

Mental health care for socially marginalised groups in Europe



By [Stefan Priebe](#),
Professor of Social & Community Psychiatry

Socially marginalised groups tend to have higher rates of mental disorders than the general population and can be difficult to engage in health care. Providing mental health care for these groups represents a particular challenge. There is limited evidence on what form of mental health-care generic (i.e. not targeting a specific social group) and group-specific services provide to socially marginalized groups in Europe. Evidence is required on what is good practice in delivering and coordinating care that is provided by health and social care services.

The PROMO study selected two highly deprived areas in 14 different European capital cities (in London these were Tower

Hamlets and Hackney) and explored the provision of mental health care for six socially marginalised groups: long-term unemployed; street sex workers; homeless; refugees/asylum seekers; irregular migrants; and members of the travelling communities.

The large project had two parts. In the first, all services providing care for one or more of the marginalised groups were identified and assessed. In the second, experts on the provision of care were identified for each marginalised group and in each deprived area, and interviewed about how care is provided in the given area and what are its the strengths and weaknesses.

In the first part of the study (see Priebe et al. in *Eur J of Public Health*) all health and social care services providing

some form of mental health care for to these socially marginalised groups were contacted; data were obtained on service characteristics, staff and programmes.

In eight capital cities (with response rates of >50%), 516 out of 575 identified services were assessed (90%); 297 services were generic (18–79 per city) and 219 group-specific (13–50). All cities had group-specific services for the homeless, street sex workers and asylum seekers/refugees. Generic services provided more healthcare programmes. Group-specific services provided more outreach programmes and social care. There was a substantial overlap in the programmes provided by the two types of services.

One may conclude that in deprived areas of European capitals, a considerable number of services provide mental health care to socially marginalized groups. The findings of this study suggest that access to these services often remains difficult. Group-specific services have been widely established, but their role is not clearly distinct from that of generic services. More research and conceptual clarity is required on what generic and specific services should do and how they should collaborate to avoid duplication and maximise their benefits for mentally ill people in socially marginalised groups.

In the second part of the PROMO study (Priebe et al. in *BMC Public Health*) experiences and views of experts for each of the six marginalised groups were

Continued on page 2



Prof. Stefan Priebe,
Director of Research

Hello to all
GPs in East
London!

Welcome to the Trust's *R&D Newsletter*, which we are now circulating to all GPs in the boroughs we serve. We hope that you find it both informative and useful and that it serves to forge new collaborations in research in East London.

We use this forum to communicate the latest evidence from research taking place in East London, highlight new studies in which service users or staff can enrol, inform prospective investigators about how to navigate the bureaucracy surrounding research governance, and publicise upcoming events and newly published papers. We welcome contributions and comments from all our readers at ResearchOffice@eastlondon.nhs.uk



Discussion [Page 3](#)

Adolescent question?

Economics [Page 4](#)

The unseen price of war



Access [Page 2](#)

Reaching Drug users



In print [Pages 7&8](#)

Recent publications

Mental health care for socially marginalised groups in Europe

Continued from page 1

explored in each deprived area. Semi-structured interviews with case vignettes were conducted to assess experiences of good and of problematic practice. The interviews were analysed using thematic analysis

In a total of 154 interviews, four components of good practice were identified across all six groups: a) establishing outreach programmes to identify and engage with individuals with mental disorders; b) facilitating access to services that provide different aspects of health care, including mental health care, and thus reducing the need for further referrals; c) strengthening the collaboration and co-ordination between different services; and d) disseminating information on services both to marginalised groups and to practitioners in the area.

From this work, we can conclude that experts across Europe hold similar views on what constitutes good practice in mental health care for marginalised groups. Care may be improved through better service organisation, coordination and information.

Specifically for East London, the findings show that a reasonable number of services have been established to provide care for marginalised groups, but their co-ordination could be improved. This might be achieved through simple measures such as annual meetings of all services providing mental health care to a marginalised group in a Borough, a joint policy regarding which service is supposed to provide what aspects of care, and simplified referral procedures.

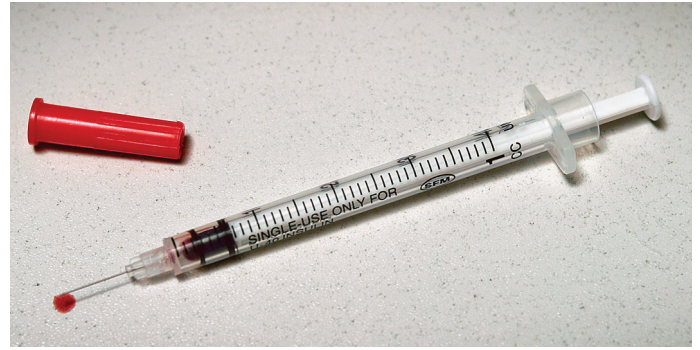
Improving Access to Healthcare for a Difficult to Reach Group

By **Mandie Wilkinson**,
Blood Borne Virus Team

A major concern associated with treating injecting drug users for Hepatitis C is that they will not comply with monitoring for the significant side effects, which include psychiatric problems, or that they will re-infect themselves; therefore although treatment is available, it is not routinely offered to this group.

The Blood Borne Virus (BBV) team provide a range of healthcare interventions to address the physical impact of drugs and alcohol; this includes Hepatitis C virus (HCV) treatment (offered in conjunction with Hepatology services at Bart's Health). So far we have treated 200 drug users and obtained successful treatment rates that compare favourably with services treating non drug users.

The team is pro-active in researching ways to improve treatment uptake. For example, a current study is comparing standard treatment with nurse-initiated treatment. Patients with no contraindications are started on treatment within a short timeframe by the BBV nurses,



without having to attend a liver clinic. The aim of the project is to see if reducing barriers increases uptake or engages more chaotic drug users in to HCV treatment.

