr.** vol. 5, no. 4, pp. 339-343.

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Continues on page 12

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Continued from page 11

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■ Laugharne, R., Priebe, S., McCabe, R., Garland, N., & Clifford, D. 2012, *Trust, choice and power in mental health care: Experiences of patients with psychosis*, **Int.J Soc.Psychiatry**, vol. 58, no. 5, pp. 496-504.

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■ Lee T, Ellingford C, Blackburn, S, Bishop, E, Ragiadakos, N, Bhui K *Report from the field: Selecting staff for a Personality Disorder Service*. **Psychiatrist** 2012, 36,50-54.

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■ Priebe Stefan, Golden Eoin, McCabe Rosemarie, Reininghaus Ulrich *Patient-reported outcome data generated in a clinical intervention in community mental health care - psychometric properties* **BMC Psychiatry**

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