R&Dnewsletter

East London **NHS**
NHS Foundation Trust

What is meant by reciprocity in professional – service user relationships?

By **Sima Sandhu**, Postdoctoral Research Assistant, Unit for Social & Community Psychiatry

Reciprocity is the process of giving and taking and has long been recognised as a part of all human interactions. We exchange emotions and services with each other all of the time and this is an inherent part of human life. However, when it comes to reciprocity in professional helping relationships the traditional view has been unidirectional, insofar as the professional receives payment in order to provide care to service users (also known as the 'care contract'). However, there is evidence to suggest that the relationship between professionals and service users is a more complex array of exchanges, and it may be more reciprocal than originally considered.

In previous work on resource oriented models, we know that peer-support and group therapeutic approaches encompass reciprocal helping relationships, in which equality and shared experiences are particularly important. However, the reciprocity in traditional professional – service user relationships has not been explored. Given that service have tended to move towards more collaborative approaches between service users and professional in the delivery of care, we wanted to explore what does reciprocity mean in professional – service user relationships?

In order to address this question, we conducted a conceptual review (recently published online in the *International Journal of Mental Health Nursing*) to understand how the concept of reciprocity applies to professional – service user relationships. We conducted a systematic search of six bibliographic databases and tracked citations of relevant articles. To analyse the papers we found to be relevant to professional therapeutic relationship we conducted a narrative synthesis, a systematic method used to seek out the common themes is relation to reciprocity.

Our systematic search identified 11 papers where reciprocity has been used to describe the relationship between mental health professionals and service users. Most of these papers were based on qualitative studies that included both the professional and service user's experiences, or from the perspective of one or the other. The narrative synthesis led to the identification of four broad themes on reciprocity between professionals and service users: dynamic equilibrium, shared affect, asymmetric alliance, and recognition as a fellow human being.

In essence, reciprocity was conceptually understood as the presence of shared interactions or shared exchanges, where the professional and service user behave and respond to each other. Both parties may not have the same understanding or experience of the exchange at any given moment, but they maintain engaged in the interaction with awareness of the other, whilst meeting their own personal needs as professional and service user. The shared affect in the reciprocal relationship entailed a balanced approach to emotional involvement by having as much concern for oneself as for the other, but also maintaining a distinct sense of self from the other at the same time. Reciprocity was distinct from peer and group therapeutic relationships because of the asymmetric alliance of one being the care giver and the other being the care recipient. However, key to the reciprocity in the professional – service user relationship was the recognition of each other as a fellow human being, with the same value and rights to promote their own interests and to share experiences, and this reduced the asymmetry in the relationship.

These findings highlighted that reciprocity exists in professional – service user relationships and depends on the roles and goals of professionals and service users, which are distinct and somewhat separate. However, there was a level of interdependence in these relationships with one relying on the other in order to have their needs fulfilled, professionally or personally. Furthermore, recognising each other as fellow human beings within a professional - service user relationship does not require a 'like for like' exchange in terms of resources given or received because of the bounded nature of the reciprocal relationship. The equality in these reciprocal relationships comes from respect for the fellow human being, as much as the asymmetric alliance between two parties that share trust, decisions, and obligations in professional-guided services.

Streetwise; using serious gaming to support preparation for discharge from secure forensic mental health services

By **Dr Lisa Reynolds**,
Divisional Lead, Nursing Division,
City University School of Health Sciences

Users of Forensic Mental Health Services are largely detained under the Mental Health Act 2007 and often have a history of offending that is considered to mean that they present a risk to the public. Forensic mental health services aim to work with the service user to promote recovery and the self-management of risk and mental health problems. However, whilst detained within a secure setting Forensic mental health service users' opportunities to prepare for independent living are limited by the separation from their local community.

An innovative approach was taken to enable service users to bridge this gap and develop their skills and confidence in preparation for discharge whilst detained within a secure setting. This involved the development of a serious game where service users could safely rehearse responses to situations and develop skills within a simulated environment.

A serious game is a computer game that has been developed for education or skills development rather than for the purpose of entertainment. Serious games use virtual environments for exploration, role play and problem solving, where real life rehearsal may not be possible or practicable. For example serious games have been used to enable the rehearsal of the management of emergencies such as floods, and to practice skills such as flying a plane.