The BBV team is also about to participate in the international ACTIVATE study, which as well as looking at reducing duration of treatment regimes for HCV, is one of the first studies recruiting actively injecting drug users. There are a number of new drugs being developed which will increase the rates of successfully treated HCV but, due to lack of information on interactions with illicit drugs, current drug users are unlikely to be offered them. ACTIVATE hopes to prove that intravenous drug users can participate in drug trials.

Factors predicting the outcome of psychotherapy for borderline personality disorder

There is substantial variation between individuals with borderline personality disorder (BPD) in the degree of benefit gained from psychotherapy. Information on factors predicting the outcome of therapy for this group could facilitate identification of those at risk for poor outcome, and could enable helpful therapy processes to be identified.

A systematic review by Barnicot et al. published in *Clinical Psychology Review*,

identified two consistent positive predictors of symptom change: pre-treatment symptom severity and patient-rated therapeutic alliance. Contrary to theories predicting increasing immutability with age, there was no evidence that age predicted poorer outcome.

More severely ill patients may have greater potential to achieve change during therapy, and should remain a focus for psychotherapy services. The

therapeutic alliance is an important common factor predicting outcome in patients with BPD, even in highly disorder-specific treatments. Outcomes may be improved by further clinical and research focus on forming strong therapeutic alliances. The advancement of the field requires identification and testing of new predictors of outcome, especially those related to specific theories of therapeutic change in BPD.

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
25 June	<i>DIALECT: the effectiveness of Dialectical Behaviour Therapy on self-harm in people with Borderline Personality Disorder</i>	Nyla Bhatti
23 July	<i>What helps and hinders service users into employment?</i>	Louise Blanks
27 August	BANK HOLIDAY	
24 September	<i>Recovery from Psychosis: What may ideas from a Compassionate Mind approach add to current understanding?</i>	Lisa Wood
22 October	<i>Experiences of psychodynamic group psychotherapy among people with psychosis</i>	Natalia Solovieva

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

Personality Disorder: Does It Exist in Adolescents?

A panel discussion with Dr Harriet Stewart, Dr Ruma Bose, Dr Rafik Refaat & Dr Osman Malik chaired by Dr Georgina Hawkes

What we recognise as signs of adolescence is remarkably similar to symptoms of Personality Disorders (PD), in particular Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (APD), for example stark mood swings from doom to exuberance; lack of impulse control; poor cognitive assessment of risks; depressive thinking; difficulties in maintaining stable relationships and in managing closeness or distance; substance misuse; aggressive behaviour; withdrawal.

Adolescents referred to mental health services often show symptoms that are consistent with PD, in particular BPD and APD, such as self harming (cutting), suicidal thoughts and actions, and occasionally violence. At the same time, many are initially recognised as suffering from Depression, Anxiety, Eating Disorder, or Attachment Disorder. The diagnosis of these so-called Axis-I disorders may, however, risk overlooking their high co-morbidity with PD.

One of our consultants therefore combed through the mental health records of adolescents discharged from the Coborn Centre since 2001. She reviewed them for symptoms that would match six indicators (self-harm; affective instability; impulsivity; relationship instability; self-image disturbance; feelings of



emptiness) generally symptomatic for PD if at least four are evident. Her study showed that some young patients were diagnosed with PD though they met less than four of these indicators, whereas some met four or more of them yet were not diagnosed with PD but with an Axis-I disorder instead.

This shows both caution and uncertainty in the diagnosis of adolescents: some of the symptoms may stop spontaneously or following treatment and hospitalisation, or re-emerge. One symptom might conceal another. With this fluidity and the incomplete growing-up process of a youngster in mind, professionals tended to diagnose PD in adolescents reluctantly.

The starkness of a PD “verdict” is sometimes

feared by patients and their carers because of its implied immutability and public (mis-)perception, and this may cause resistance to treatment. Many families would consider a youngster’s personality as not yet fully established and derive hope from this for improvement in the future, which a PD diagnosis may – rightly or wrongly - destroy. Other adolescent patients and their families are, however, relieved to finally be able to put a name to the disturbing symptoms and become very supportive of treatment.

Increasingly, research shows a certain level of stability in PD from adolescence to adulthood; its symptoms are very similar, and they remain more pervasive if there is co-morbidity with Axis-I disorders. Carried out carefully, an early diagnosis of PD (and co-morbidity disorders) is a good predictor for later presentations. NICE Guidelines (2009) have indeed adopted the term “Young People with BPD” (but would find it uncommon to use the BPD diagnosis in someone under 13 years of age).

As the dysfunctions and maladaptive behaviours that come with PD can decrease in later adulthood (in their 30s), the balance now seems to favour PD diagnosis in adolescents. Mental health services can offer the appropriate treatments early, the young person has a chance to consolidate their education and training phase, and their patterns of thinking, feeling and behaviour are still malleable enough to allow them to learn how to live safely with their symptoms.

Do young people with HIV feel stigmatised as a result of their status?

By [Tomás Campbell](#),
Newham Psychological Services

There is little literature on the impact of HIV-related stigma and young people in the UK but the context in which young HIV+ people are developing and maturing is one in which HIV-stigma is a reality and is expressed in many ways. HIV-stigma may also be highest in the African communities from which most young HIV+ people originate. HIV stigma may have complex and negative effects on HIV+ people (e.g. poorer social support, poorer mental health, disclosure difficulties, negatively affect adherence to anti-retroviral medication and HIV stigma can be a barrier to accessing health care).

A pilot study was conducted with 21 HIV+ young people with the aim of exploring experiences of stigma in this group. Participants completed a stigma questionnaire and participated in a one-day intervention designed to equip them with some knowledge and skills to counter HIV stigma. Participants were of African origin (12 females, 8 males), had been infected vertically and were aged between 12-21 years.

