R&D newsletter
Summer 2015
East London NHS
NHS Foundation Trust

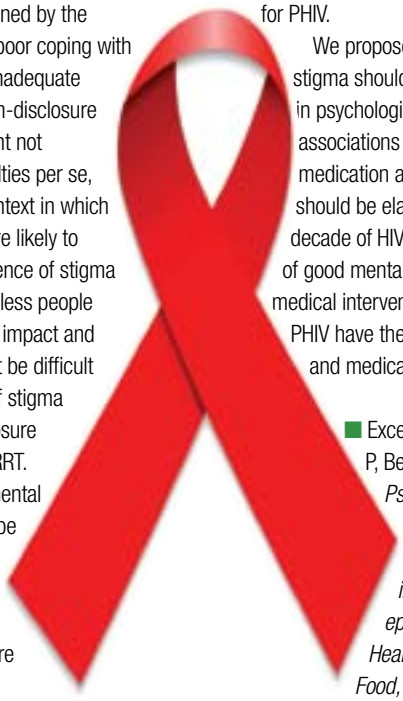
Psychological interventions in people with HIV disease: Considering the challenges in the fourth decade of the epidemic

By Dr Tomas Campbell, Head of Psychology & Health, with P Rohleder, S Beadle & T O'Keefe

Major advances have been made over the last twenty years with regard to the medical treatment and care of people with HIV (PHIV) but the disease remains an important global health issue. While the success of anti-retroviral medication suggests that HIV is under medical control this obscures the considerable challenges that people living with HIV continue to face.

We suggest that HIV also remains highly stigmatised and this issue is an important factor that increases poorer mental health, complicates the development of effective coping strategies and affects adherence to highly active anti-retroviral medication (HAART). For HIV+ parents, poorer coping may negatively affect their ability to effectively manage the psychosocial challenges of the complexity of issues to be addressed within their families. The interaction of personal characteristics which are already stigmatized (e.g. drug use, sexual orientation) and HIV disease provides a context in which the importance of the individual factors become blurred and stigma, for the people who possess these characteristics, is experienced at many levels.

However, it has been difficult to measure the direct impact of stigma on the HIV epidemic because stigma operates at multiple levels – the level of the individual as well as organisational and societal levels, which in turn is affected by different cultural or national settings. Much of the research on HIV stigma prevention has focused on changing negative attitudes towards people living with HIV, as well as HIV-positive adults' perceptions of stigma and how this impacts on their psychological and physical wellbeing. Most interventions have sought to change stigmatizing attitudes through mass media campaigns, education about HIV transmission and of the introduction of anti-discriminatory laws. However, research suggests that HIV-related stigma is highly resistant to change. We suggest that many of the mental health difficulties associated with HIV are underpinned by the experience of HIV stigma. While poor coping with HIV (poor adherence to HAART, inadequate engagement with healthcare, non-disclosure of status to sexual partners) might not evidence of mental health difficulties per se, these issues may provide the context in which mental health difficulties are more likely to emerge. In any event, the experience of stigma is pervasive and negative and unless people with PHIV are able to identify the impact and effects on their own lives it might be difficult to disentangle the lived impact of stigma from other issues e.g. non-disclosure of status, poor adherence to HARRT. Psychological interventions for mental health problems have tended to be individually focused and while this is not doubt beneficial for the particular individuals there is little evidence from the literature that these interventions have addressed the impact of stigma and how these experiences shape and perhaps create the emotional and psychological difficulties. It may well be that such issues emerge in the course of treatment between individual therapists and their clients but standard psychological interventions for depression, anxiety in PHIV etc. do not routinely recommend that stigma be addressed as a core feature of the therapeutic intervention. We consider that and exploration of the individual meanings and impact of stigma should be placed at the heart of any psychological intervention for PHIV.