Serious games have been used in health care settings before, but have not previously been used within forensic mental health services. As this was a novel approach, a small scale feasibility study was undertaken, to ascertain whether serious gaming would be suitable within a secure forensic environment.

In our feasibility study (Hodge et al, Procedia Computer Science), we aimed to develop and test the acceptability and usability of a serious game to support forensic mental health service users within one low secure forensic rehabilitation service with

their preparation for discharge from secure forensic mental health services back to the community.

Forensic mental health service users who were expected to be discharged from the forensic services within six months were recruited to take part in the study. A production group of 8 service user participants, researchers and a games developer was formed, which then co-produced a prototype serious game. The prototype game was then trialled by a second group of service users who also participated in an evaluation of the game, and their views sought on the acceptability of the game for use in forensic mental health services.

The game was based on real life situations and used dialogue and an environment that was drawn from the experiences of service user participants. The game was named Streetwise (http://streetwise. website/) by the service user participants, as they felt that it enabled them to think about how to address some of the challenges that they face in the community.

Eight service providers; nurses, doctors, managers, psychologists and therapists were interviewed and asked for their views as to how acceptable they thought it would be to use a serious game within forensic mental health care.

Overall the game was well received by service user and provider participants. The themes that emerged from the interviews and evaluation group were the importance of the game being realistic, the opportunity to develop skills, and support for therapeutic rehabilitation. In regards to the usability of the game the participants noted the importance of having realistic dialogue, but were divided on whether the game should include scoring, as it was felt this may lead to superficial engagement to achieve the score that was felt was needed. However others felt that having a score would motivate service users to continue to engage with the game. Additional comments included the need for written instructions and text on the screen as well as spoken word. Participants also highlighted the different ways that the game may be used to support existing therapies, with consensus that the game should be integrated with existing therapy rather than being used as a standalone intervention.

This study has demonstrated the feasibility of using a serious game within forensic mental health services. The next step is to seek additional funding to further develop and trial the game; and to explore how the game might best be used to augment existing therapeutic work.

The study was funded by the School of Health Sciences City University London and was conducted in collaboration between the university and East London NHS Foundation Trust.

■ For further information about the study please contact Lisa Reynolds. l.reynolds@city.ac.uk

OTHER NEWS

NEW WEBSITE FOR NIHR HORIZON SCANNING RESEARCH & INTELLIGENCE CENTRE (HSRIC)

The NIHR HSRIC, supplier of information about new and emerging health technologies to the NHS and NIHR research programmes, has launched a new website: www.hsric.nihr.ac.uk. The website has been completely redesigned with three aspirations; functionality, usability and effortless searching. The new design with its fully searchable technology database means that users can benefit from a richer online experience that is easier to navigate and share with others. The website continues

to provide free access to all NIHR HSRIC reports on new and emerging health technologies, in-depth identification reviews and research papers. If you have previously received NIHR HSRIC content via an RSS feed you will have to re-set the feed from the new website.

ANNUAL EAST LONDON RESEARCH PRESENTATION DAY

The Trust's 13th Annual East London Mental Health Research Presentation Day took place on 7 October 2015 in the Robin Brooks Centre at Barts Hospital; the event was open to all Trust staff and was well attended by staff, trainees, and representatives from the Governors' Council. The format of the day was a series

of very brief presentations on a wide range of research projects being conducted in the Trust. Attendees were able to get information about 14 different projects, ranging from epidemiological studies to clinical trials and qualitative work. Feedback from the day was overwhelmingly positive: The event was "inspiring and motivating", "very informative and engaging", and showcased the "excellent quality of research". It was "great to network" and "a buzz to see the enthusiasm of the presenters". "What an impressive event! … Wonderful to see such disciplined, succinct presentations on such a wide variety of issues." "Interesting and appropriate to non-mental health organisations as much as MH focused." "Brilliant. Carry on researching"

HRA Approval is coming!

HRA Approval is the new approval that will be required for research to commence in the NHS in England. It is a new process that comprises a review by a Research Ethics Committee as well as an assessment of regulatory compliance and related matters undertaken by staff of the Health Research Authority (HRA) located in centres around England.