Questionnaire responses showed mixed patterns in which there were marked gender differences. Females had more experiences of stigmatised actions directed towards them than males; females were also more likely than males to have family members and friends who are aware of their status. Males were more likely to have friends who were completely unaware of their status.

This is a small sample and the data should be interpreted cautiously. However, HIV+ young people appear to feel stigmatised about their status and young women more so than young men. It would be of interest to further explore if the young people are actually feeling stigmatised or whether their fear of this occurring is affecting their behaviour. Anti-stigma interventions should be a routine component of care for these youths so that the impact of stigma does not become a major negative component in their ability to cope with the disease in the future.

Further reading: Hogwood et al (2012) *I wish I could tell you but I can't: Adolescents with perinatally acquired HIV and their dilemmas around self-disclosure. Clinical Child Psychology.*

Family Caregivers’ Experiences of Involuntary Psychiatric Hospital Admissions of their Relatives

Carers of people with mental disorders are frequently involved in involuntary hospital admissions of their relatives.

A recent paper in PLoS ONE explores carers’ experience of involuntary admission of their relative by conducting qualitative interviews. 30 in-depth interviews were conducted with carers of 29 patients who had been involuntarily admitted to 12 hospitals across England.

Interviews were analysed using thematic analysis. In results, four major themes of experiences were identified: relief and conflicting emotions in response to the relative’s admission; frustration with a delay in getting help; being given the burden of care by services; and difficulties with confidentiality.

Relief was a predominant emotion as a response to the relative’s admission and it was accompanied by feelings of guilt

and worry. Carers frequently experienced difficulties in obtaining help from services prior to involuntary admission and some thought that services responded to crises rather than prevented them. Carers experienced increased burden when services shifted the responsibility of caring for their mentally unwell relatives to them.

Confidentiality was a delicate issue with carers wanting more information and a say in decisions when they were responsible for aftercare, and being concerned about confidentiality of information they provided to services. In conclusion, compulsory admission of a close relative can be a complex and stressful experience for carers.

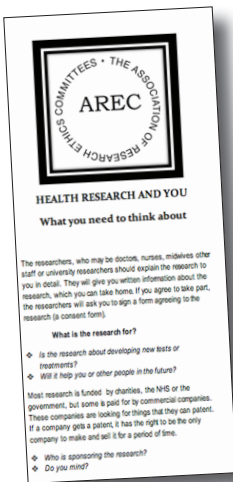
In order for carers to be effective partners in care, a balance needs to be struck between valuing their involvement in providing care for a patient and not overburdening them.

RESEARCH INCORPORATED INTO STANDARD JOB DESCRIPTION

As evidence of the central role research plays in the NHS, from April 2012, the Trust incorporated participation and support of research into all new employment contracts. This isn't really a new requirement, up to now support of research has been implicit in the duty of all staff to follow reasonable management requests; but it does show that the Trust wants to highlight that research forms a core part of what we do and is not to be treated as optional or incremental to our daily work.

AREC PUBLISH UPDATED 'HEALTH RESEARCH AND YOU' LEAFLET

The Association of Research Ethics Committees has started to update and reproduce information sheets. To keep costs to a minimum, and also to try and ascertain the demand for this information, AREC have made the first leaflet 'Health Research and You' available to download from the AREC website. If it



does prove to be popular, they will add 'Medical Research and YOU' and 'Genetic Research and YOU', aiming eventually to provide a dedicated email address for enquiries, as well as audio cassettes. To download a copy, see: <http://www.arec.org.uk/health/>

HEALTH RESEARCH AUTHORITY COMES A STEP CLOSER

An independent review of medical research regulation and governance by the Academy of Medical Sciences, which reported in January 2011, recommended rationalising research regulation into a new arm's length body.

In response, the Health Research Authority (HRA), which will provide a new pathway for the regulation and governance of health research, has now been established as a Special Health Authority with the National Research Ethics Service at its core. The first Board meeting was held on 01 December 2011.

The HRA has a vital role to play in the health research system. Its central purpose is to protect and promote the interests of patients and the public in health research. The aim is to streamline regulation, create a unified approval process, and promote proportionate standards for compliance and inspection within a consistent national system of research governance.

For more visit: www.hra.nhs.uk

Long-Term Impact of War on Healthcare Costs

Exposure to war can negatively affect health and may impact on healthcare costs. Estimating these costs and identifying their predictors is important for appropriate service planning. A study by Sabes-Figuera et al. in *PLoS One* aimed to measure use of health services in an adult population who had experienced war in the former-Yugoslavia on average eight years previously, and to identify characteristics associated with the use and costs of healthcare.

War-affected community samples in Bosnia-Herzegovina, Croatia, Kosovo, FYR Macedonia, and Serbia were recruited through a random walk technique. Refugees in Germany, Italy and the UK were contacted through registers, organisations and networking. Current service use was measured for the previous three months and combined with unit costs for each country for the year 2006/7.

A two-part approach was used, to identify predictors of service use with a multiple logistic regression model and predictors of cost with a generalised linear regression model.

In the Balkan countries, 3,313 participants were interviewed and in Western European countries a further 854 refugees.

Traumatic events and mental health status were related to greater service use in the Balkan countries, while in Western countries these associations were not found. Participants in Balkan countries with post traumatic stress disorder (PTSD) had costs that were 63% higher ($p = 0.005$) than those without PTSD. Distress experienced during the most traumatic war event was associated with higher costs ($p = 0.013$). In Western European countries costs were 76% higher if non-PTSD anxiety disorders were present (0.027) and 63% higher for mood disorders ($p = 0.006$).

War experiences and their effects on mental health are associated with increased health care costs even many years later, especially for those who stayed in the area of conflict. Focussing on the mental health impact of war is important for many reasons including those of an economic nature.



Survivors of the London Bombings with PTSD

After the London bombings on 7 July 2005, trauma-focused cognitive behavioural therapy (TF-CBT) was provided for survivors with posttraumatic stress disorder (PTSD).