We propose that the issue of HIV stigma should be more actively targeted in psychological interventions and its associations with disclosures difficulties, medication adherence and poor coping should be elaborated. Finally, in the fourth decade of HIV we need to place the supporting of good mental health firmly alongside effective medical interventions in order to ensure that PHIV have the best psychological, emotional and medical quality of life possible.

Excerpted from Campbell T, Rohleder P, Beadle S & O'Keefe T (2015) *Psychological interventions in people with HIV disease: Considering the challenges in the fourth decade of the epidemic* In: *Watson RR (Ed). Health of HIV Infected People: Food, Nutrition and Lifestyle with Antiretroviral Drugs*, Vol. I, 551-569. Academic Press, Elsevier

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Recent publications

Are group psychotherapeutic treatments effective for patients with schizophrenia?

By **Stavros Orfanos**, **Ciara Banks** & **Stefan Priebe**, Unit for Social and Community Psychiatry

Across both in-patient and out-patient settings, different psychological treatments for schizophrenia are delivered in groups. From an economic perspective, a group setting is seen as a useful approach, as it allows for one therapist to treat several people at the same time. From a clinical perspective, group treatments are also believed to offer social advantages relevant to this population, who often have smaller social networks and less satisfactory interpersonal relationships compared to a healthy population.

However, little empirical research has been conducted to explore whether these group interventions for people with schizophrenia are effective across different treatments with varying therapeutic orientations. Whilst attempts have been made to summarise findings from controlled trials exploring the effectiveness of group psychotherapeutic treatments for schizophrenia, the conclusions from these studies are limited in scope. For example evidence from nonverbal creative group arts therapies (including music therapy, body psychotherapy and art therapy) is often not included in these reviews, and findings are limited to a descriptive analysis of the literature.

This review aimed to

i) estimate the effect of different group psychotherapeutic treatments for schizophrenia, and

ii) to explore whether any overall 'group effect' is moderated by treatment intensity, diagnostic homogeneity and therapeutic orientation.

In other words, we attempted to establish whether there is an overall 'group effect' across a range of group psychotherapeutic treatments as compared to treatment-as-usual (TAU). Unlike previous efforts, this review aimed to do so by statistically pooling together the existing evidence using meta-analytical techniques. If people with schizophrenia benefit from a non-specific 'group experience', one would expect to see clinical improvements in participants across a range of group psychotherapeutic treatments.

A systematic search of randomised controlled trials exploring the effectiveness of group psychotherapeutic treatments for people with schizophrenia was conducted and identified 5078 studies. Studies were assessed for potential risk of bias and were excluded if rated high risk. Following the exclusion of duplications and removal of studies at the title screening phase, 1552 abstract articles were reviewed and 324 studies identified for full paper review and 34 studies were included. Seven studies used the data from three data sets, one study included data from two separate trials, and one study had two control arms. Hence in total, 32 data sets were included in the final meta-analysis.

The primary outcome was symptom scores measured after treatment had finished (including positive, negative, general and/or total symptom scores). All findings from different studies were pooled together into one analyses (meta-analysis). We compared the overall symptom scores in participants who took part in a group psychotherapeutic treatment with those who didn't (including those who continued with treatment-as-usual and those who took part in an active sham group instead). Findings on social functioning were described narratively and meta-regression analyses on group characteristics were carried out.

Conclusion

This review found that group psychotherapeutic treatments were more effective than treatment-as-usual (TAU) in reducing negative symptoms across a diverse range of psychotherapeutic orientations. This effect was apparent only when these group psychotherapeutic treatments were compared against TAU, not active sham groups. The narrative summary of studies indicated that overall, participants in group psychotherapeutic treatments benefited more in terms of reduced social functioning deficits in the treatment condition compared to TAU. No evidence was found for an effect of therapeutic orientation or diagnostic homogeneity. However, there was a significant positive relationship between treatment intensity and reduced negative symptoms.