Although HRA Approval will include a study-wide review in line with the UK-wide agreed standards, the assessment will go beyond this to include new standards and assurances; for example, assessment will include the co-ordination of clinical support assurances for pharmacy and radiation.

HRA Approval will support and complement local processes relating to assessing, arranging and confirming local capacity and capability to undertake the study. When HRA Approval is in place and local capacity and capability confirmed, sites will be able to confirm with the sponsor their readiness to recruit and the study will start at the site.

What difference will it make?
The idea is that new system will simplify the approvals process for research, making it easier for research studies to be set up.

HRA Approval will be a formal approval of research for the whole NHS in England. It will not mean that NHS organisations will be required to

participate in studies where they are named as potential sites, but it does mean that the decision to participate will be made on local consideration of capacity and capability alone. It will provide an authoritative assurance to NHS organisations about the suitability, compliance and quality of research proposals. This will also provide a foundation for the implementation of the new European Clinical Trials Regulations in 2016-17.

When will this happen?
The phased roll-out of HRA Approval started in May 2015 included only studies limited to NHS staff which does not require review by an NHS Research Ethics Committee. The second cohort started in early August 2015 and included studies taking place in primary care independent contractor settings only.

As of December 2015, HRA Approval will be extended to studies which are not clinical trials or clinical investigations. The fourth cohort (date to be announced) will cover all study types including clinical trials or clinical investigations except studies solely for educational purposes and those undertaken at a single site where that site is also the

sponsor of the study which will only be included after full evaluation of the earlier cohorts.

What will a valid application look like?
A valid application for HRA Approval will look similar to the current REC and R&D applications. A form will be submitted electronically in IRAS alongside a checklist of documents required for the governance assessment and ethical review.

An application will be validated in very much the same way as current REC applications are. Once it has been submitted electronically in IRAS, the HRA will work to a Standard Operating Procedure (SOP) for validation and will give a response within a specified number of days. Validation will be carried out by HRA staff.

Further Information is available on the HRA website – www.hra.nhs.uk – including:
- Guidance for applicants applying for HRA Approval
- Guidance for NHS organisations

If you wish to subscribe to HRA communications, please email hra.comms@nhs.net or follow them on Twitter @HRA_Latest

OTHER NEWS

ORCID ID NOW MANDATORY FOR NIHR PERSONAL AWARD APPLICATIONS

From 23 September 2015 a digital identifier that distinguishes researchers – an ORCID iD – became mandatory for all new NIHR personal award applications. An ORCID iD is a Uniform Resource Identifier (URI) containing a unique 16-digit number, which is available to researchers through registering on the Open Researcher and Contributors ID (ORCID) repository; an open, not-for-profit, community-driven initiative to resolve authorship confusion in scholarly work. Researchers can use this unique identifier to correctly distinguish their publications and other research activities from others who may have the same, or similar, name. THE NIHR believes that making the ORCID iD mandatory will introduce valuable distinguishable information and increase the effectiveness and accuracy of the analysis of outputs in order to demonstrate the impact of NIHR research. In the longer term, with the introduction of functionality to enable information to pass between the NIHR's own information systems and ORCID, the NIHR will be able to reduce the administrative burden for researchers having to fill in the same information in multiple locations for applications and reports.

Are helpful treatments for PTSD available in Europe?

By **Dr Domenico Giacco**,
Senior Lecturer – Research Fellow,
Unit for Social & Community Psychiatry

Posttraumatic stress disorder (PTSD) is a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock. It may involve a constant state of severe anxiety, disturbance of sleep and constant vivid recall of the traumatic experience, and dulled responses to others and to the outside world.

PTSD is frequent, with 2% of people living in Europe experiencing this disorder at some point in their life. There are a number of interventions that can reduce psychological distress in patients with PTSD. They include pharmacotherapy, psychoeducation, cognitive-behavioural therapy (CBT) as well as some therapies developed specifically for PTSD, such as eye movement desensitization (EMDR) and reprocessing, stress management and group trauma-focused CBT. However, it remains unclear whether these helpful treatments are available in countries across Europe and if mental health care professionals receive training that would enable them to provide these interventions.