A "screen and treat" approach was used. In a study by Wilson et al. in *Traumatology*, the transcripts of 18 audiotaped CBT treatment sessions with these patients were analyzed using the qualitative method of thematic analysis. Interviews comprised participants' direct experiences of the terrorist attack and its impact on their lives.

Themes identified were shock and disorientation, horror, getting out, reorientation and reconnecting with the outside world (on the day of the bombings); and posttraumatic stress and depression, feeling different, and recovery and resilience (following the day of the bombings).

Services may be part of wider political responses to terrorism but this did not preoccupy participants. In CBT, during elaboration of traumatic memories, attention might usefully be paid to clients' experiences of collective action taken during a terrorist attack.

Group music therapy for patients with persistent PTSD

ELFT is committed to strengthening and developing the arts therapies services but further research is needed to underpin the delivery of these services and build an evidence base. A number of treatments are available to treat post-traumatic stress disorder (PTSD), including cognitive behaviour therapy (CBT). However, a small but significant number of people do not respond sufficiently and still have significant symptoms after therapy.

Literature suggests group music therapy might be beneficial in treating PTSD. Patients sometimes perceive talking therapies as distressing and intrusive; whereas music engages people in a perceived safe and enjoyable context, and can be means of motivating and encouraging people to engage in treatment. Observational studies suggest that music therapy can aid unwanted re-experiencing of trauma through its potential to evoke memories and emotional responses providing access for discussion and processing of the past. Active music making on instruments may provide a means of control and self-expression of the traumatic memory without necessarily requiring words. The social process of making music in a group with others may also encourage and aid the building of trust and engagement whilst emotional responses can be experienced and explored.

Despite the promising indications in literature, no research to date has been done to ascertain the effectiveness of music therapy in treating PTSD. A preliminary study by Carr et al. in *Psychology and Psychotherapy* sought to assess whether group music therapy was feasible for patients who did not respond to CBT, and whether it has an effect on PTSD symptoms and depression.

Mixed methods

Mixed methods were used comprising of an exploratory randomized controlled trial, qualitative content analysis of therapy, and patient interviews. Patients who had significant PTSD symptoms following completion of CBT were randomly assigned to treatment or control groups. The patients came from diverse backgrounds and had experienced very different types of trauma. The treatment

group received ten weeks of group music therapy after which exit interviews were conducted. Control group patients were offered the intervention at the end of the study.

Within group music therapy, a wide range of instruments are provided with many requiring little or no prior musical knowledge. A combination of active music making and receptive listening are used, with an emphasis upon the group freely improvising music together. Music therapists support this process both musically and verbally, guiding the musical activities, providing musical support and encouraging verbal reflection on thoughts and feelings arising from the musical



experience. For the purposes of this study, the intervention was manualised, with a particular focus on building trust and safety, offering opportunities for socialisation and support, providing supportive psychotherapeutic interventions and using music to lower anxiety, enhance self-esteem, and alleviate re-experiencing, avoidance, hyperarousal and associated depression.

Treatment-group patients experienced a significant reduction in severity of PTSD symptoms and a reduction in depression. The qualitative findings provided detailed insights into the music therapy processes and subjective experiences of patients. Patients viewed music therapy as helpful and suggested that the group had helped them to feel calmer and more at ease. The social opportunities offered by the group were of particular importance particularly the opportunity to meet others who shared traumatic experiences without having to explicitly speak of this. Instruments were valued for their potential to express emotions and drums appeared to aid expression of anger and frustration. The sound qualities of instruments (particularly high-pitched, sonorous, or loud instruments) were most often cited as unhelpful, and a particular feature of the therapy process was learning to deal

with the conflicts this created within the group. Patients acknowledged the difficulty they had in sharing their traumatic memories, and expressed a wish for the group to have been able to share more of this.

Emotional responses

Patients reported music therapy as a helpful means of emotional expression and regulation. Within this study, patients reported physically tapping rhythms outside of therapy to recall the group's music and self-regulate arousal. Instruments and music eliciting strong emotional responses were quickly identified; the capacity to tolerate particular sound qualities of instruments appears to have played a key role in the music therapy process. Whilst instruments could evoke traumatic memories, patients learned to tolerate, communicate and acknowledge the impact of their instrument upon other group members.

Engagement with music therapy was remarkably high; mean attendance of therapy was seven sessions. This engagement level supports suggestions that music can be enjoyable and motivating (Gold et al., 2009). Patients initially expressed anxiety and fear about what was expected of them, but then moved to describing experiences of safety and calm. Patients were provided with activities that were non-demanding, controlled, boundaried and explicit. Guidance and repetition of structured activities may have reduced initial fears and encouraged habituation to individual sounds. Patients spoke of music providing a point of focus and link to the present which may have enabled patients to associate and incorporate safer memories alongside traumatic memories (Van Der Kolk, 2006).

This small pilot study suggests that group music therapy is feasible and effective for PTSD patients who have not sufficiently responded to CBT. Limitations of the study include the small sample size and lack of blinding. Outcomes could have been achieved through a group effect rather than specifically music therapy. We hope that further research will address these limitations, test sustainability, and identify specific factors that address symptoms in treatment.

OTHER NEWS 2

NEW INVOLVE GUIDANCE FOR RESEARCHERS PUBLISHED

INVOLVE has published a new edition of its Briefing Notes for Researchers to help them involve more members of the public in research. Public involvement in research sits in a changing and evolving environment. There is now a greater commitment to the importance and contribution public involvement can make to research and there are far more organisations and individuals supporting public involvement. There are also many more researchers and research commissioners working alongside the public for the first time. INVOLVE has restructured some of its thinking about the framework for public involvement in research. In the past they had used the terms consultation, collaboration and user controlled to describe different levels of involving people in research. Over time it has become clear that in practice researchers can use a combination of these three and it is more helpful to describe them as approaches rather than levels.