This study has a number of strengths. It is the first systematic review to explore the effectiveness of psychotherapeutic treatments delivered in groups using meta-analytic techniques. We used rigorous methods and a wide array of search terms encompassing a broad range of verbal and nonverbal psychotherapeutic group treatments. Stringent measures controlled for study quality.

There are also a number of potential limitations. The majority of the sample represented were outpatients (71%) and male (64%), which may limit generalisability. Furthermore, group psychotherapeutic treatments have not been assessed against individual psychotherapeutic treatments. Without controlling for the specific factors potentially relevant to the psychotherapeutic treatment itself, it is difficult to make firm conclusions about the benefits of non-specific group effects.

Overall, evidence from this review supports the view that group mechanisms underpinning different group psychotherapeutic treatments can be clinically advantageous for people with schizophrenia in the treatment of negative symptoms and social functioning deficits. Therefore the group experience itself appears to be clinically useful for this population who are often isolated and relate poorly with others. Both the effectiveness of group psychotherapeutic treatments across different therapeutic orientations as compared to TAU, and the absence of a significant effect as compared to active sham groups, is consistent with the hypothesis that beneficial group mechanisms are non-specific. In support of the 'contextual' model of psychotherapy, these findings support the view that the benefit of group therapeutic mechanisms is due to common factors.

Future research should therefore identify the underlying mechanisms for the positive effect of participating in groups and explore how they can be maximised to increase the therapeutic benefit.

Medication administration errors on mental health wards

By **Alan Cottney**, Clinical Pharmacist, East London NHS Foundation Trust

Pharmacological therapy has become a cornerstone of treatment for a huge number of conditions and complaints; from chronic pain to high blood pressure, and from chest infections to depression. The vast majority of people admitted to hospital will now be prescribed some form of medication during their inpatient stay. The sole purpose of using medication is to try to improve the lives of those taking it, but often it can have the opposite effect – injuring or harming people instead of helping them. The National Reporting and Learning System (NRLS) is a database of all the reports of incidents involving compromises to patient safety that occur in hospitals in England and Wales. The information released by the NRLS indicates that incidents involving medication are amongst the most commonly reported types of patient safety incidents in the country. Often these incidents involving medication occur as a result of human error – meaning that patients are suffering unnecessary harm because of mistakes made by healthcare professionals.

Medication use in hospitals can be thought of as a chronological process which moves from the drug being prescribed, to it being dispensed in a pharmacy, and then administered to the patient on the ward. Errors can be introduced at any of the stages of this process, but the majority of the most serious errors – those causing death or severe harm – are reported to occur at the administration stage; when the medication is actually being given to the patient. This means that a large percentage of the most serious harm from medication could be reduced by taking steps to combat errors specifically at the administration stage. However, before strategies are put in place to combat medication administration errors, it is first necessary to gain an understanding of the exact types of errors that are happening in a particular hospital. It is vital that error-reduction strategies are based upon sound information about the errors that occur most commonly in a particular setting so that the specific problem areas in that setting can be targeted for improvement.

Numerous studies have shown that the most accurate way to detect medication administration errors is to use direct observation. In this type of methodology, staff who are administering medication to patients are observed by an investigator who records details of any errors that are made. Previous research has shown that for every one error detected by traditional incident reporting systems, 300 errors would be detected if the direct observation methodology was used to assess medication administration.

Direct observation methodology has been applied widely in the general hospital setting, but so far there have been few such studies looking at medication administration errors in the mental health setting. Therefore we decided to conduct a direct observation study of medication administration errors on the inpatient mental health wards in East London NHS Foundation Trust (ELFT). We hoped that the study would address the gap in the current literature evidence, and give us a really good insight into the errors that were being made on the wards – so that we could take steps to prevent them.