This was explored in a survey (Koelkebeck et al, Eur J Psychotraumatol.) encompassing 23 European countries. We wanted to know: (1) whether evidence-based interventions are available in the majority of centres in each country; and (2) whether training options in PTSD treatment are included in national training curricula and if so, in what form.

Pharmacological interventions were the most frequently available treatment for PTSD across European countries. Psychoeducation was widely available in more than 50% of the countries, whilst CBT and other specific interventions (EDMR, stress management and trauma-focused CBT) were most often provided only in specialised centres.

National guidelines for treatment of PTSD were available in 11 countries (47.8%). Their impact on practice was considered as "high" in only four countries (Croatia, Netherlands, Romania, and Switzerland). Training was provided in the majority of countries in the form of theoretical seminars (43.5%), discussion of clinical cases (39.1%), individual supervision (30.4%), group supervision (13.0%) and continuing medical education (CME) courses (21.7%).

The reasons for a poor implementation of evidence-based practice (more than one answer was possible) were: lack of funding (34.7%), lack of expertise in the country (34.7%), poor recognition and identification of PTSD by psychiatrists (13.1%) and problems with organization of mental health care (31.1%). Four experts did not report problems in implementation in their countries (Finland, Germany, Portugal and Romania). A wider availability of training options for PTSD treatments outside specialized centres was given mostly in a few Western European countries (Finland, Germany, Netherlands and Malta) and in Serbia.

The data gathered in this survey represent a snapshot of the current provision of helpful treatments for PTSD and of their presence in national training curricula in European countries. Our findings emphasize the need for strategies to increase the availability and training of professional on interventions for PTSD in European countries, especially in Eastern Europe.

A lack of funding and lack of expertise in the countries were the most common reasons given for lack of availability of evidence-based practices. Even when training was available in national training curricula, it was mainly based on theoretical seminars. In only 30% of the countries, CME initiatives on PTSD treatment were offered.

These findings echo previous studies, which emphasize major differences in psychiatric training curricula across Europe and clearly demand for improvement.

Theoretical seminars are not enough to facilitate the development of expertise in clinical practice. Training curricula should involve not only formal lectures but also interactive workshops as well as procedures to validate and monitor practice.

The availability of treatments for PTSD may be increased by initiatives on a European-wide level. Some initiatives are already offered. Examples are the Certificate in Psychotrauma and the European Network for Traumatic Stress of the European Society for Traumatic Stress Studies or the European Guideline for Target Group-Oriented Psychosocial Aftercare. "Summer schools" using a successful model adopted by the European Psychiatric Association might act as models for cross-European training initiatives. Potential language barriers could be overcome if similar approaches were implemented on national levels in the language of the host countries. Internet-based training and training of national trainers may also be viable strategies.

In conclusion, the availability of treatments for PTSD within mental health care services needs to be increased. Ensuring that the highest standard of training on PTSD treatment is part of national psychiatric curricula is an important factor in increasing availability of helpful interventions. Lack of trained professionals may reduce the likelihood of PTSD detection and limit the provision of helpful treatments to specialized centres, limiting access of patients with PTSD to appropriate care.

City/ELFT researchers at 21st International Network of Psychiatric Nursing Research Conference

Researchers from the Centre for Mental Health Research at City University London and East London NHS Foundation Trust organised innovative workshops and spoke about their research at the recent Network for Psychiatric Nursing Research (NPNR) conference.

Running every year, the NPNR is an international network for psychiatric nursing research attracting mental health nurses, researchers, academics, professionals and service users from around the world. The NPNR is administered by the Royal College of Nursing and Mental Health Nurse Academics UK.

As part of the event, the SUGAR (Service User & Carer Group Advising on Research) team, developed and ran an interactive workshop which was delivered by service users and carers and facilitated by Dr Julia Jones, to explore the benefits and challenges of working collaboratively with service users and carers from the very beginning of a research project.

Drawing on the format of Dragons' Den, a popular BBC TV show, NPNR delegates were asked to propose a research idea that they would like to discuss with members of SUGAR in the workshop. The delegates were then invited to 'pitch' their idea in five minutes to the panel of SUGAR members, who then asked questions about the proposed research idea and made suggestions about how it could be developed further, including suggestions regarding how service users and carers can collaborate in the study.