This new publication provides an introduction for those new to public involvement in research.

However, it will also be of interest to researchers with experience of public involvement who are looking to update and refresh their knowledge and skills and helpful to others interested in public involvement in research. There is information on why members of the public should be involved in research, how to involve members of the public and the different ways people can be involved in the stages of the research cycle.

The briefing notes are part of a larger online resource that will be developed to include more detailed information, examples and templates. For further details and the new guidance see: <http://www.invo.org.uk/resource-centre/resource-for-researchers>

EU UMBRELLA ORGANIZATIONS CALL FOR A CONCRETE EU-LEVEL ACTION FOR BETTER ADHERENCE TO THERAPIES

In a lunch debate held at the European Parliament in Brussels EPF, CPME, PGEU and EFPIA brought together perspectives of patients, doctors, community pharmacists and the research-based pharmaceutical industry presenting examples of best practices on adherence to therapies and demonstrating how a coordinated, multi-stakeholder and patient-centred approach – involving patients, their carers/families, health professionals, industry, and the public, is a key factor in improving patient safety and the quality of healthcare tailored to patients' needs. Further information can be accessed at: <http://www.efpia.eu/content/default.asp?PageID=559&DocID=12037>

NEW NIHR HEALTH SERVICES & DELIVERY RESEARCH PROGRAMME

From January 2012 the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme will be merging to create a new National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) programme. The HS&DR programme will fund high-quality research on themes relating to the delivery of health services. It will build on the strengths and contributions of the SDO and HSR programmes.

The programme will aim to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes.

There will be more funding opportunities because the new programme's remit will include research on implementation, as well as the themes of its predecessor programmes. It will support ambitious evaluative research to improve health services and commission work, and fill strategic gaps in the joint portfolio of the SDO and HSR programmes.

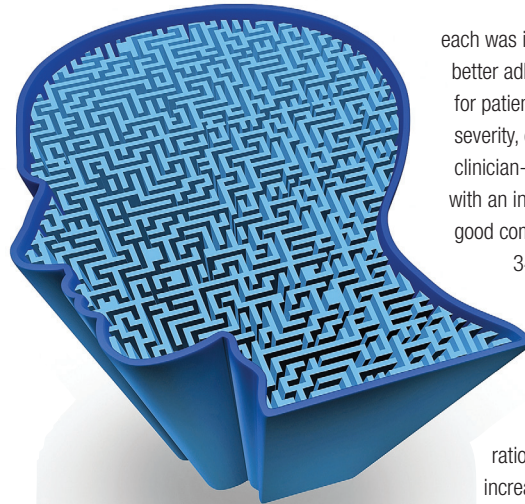
For more information please visit www.netsc.ac.uk

The Therapeutic Relationship and Adherence to Antipsychotic Medication in Schizophrenia

Previous research has shown that a better therapeutic relationship (TR) predicts more positive attitudes towards antipsychotic medication, but did not address whether it is also linked with actual adherence.

In a European multi-centre study (McCabe et al in *PLoS One*) of 134 clinicians and 507 of their patients with schizophrenia or a related psychotic disorder, a logistic regression model examined how the TR as rated by patients and by clinicians is associated with medication adherence, adjusting for clinician clustering and symptom severity.

The study found that patient and clinician ratings of the TR were weakly inter-correlated ($r_s = 0.13, p = 0.004$), but



each was independently linked with better adherence. After adjusting for patient-rated TR and symptom severity, each unit increase in clinician-rated TR was associated with an increase of the odds ratio of good compliance by 65.9% (95% CI: 34.6% to 104.5%).

After adjusting for clinician-rated TR and symptom severity, for each unit increase in patient-rated TR the odds ratio of good compliance was increased by 20.8% (95% CI: 4.4% to 39.8%).

Based on these results, it appears that a better TR is associated with better adherence to medication among patients with schizophrenia. Patients' and clinicians' perspectives of the TR are both important, but may reflect distinct aspects.



NHS R&D APPLICATIONS CREATED BEFORE IRAS V3.3 AND PROCESSED VIA NIHR CSP – CHANGE TO SUBMISSION PROCESS

The process for submission of applications for NHS permission processed via the NIHR Coordinated System for gaining NHS permission (NIHR CSP) has been changed for NHS R&D applications in projects created in IRAS before IRAS v3.3 (i.e. before 18 July 2011).

Previously, the application form was electronically submitted from IRAS and supporting documentation was emailed. Now PDF and XML versions of the application form must be created in IRAS and submitted by email along with supporting documentation to the NIHR CSP Unit.

Applicants are strongly advised to refer to the guidance provided on the submission tab for these forms.

Projects created since IRAS v3.3 are unaffected by this change, which is part of the rollout of a new system for the processing of applications for NHS R&D permission via NIHR CSP. Please direct any queries about this process to crncc.csp@nihr.ac.uk

Symptom levels and initial appraisal of hospital treatment in patients with schizophrenia

The initial appraisal of treatment by inpatients with schizophrenia has been found to be a significant predictor of clinical outcomes. A paper by Savill et al. in *Psychiatry Research* aimed to examine whether specific types of symptoms are associated with the initial appraisal of treatment after controlling other patient characteristics. Data of 2105 inpatients with schizophrenia (ICD-10 F20-9) were pooled from three national and international multi-centre studies.

Patients were interviewed within the first week of their inpatient admission.

Higher levels of manic and positive symptoms were significantly associated with a less favourable initial appraisal of treatment, whilst no association was found with depression/anxiety and negative symptoms. Detained patients had more negative initial treatment appraisals, and the association with manic symptoms was significantly stronger in detained patients compared to those admitted voluntarily.

Whilst patient-reported outcomes in psychiatry are usually associated with mood symptoms, this appears not to be the case for the initial appraisal by inpatients with schizophrenia. The association with manic and positive symptoms may be explained by the influence of such symptoms on the hospital experience. Focusing on the initial management of mania and positive symptoms might improve patients' appraisal of treatment in the inpatient environment.

Testing the Psychopathology of Psychosis

Psychiatric taxonomists have sometimes argued for a unitary psychosis syndrome and sometimes for a pentagonal model, including five diagnostic constructs of positive symptoms, negative symptoms, cognitive disorganization, mania, and depression. This continues to be debated in preparation for impending revisions of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. In a paper by Reininghaus et al in *Schizophrenia Bulletin*, the authors aimed to identify general and specific dimensions underlying psychopathological features of psychosis.

The samples comprised 309 patients admitted to psychiatric services in the acute phase of their first or second episode of psychosis and 507 patients with enduring psychosis recruited from community mental health teams.

Patients' symptoms were assessed on the Positive and Negative Symptom Scale. Analyses compared unitary, pentagonal, and bifactor models of psychosis.

In both samples, a bifactor model including one general psychosis factor and, independently, five specific factors of positive symptoms, negative symptoms, disorganization, mania, and depression gave the best fit. Scores of general and specific symptom dimensions were differentially associated with phase of illness, diagnosis, social functioning, insight, and neurocognitive functioning.

The findings provide strong evidence for a general psychosis dimension in both early and enduring psychosis. Findings further allowed for independent formation of specific symptom dimensions. This may inform the current debate about revised classification systems of psychosis.

Upcoming Events

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 more information, call Carolanne Ellis on 020 7540 4210.

Date	Title	Presented by
3 September	<i>Symptoms and quality of life in severe mental disorders</i>	Domenico Giacco
10 September	<i>Modelling of group music therapy for acute adult psychiatric inpatients</i>	Catherine Carr
17 September	<i>Institutional care</i>	Winnie Chow
24 September	<i>The EPOS trial</i>	Domenico Scaringi
1 October	<i>Research programme on housing services for people with mental disorders</i>	tb
8 October	<i>Investigating the relationship between changes in self-harm and clinical symptoms associated with BPD</i>	Nyla Bhatti
15 October	<i>Nonverbal communication in schizophrenia</i>	Mary Lavelle
22 October	<i>Quality of life after experiences of war</i>	Aleksandra Matanov
29 October	<i>Process research in psychotherapy for BPD</i>	Kirsten Barnicot
5 November	<i>Measuring social contacts in mental health</i>	Claudia Palumbo
12 November	<i>NESS – Body psychotherapy in the treatment of negative symptoms of schizophrenia</i>	Mark Savill

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.

- Aslam R W & Bhui K (2012) *Parity of Esteem as a guiding principle for commissioning, service provision and laws related to health care: what do we know.* **Ethn Health.** 17(1-2): 13-15.
- Bache RA, Bhui K S, Dein S & Korszun A (2012) *African and Black Caribbean origin cancer survivors: a qualitative study of the narratives of causes, coping and care experiences.* **Ethn Health.** 17(1-2): 187-201.
- Barnicot K, Katsakou C, Bhatti N, Savill M, Fearn N, Priebe S (2012) *Factors predicting the outcome of psychotherapy for borderline personality disorder: a systematic review.* **Clinical Psychology Review.** 32:400-412 [doi: 10.1016/j.cpr.2012.04.004]
- Barr W, Brown A, Quinn B, McFarlane J, McCabe R & Whittington R (2012) *How effective is high-support community-based step-down housing for women in secure mental health care? A quasi-experimental pilot study.* **J Psychiatr Ment Health Nurs.** [Epub ahead of print]
- Bhui K & Harding S (2012) *Editors' foreword.* **Ethn Health.** 17(1-2): 1-2.
- Bhui KS, Dinos S & McKenzie K (2012) *Ethnicity and its influence on suicide rates and risk.* **Ethn.Health.** 17(1-2): 141-148.
- Bhui KS, Hicks MH, Lashley M & Jones E (2012) *A public health approach to understanding and preventing violent radicalisation.* **BMC Med.** 10(1): 16.
- Bhui KS, Lenguerrand E, Maynard MJ, Stansfeld SA & Harding S (2012) *Does cultural integration explain a mental health advantage for adolescents?* **Int J Epidemiol.** [Epub ahead of print]
- Bhui KS, Mohamad S, Warfa N, Curtis S, Stansfeld S & Craig TJ (2012) *Forced residential mobility and social support: impacts on psychiatric disorders among Somali migrants.* **BMC Int Health Hum Rights.** 12(1): 4.
- Bhui K, Ascoli M & Nuamh O (2012) *The place of race and racism in cultural competence: What can we learn from the English experience about the narratives of evidence and argument?* **Transcult Psychiatry.**
- Bogic M, Ajdukovic D, Bremner S, Franciskovic T, Galeazie GM, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schützwohl M, Wang D, Priebe S (2012) *Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK.* **British Journal of Psychiatry.** 200:216-223. [doi: 10.1192/bjp.bp.110.084764]
- Bowers L, Ross J, Owiti J, Baker J, Adams C & Stewart D (2012) *Event sequencing of forced intramuscular medication in England.* **J Psychiatr Ment Health Nurs.** [Epub ahead of print]
- Brugha TS, Taub N, Smith J, Morgan Z, Hill T, Meltzer H, Wright C, Burns T, Priebe S, Evans J, Fryers T (2012) *Predicting outcome of assertive outreach across England.* **Social Psychiatry and Psychiatric Epidemiology,** 47:313-322. [doi: 10.1007/s00127-010-0338-4]
- Campbell T, Griffiths J, Sambath A & O'Connell (2012) *A review of referrals and uptake of service for psychological support in an HIV treatment centre.* **HIV Medicine.** 13(Suppl 1): 24.
- Campion J, Bhui K & Bhugra D (2012) *European Psychiatric Association (EPA) guidance on prevention of mental disorders.* **Eur Psychiatry.** 27(2): 68-80.
- Carr C, d'Ardenne P, Sloboda A, Scott C, Wang D, Priebe S (2012) *Group music therapy for patients with persistent post-traumatic stress disorder – an exploratory randomized controlled trial with mixed methods evaluation.* **Psychology and Psychotherapy: Theory, Research and Practice.** 85:179-202. [doi:10.1111/j.2044-8341.2011.02026.x]
- Clark C, Head J & Stansfeld S (2012) *The long-term effects of aircraft noise exposure on children's cognition: findings from the UK RANCH follow-up study.* **J Acoust Soc Am.** 131(4): 3508.
- Das-Munshi J, Leavey G, Stansfeld SA & Prince MJ (2012) *Migration, social mobility and common mental disorders: critical review of the literature and meta-analysis.* **Ethn Health** 17(2): 17-53.
- Dauvrin M, Lorant V, Sandhu S, Deville W, Dia H, Dias S, Gaddini A, Ioannidis E, Jensen NK, Kluge, U, Mertaniemi R, Puigpinos i Riera R, Sarvary A, Straßmayr C, Mindaugas S, Soares JF, Welbel M, Priebe S (2012) *Health care for irregular migrants: pragmatism across Europe. A qualitative study.* **BMC Research Notes,** 5(1): 99 (Open Access). [doi:10.1186/1756-0500-5-99]
- Devasahayam A, Lawn T, Murphy M & White PD (2012) *Alternative diagnoses to chronic fatigue syndrome in referrals to a specialist service: service evaluation survey.* **JRSM Short Rep.** 3(1): 4.
- 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 (2012) *Stressful life events and the serotonin transporter gene (5-HTT) in recurrent clinical depression.* **J Affect Disord.** 136(1-2): 189-193.
- Freestone M, Taylor C, Milsom S, Mikton C, Ullrich S, Phillips O & Coid J (2012) *Assessments and*