Researchers from England and Qatar pitched their proposals and the winning research idea came from a newly qualified mental health nurse from south-west England called Cher Hallett, whose proposed research idea is an evaluation of how mental health nurses administer medication via intra-muscular injections.

SUGAR members were impressed not only by the originality and importance of the topic but also by Cher's passion to improve the care provided to mental health service users.

As part of the prize, Cher will have the opportunity to be supported and mentored by SUGAR and academic researchers as the research develops and has been invited to come to City University London to discuss her research in greater detail at a forthcoming SUGAR meeting.

Other academics from the Centre for Mental Health Research also had a strong presence at the conference, with Professor Alan Simpson, Dr Sally Barlow and colleagues from Wales leading a symposium on recent research in England and Wales on recovery-focused care planning (COCAPP).

Care planning and coordination is at the heart of effective mental health service delivery and is increasingly required to be personalised and focused on recovery, yet there has been little research conducted that explores these key aspects.

In this recent study, the team found that positive therapeutic relationships appeared most important in facilitating recovery-focused care planning and that excessive administrative tasks and inflexible information technology prevented care coordinators spending more time with service users and carers.

At the conference, the implications of these and other findings around the discussion of risk between service users and care coordinators were discussed and future challenges were also explored.

Other academics from the School of Health Sciences also gave presentations, with Dr Chris Flood presenting on his innovative work conducted with the SUGAR group on 'Measuring utility based health states amongst service users and the general population'. The implications of initial results from an online survey of service users, staff and members of the public, hosted by mental health charity Rethink, were discussed.

Frédérique Lamontagne-Godwin presented the first results of a qualitative study aimed at improving diabetes care for people with severe mental illness. Analysis of interviews with service users, family carers and healthcare professionals was presented and the conference was informed about future plans by a multi-disciplinary team at City University, ELFT and QMUL to develop and evaluate a self-management intervention for this patient population.

Nurse Consultant Rikke Albert in Tower Hamlets' RAID Service and former Clinical Academic with City University also presented at the conference on identifying unmet mental health needs in long stay patients in acute general hospitals.

Finally, Betsy Scott, Practice Experience Manager for ELFT gave a poster presentation outlining work of the cross-London Association of Mental Health Nursing Practice (LAMP), which aims to improve the support of mentors and the student experience in clinical practice areas.

Speaking about the conference, Professor Alan Simpson, lead of the Centre for Mental Health Research said: "It was impressive to see so much excellent research from the School of Health Sciences and the Trust presented at this leading mental health nursing research conference. There is brilliant work going on in in east London on a range of mental health topics and it was great to share this with the wider psychiatric nursing community. We had a great showing".

■ Members of the SUGAR Dragon's Den panel with winner Cher Hallett (centre)

■ **Alan Simpson, Michael Coffey (Swansea), Sally Barlow (City), Ben Hannigan (Cardiff) during the COCAPP symposium at NPNR**

What it means to be a Principal Investigator and how Noclor can support staff who want to be one

Clinical research means patients get access to new treatments, interventions and medicines, and investment in research means better, more cost-effective patient care. It can benefit patients in a number of ways such as a better understanding or management of their condition, additional contact with clinicians and being able to give something back to the NHS, and contribute to better treatments.

It can also benefit careers; for many healthcare professionals, clinical research provides a career path that is both intellectually challenging, and rewarding. Delivering a well-designed clinical study generates new knowledge and benefits for patients; an opportunity to spend more quality-time engaging with patients and the chance to learn new techniques and approaches to treatment.

The Trust would like more clinical staff to get involved in research; one way you can do this is to become Principal Investigators on research projects.

What is a Principal Investigator?

The definition given by the Health Research Authority says "The principal investigator (PI) is the investigator responsible for the research site where the study involves specified procedures requiring Site Specific Assessment (SSA). There should be one PI for each research site. In the case of a single-site study, the chief investigator and the PI will normally be the same person".

What does this mean in reality? The PI is the person at each site responsible for the day to day running of the research project. They make sure that the study is conducted in line with the protocol, sponsor instructions, GCP and relevant legislation; as well as making sure the well-being of subjects are given priority. For Clinical Trials of Investigational Medicinal Products (CTIMPs), the Principal Investigator must be an authorised healthcare professional.