Continued on page 8

Recent Publications Continued

Continued from page 7

admissions during the first 6 years of a UK medium secure DSPD service. **Crim Behav Ment Health.** 22(2): 91-107.

■ Gregoire SM, Smith K, Jager HR, Benjamin M, Kallis C, Brown MM, Cipolotti L & Werring DJ (2012) *Cerebral Microbleeds and Long-Term Cognitive Outcome: Longitudinal Cohort Study of Stroke Clinic Patients.* **Cerebrovasc Dis.** 33(5): 430-435.

■ Henderson M, Richards M, Stansfeld S & Hotopf M (2012) *The association between childhood cognitive ability and adult long-term sickness absence in three British birth cohorts: a cohort study.* **BMJ Open.** 2(2): e000777.

■ Hogwood J, Campbell T & Butler S (2012) *I wish I could tell you but I can't: Adolescents with perinatally acquired HIV and their dilemmas around self-disclosure.* **Clinical Child Psychology and Psychiatry** [doi: 10.1177/1359104511433195]

■ Kandaswamy R, McQuillin A, Curtis D, Gurling H (2012) *Tests of linkage and allelic association between markers in the 1p36 PRKCZ (Protein Kinase C Zeta) gene region and bipolar affective disorder.* **Am J Med Genet B Neuropsychiatr Genet** 159B(2): 201-9.

■ Keers R & Uher R (2012) *Gene-environment interaction in major depression and antidepressant treatment response.* **Curr Psychiatry Rep.** 14(2): 129-137.

■ Lee T, Ellingford C, Blackburn S, Bishop E, Ragiadacos N, Elcock P & Bhui K (2012) *Selecting staff for a personality disorder service: report from the field.* **The Psychiatrist** 36: 50-54

■ Loos S, Kilian R, Becker T, Janssen B, Freyberger H, Spiessl H, Grempler J, Priebe S, Puschner B (2012) *Psychometric properties of the German version of the scale to assess the therapeutic relationship in community mental health care (D-STAR).* **European Journal of Psychological Assessment** [Epub ahead of print, doi: 10.1027/1015-5759/a000105]

■ Massey LA, Micallef C, Paviour DC, O'Sullivan SS, Ling H, Williams DR, Kallis C, Holton JL, Revesz T, Burn DJ, Youstry T, Lees AJ, Fox NC & Jager HR (2012) *Conventional magnetic resonance imaging in confirmed progressive supranuclear palsy and multiple system atrophy.* **Mov Disord.** [Epub ahead of print]

■ McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinez-Leal R, Rössler W, Salize HJ, Svensson B, Torres-Gonzalez F, van den Brink R, Wiersma D, Priebe S (2012) *The therapeutic relationship and adherence to antipsychotic medication in schizophrenia.* **PLoS One.** 7: e36080 (Open Access). [doi:10.1371/journal.pone.0036080]

■ Nicaise P, Tulloch S, Dubois V, Matanov A, Priebe S, Lorant V (2012) *Using social network analysis for assessing mental health and social service inter-organisational collaboration: Findings in deprived areas in Brussels and London.* **Administration and Policy**

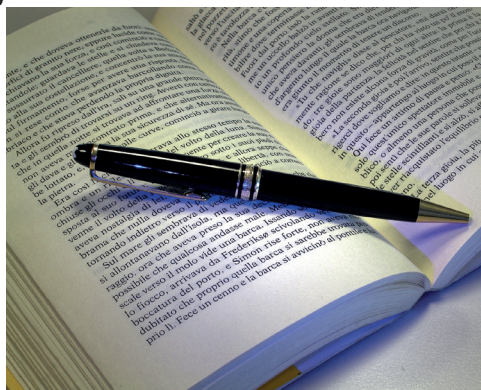
in Mental Health and Mental Health Services Research. [Epub ahead of print, doi: 10.1007/s10488-012-0423-y]

■ Owiti J & Bhui KS (2012) *The reciprocal relationship between physical activity and depression in older European adults.* **Evid Based Nurs.** [Epub ahead of print]

■ Palazidou E (2012) *The neurobiology of depression.* **Brit Med Bull** 101(1): 127-145.

■ Piquero AR, Farrington DP, Fontaine N, Vincent G, Coid J, Ullrich S (2012) *Childhood Risk, Offending Trajectories, and Psychopathy at Age 48 Years in the Cambridge Study in Delinquent Development.* **Psychology, Public Policy, and Law**, doi: 10.1037/a0027061

■ Priebe S (2012) *Wo ist der fortschritt? (Where is the progress?).* **Psychiatrische Praxis**, 39(2): 55-56 [doi: 10.1055/s-0031-1298907]



■ Priebe S, Matanov A, Barros H, Canavan R, Gabor E, Greacen T, Holcnerová P, Kluge U, Nicaise P, Moskalewicz J, Diaz-Olalla JM, Straßmayr C, Schene AH, Soares JF, Tulloch SA (2012) *Mental health-care provision for marginalized groups across Europe: findings from the PROMO study.* **The European Journal of Public Health** [Epub ahead of print, doi:10.1093/eurpub/ckr214]

■ Priebe S, Matanov A, Schor R, Straßmayr C, Barros H, Barry MM, Diaz-Olalla JM, Gabor E, Greacen T, Holcnerová P, Kluge U, Lorant V, Moskalewicz J, Schene AH, Macassa G, Gaddini A (2012) *Good practice in mental health care for socially marginalised groups in Europe: a qualitative study of expert views in 14 countries.* **BMC Public Health**, 12(1): 248 (Open Access). [doi: 10.1186/1471-2458-12-248]

■ Reininghaus U, McCabe R, Burns T, Croudace T, Priebe S. (2012) *The validity of subjective quality of life measures in psychotic patients with severe psychopathology and cognitive deficits: an item response model analysis.* **Quality of Life Research**, 21(2): 237-246.

■ Reininghaus U, Priebe S, Bentall RP (2012) *Testing the psychopathology of psychosis: Evidence for a general psychosis dimension.* **Schizophrenia Bulletin** [Epub ahead of print, doi:10.1093/schbul/sbr182]

■ Röhrich F, Gadhia S, Alam R & Willis M (2012) *Auditing Clinical Outcomes after Introducing Off-Licence Prescribing of Atypical Antipsychotic Melperone for Patients with Treatment Refractory*

Schizophrenia. **Scientific World Journal** [doi:10.1100/2012/512047]

■ Sabes-Figuera R, McCrone P, Bogic M, Ajdukovic D, Franciskovic T, Colobini N, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schützwahl M, Priebe S (2012) *Long-term impact of war on healthcare costs: An eight-country study.* **PLoS One**, 7(1): e29603 (Open Access). [doi:10.1371/journal.pone.0029603]

■ Savill M, Jankovic J, Katsakou C, Kallert T, Priebe S (2012) *Symptom levels and initial appraisal of hospital treatment in patients with schizophrenia.* **Psychiatry Research** [Epub ahead of print, http://dx.doi.org/10.1016/j.psychres.2012.04.011]

■ Stansfeld S & Clark C (2012) *Future environmental noise and health research needs for policy.* **J Acoust Soc Am.** 131(4): 3295.

■ Stansfeld S (2012) *The complexity of explaining ethnic differences in suicide and suicidal behaviours.* **Ethn Health.** 17(1-2): pp. 3-6.

■ Straßmayr C, Matanov A, Priebe S, Barrow H, Canavan R, Diaz-Olalla JM, Gabor E, Gaddini A, Greacen T, Holcnerová P, Kluge U, Welbel M, Nicaise P, Schene AH, Soares JF, Katschnig H (2012) *Mental health care for irregular migrants in Europe: Barriers and how they are overcome.* **BMC Public Health**, 12:367 (Open Access). [doi:10.1186/1471-2458-12-367]

■ van Kempen E, Fischer P, Janssen N, Houthuijs D, van Kl, Stansfeld S & Cassee F (2012) *Neurobehavioral effects of exposure to traffic-related air pollution and transportation noise in primary schoolchildren.* **Environ Res** [Epub ahead of print]

■ Virtanen M, Stansfeld SA, Fuhrer R, Ferrie JE & Kivimaki M (2012) *Overtime Work as a Predictor of Major Depressive Episode: A 5-Year Follow-Up of the Whitehall II Study.* **PLoS One.** 7(1): e30719.

■ Weich S, Griffith L, Commander M, Bradby H, Sashidharan SP, Pemberton S, Jasani R & Bhui KS (2012) *Experiences of acute mental health care in an ethnically diverse inner city: qualitative interview study.* **Soc Psychiatry Psychiatr Epidemiol.** 47(1): 119-128.

■ White PD & Chalder T (2012) *Chronic fatigue syndrome: treatment without a cause.* **Lancet.** 379: 1372-1373.

■ Wilson N, d'Ardenne P, Scott C, Fine H, Priebe S (2012) *Survivors of the London Bombings with PTSD: A qualitative study of their accounts during CBT treatment.* **Traumatology** [Epub ahead of print, doi: 10.1177/1534765611426793]

■ Windsor RE, Strauss SJ, Kallis C, Wood NE & Whelan JS (2012) *Germline genetic polymorphisms may influence chemotherapy response and disease outcome in osteosarcoma: A pilot study.* **Cancer.** 118(7): 1856-1867.

■ Zavos HM, Wong CC, Barclay NL, Keers R, Mill J, Rijdsdijk FV, Gregory AM & Eley TC (2012) *Anxiety Sensitivity in adolescence and young adulthood: the role of stressful life events, 5HTTLPR and their interaction.* **Depress Anxiety.** [Epub ahead of print].