The responsibilities of the Principal Investigator for a study are clearly outlined in an agreement. The PI can nominate an appropriately experienced person, for example a Research Nurse or Clinical Studies Officer, to assist in the management of the study at the site. This person along with the PI should discuss and agree the allocation of tasks to appropriate staff.

Training and support

Noclor provide a series of training courses that are suitable for PIs: GCP, Informed Consent, Setting up and Managing the Trial Master File. We are currently developing a training course for PIs, which will be rolled out in the New Year; it will focus on the areas detailed below:

- Feasibility and delivery planning
- Key principles of Research Governance
- Management of the Consent Process
- Responsibilities of the Principal Investigator and Delegation of Duties
- Reporting safety issues and incidents
- Site file set-up and maintenance,

Our staff also offer i individual support for PIs just starting out, we can help with the completion of paperwork, helping you complete CVs to an agreed template as well as filling in the R&D form. They will also support you through the necessary steps of setting up a study. The team are always happy to come out and meet with PIs on site and aim to make the process as simple as possible.

For details visit: https://www.noclor.nhs.uk/study-team/principal-investigator

---

How can a positive self-help technology be used for depression & anxiety?

We would like to create a smartphone app for people with mild-to-moderate depression and anxiety. This will promote positive emotions and behaviours in a personalised, non-stigmatising and flexible way

Share your views on the usefulness and appeal of this approach in a one-off individual or group discussion.

Patients can participate if they:
- are working age (18-65)
- have sought help for anxiety or depression from your GP, counsellor or therapist in the last 12 months
- have sufficient command of the English language

Health care staff can participate if they:
- are qualified as GP, Nurse or psychological practitioner (e.g. psychologist, low intensity practitioner, wellbeing practitioner)
- have at least 12 months professional experience within stepped care pathways (1-3)

The interview will take just one hour and can be arranged at a suitable location and time; patients will receive £20 for their time.

To find out more contact Sophie Walsh by phone 020 7540 4380 ext: 2309, 07706 678 176 or email sophie.walsh@qmul.ac.uk

---

Financial incentives to improve adherence to antipsychotic depot medication: Does it change over time?

By **Hana Pavlickova**, Trial Manager,
Unit for Social and Community Psychiatry

Poor adherence to antipsychotic medication is common problem in patients with psychotic disorders. In a recent randomised controlled, we tested whether patients offered £15 for each depot that they receive show better adherence than those receiving treatment as usual. The intervention lasted for 12 months. The results showed that offering financial incentives is indeed effective for improving adherence to treatment, with patients in the intervention group showing adherence over 10% better than those in control group.

However, other clinically relevant questions remain: How quickly can clinicians expect an improvement? Will adherence decrease over time again despite the money? Does the amount of money patients receive influence adherence?

To address the first two questions we divided the 12-month intervention period into four three-month long intervals and calculated adherence for each interval. Improved adherence occurred already within the first interval. Second, the improvement in the intervention group remained stable over the whole time patients were offered the money. This finding is contrasting to studies on other health related behaviours, such as smoking or drug cessation, where the effect financial incentives diminishes over time unless patients are offered more money. Here, we can argue that in comparison to other health related behaviours depot appointments are relatively infrequent behaviours and hence easier to sustain.

This takes us to the third question: does the amount of money have an effect on adherence? Answering this question is complicated by the fact that in the present study, all patients were offered a fixed amount of £15 for each depot. The overall amount of money patients received over the whole intervention period however varied widely (from £195 to £780) due to the fact that some patients were on a treatment cycle as frequent as once weekly, whilst others only received medication once monthly. Looking at the effect of the amount of money on adherence, we found that the more money patients were due to receive the poorer their adherence. One explanation for this finding is that more frequent cycles remain more difficult for patients to adhere to, despite the potential financial gains.

To summarise, our findings show that offering financial incentives is indeed effective in improving adherence to antipsychotic depot medication. The improvement appears within first three months, and lasts as long as financial incentives are provided. Yet, despite the money, it is easier for patients to adhere to less frequent treatment cycles.

ELFT Service User and Carer Research Group now up and running

ELFT now has a Service user and Carer Research group in place that meets bi-monthly to discuss Recovery Care related research ideas.

The group has got currently about ten members, is chaired by Zaffran Jami, People Participation Lead from City & Hackney and supported by Dr. Domenico Giacco, Senior Lecturer / Research Fellow from the Unit for Social & Community Psychiatry in Newham, and Prof. Frank Röhricht, Associate Medical Director for Research/Innovation and Service Development.

The main purpose of the group is to consider topics and questions relevant to the service user experience of accessing mental health and social care support and to develop a service user led research agenda accordingly.

The group started to identify a range of potential Research questions from service user perspective:
- What elements in their personal lives do service users regard as most important in achieving recovery?
- What are the existing ideas (range/content/topics etc.) about recovery?
- To what extent do social networks complement treatment?
- What criteria do service users apply to rate their own recovery?
- What do individuals need in order to progress towards achieving their recovery goals?

The following issues have been at the centre of the discussion over the course of the last six months:
- Is there a mismatch between traditional service outcomes and personal patients' goals? And if so, what might be the impact?
- How can we best achieve empowerment in recovery care without losing essential support? And from carer's perspective:
- Which factors contribute to relapse of acute mental health problems and how can the transition from inpatient /acute care to community care be improved to avoid relapses?

The service user research group is also is interested in a systematic assessment of how social interactions / engagement in a social network help/facilitate/influence the understanding of recovery and the recovery process. It was discussed that whilst the role of social interactions in helping recovery is established, less is known about lived experience of the processes by which social relations facilitate recovery.

We would very much welcome your ideas and are hoping that more service users and carers will join our group meetings.

Please contact Zaffran Jami at zaffran.jami@elft.nhs.uk or 020 8510 8372 for more details.
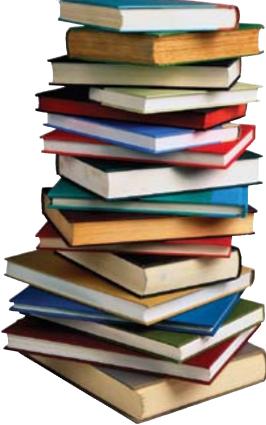
Recent Publications

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.

■ Albert R & Simpson A (2015) *Double deprivation: a phenomenological study into the experience of being a carer during a mental health crisis*, **Journal of Advanced Nursing** (in print).

■ Bhui K, Ullrich S, Kallis C, Coid JW (2015) *Criminal justice pathways to psychiatric care for psychosis*. **British Journal of Psychiatry**. (in print).

■ Bhui KS, Aslam RW, Palinski A, McCabe R, Johnson MR, Weich S, et al.(2015) *Interventions to improve therapeutic communications between Black and minority ethnic patients and professionals in psychiatric services: systematic review*. **British Journal of Psychiatry**. 207(2):95-103.

■ Blundell S, Ray KK, Buckland M, White PD (2015) *Chronic fatigue syndrome and circulating cytokines: A systematic review*. **Brain, behavior, and immunity** (in print).

■ Chalder T, Goldsmith KA, White PD, Sharpe M, Pickles AR (2015) *Rehabilitative therapies for chronic fatigue syndrome: a secondary mediation analysis of the PACE trial*. **The Lancet Psychiatry**. 2015;2(2):141-52.

■ Freestone MC, Wilson K, Jones R, Mikton C, Milsom S, Sonigra K, et al (2015) *The Impact on Staff of Working with Personality Disordered Offenders: A Systematic Review*. **PloS one**. 10(8):e0136378.

■ Giebel C, Challis D, Worden A, Jolley D, Bhui KS, Lambat A, et al (2015) *Perceptions of self-defined memory problems vary in south Asian minority older people who consult a GP and those who do not: a mixed-method pilot study*. **International Journal of Geriatric Psychiatry** (in print).

■ Hodge P, Davis J, Maiden N, Mann B, Nidsjo A, Simpson A, Reynolds L (2015) *StreetWise: A Valid Ecology for a Serious Game in a Secure Forensic Mental Health Setting*, **Procedia Computer Science** 63: 252–259.

■ Koelkebeck K, Andlauer O, Jovanovic N, Giacco D (2015) *Interventions for posttraumatic stress disorder in psychiatric practice across Europe: a trainees' perspective*. **Eur J Psychotraumatol**. 6:27818. doi: 10.3402/ejpt. v6.27818.

■ Mundt AP, Chow WS, Priebe S (2015) *Testing the Penrose Hypothesis-Reply*. **JAMA Psychiatry**. 72(7):736.;72(7):736.

■ Mundt AP, Kastner S, Larrain S, Fritsch R, Priebe S (2015) *Prevalence of mental disorders at admission to the penal justice system in emerging countries: a study from Chile*. **Epidemiology and Psychiatric Sciences**. 1-9.

■ Newton JN, Briggs AD, Murray CJ, Dicker D, Foreman KJ, Wang H, et al. (2015) *Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013*. **Lancet** (in print).

■ Pavlickova H, Bremner SA & Priebe S (2015) T*he Effect of Financial Incentives on Adherence to Antipsychotic Depot Medication: Does It Change Over Time?* **J Clin Psychiatry** 76(8):e1029–e1034.

■ Pesola F, Williams J, Bird V, Freidl M, Le Boutillier C, Leamy M, et al (2015) *Development and evaluation of an Individualized Outcome Measure (IOM) for randomized controlled trials in mental health*. **International Journal of Methods in Psychiatric Research** (in print).

■ Priebe S, Kelley L, Omer S, Golden E, Walsh S, Khanom H, et al (2015) *The Effectiveness of a Patient-Centred Assessment with a Solution-Focused Approach (DIALOG+) for Patients with Psychosis: A Pragmatic Cluster-Randomised Controlled Trial in Community Care*. **Psychotherapy and Psychosomatics**. 84(5):304-13.

■ Ramchandani D, Marcenes W, Stansfeld SA, Bernabe E (2015) *Problem behaviour and traumatic dental injuries in adolescents*. **Dental Traumatology** (in print).

■ Rapp MA, Kluge U, Penka S, Vardar A, Aichberger MC, Mundt AP, et al (2015) *When local poverty is more important than your income: Mental health in minorities in inner cities*. **World Psychiatry** 14(2): 249-50.

■ Razavi T, Clark C, Stansfeld SA (2015) *Work-family conflict as a predictor of Common Mental Disorder in the 1958 Birth Cohort*. **Longitudinal and Lifecourse Studies**. 6(3).

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

■ Sandhu S, Arcidiacono E, Aguglia E, Priebe S (2015) *Reciprocity in therapeutic relationships: A conceptual review*. **International Journal of Mental Health Nursing** (in print).

■ Savill M, Priebe S (2015) *Letter to the Editor: Concepts and methods when considering negative symptom course: a reply*. **Psychological Medicine**. 45(11):2459-60.

■ Simpson A, Hannigan B, Coffey M, Jones A, Barlow S, Cohen R, Všeteková J, Faulkner A & Haddad M (2015) *Study protocol: cross-national comparative case study of recovery-focused mental health care planning and coordination (COCAPP)*, **BMC Psychiatry**. 15:145.

■ Slade M, Bird V, Clarke E, Le Boutillier C, McCrone P, Macpherson R, et al (2015) *Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial*. **The Lancet Psychiatry**. 2(6):503-14.

■ Smith NR, Clark C, Smuk M, Cummins S, Stansfeld SA (2015) *The influence of social support on ethnic differences in well-being and depression in adolescents: findings from the prospective Olympic Regeneration in East London (ORiEL) study*. **Social Psychiatry and Psychiatric Epidemiology** (in print).

■ Stansfeld SA, Berney L, Bhui K, Chandola T, Costelloe C, Hounsome N, et al (2015) *Pilot study of a randomised trial of a guided e-learning health promotion intervention for managers based on management standards for the improvement of employee well-being and reduction of sickness absence: the GEM (Guided E-learning for Managers) study*. **Public Health Research**. Southampton (UK).

■ Thompson C, Lewis DJ, Greenhalgh T, Smith NR, Fahy AE, Cummins S (2015) *"Everyone was looking at you smiling": East London residents' experiences of the 2012 Olympics and its legacy on the social determinants of health*. **Health & Place**. 36:18-24.

■ Thompson R, Valenti E, Siette J, Priebe S (2015) *To befriend or to be a friend: a systematic review of the meaning and practice of "befriending" in mental health care*. **Journal of Mental Health**. 1-7.