Observation

The study that we conducted aimed to assess the incidence, type and clinical severity of medication errors made on the inpatient wards in the Trust. Pharmacy staff observed each of the four daily medication rounds on all 43 of the Trust's inpatient mental health wards. During the 172 medication rounds observed, 139 errors were detected in 4177 opportunities – meaning roughly 3.3% of all opportunities resulted in an error being made. This rate of errors is lower than that reported from direct observation studies in general hospital settings, but this is probably due to differences in the patterns of prescribing and medication use between general hospitals and mental health hospitals. For instance, most medication errors in general hospitals involve drugs that are given by the intravenous route of administration – a route that is very rarely used in mental health hospitals.

In ELFT, the most common error that we saw was the incorrect or unintentional omission of a dose of medication. This type of error accounted for about 37% (52/139) of all the errors observed. Other common errors included the incorrect dose of medication being given, the incorrect form of medication being given (for instance, a tablet being given instead of an injection), and medication being given at the incorrect time of day. Fifteen (11%) of the errors were of serious clinical severity – meaning they could have resulted in patients suffering harm had the observing pharmacist not intervened. The rest of the errors observed were of much less serious clinical severity.

When the observations had been completed, and the data collated, regression analysis was used to identify any factors that were associated with an increased risk of error. Factors that were found to increase the risk of error included: the nurse interrupting the medication round to attend to another activity, an increased number of 'when required' doses of medication being administered on the round, a higher number of patients on the ward at the time of the round, and an increased number of doses of medication due to be administered.

Our study was the largest direct observation study ever undertaken anywhere in the world in the mental health setting, and is amongst the largest in the world in any setting. This means that it has given us an incredibly valuable insight into the types of errors that are commonly made on our wards, and the things we can do to prevent them.

Ultimately, this research should help guide improvement efforts that will result in fewer patients suffering unnecessary harm as a result of medication errors.

Modelling clinical decision-making for high-risk offenders using Bayesian Networks

By **Mark Freestone**, Research Fellow, Violence Prevention Research Unity

Making decisions about whether patients and prisoners at high risk of future violence are suitable for release into the community is a difficult, and in many ways unenviable, task. Forensic and criminal justice professionals responsible for the detention of offenders are required to weigh many different factors relating to the individual's history, clinical presentation, and likely environment upon release in order to reach their decisions, which will have a great impact on that individual's freedom; and potentially also on the safety and security of society as a whole. To make matters more complex, previous research studies have shown that 'unstructured' clinical decision-making is often unreliable, and can lead to incorrect evaluations of the level of risk posed by an offender. Often, therefore, professionals will make use of risk assessments and structured professional judgement (SPJ) aides such as the Health-Clinical-Risk 20 (HCR20) to guide them in their decisions; yet these assessments themselves are often highly generic in their construction and do little to account for individual risk factors. Moreover, can any checklist of risk-related factors truly be representative of the process of decision-making in conditions of uncertainty?

These sorts of questions about risk and judgement, and how to resolve them using sophisticated modelling techniques, are what the Risk and Information Management (RIM) group in the Electronic Engineering and Computer Science department at Queen Mary University of London (QMUL) have been investigating for the last five years. In a collaboration between RIM and the Violence Prevention Research Unit (VPRU), comprising staff from the Trust and the QMUL Centre for Psychiatry lead by professor Jeremy Coid, researchers have been using a technique known as Bayesian Network Analysis to model the factors that clinicians take into account when making decisions about offenders, and structure them in a way that provides a causal account of possible future violent offences, in the same way that a forensic professional might do.

Bayesian Network Analysis (BNA) sounds (and looks) complicated but the technique is based on a surprisingly straightforward mathematical principle known as Bayes' Theorem, which states that the probability of any event happening is dependent to a greater or lesser degree on several other related events that have taken place before it. So, in a previous study (Constantinou et al, 2012) researchers from RIM used BNA to examine the results of Premiership football matches during the 2011 and 2012 seasons to predict future outcomes, enabling them to 'beat the bookies' by offering an evidence-based decision making process for predicting the outcome of matches. You can find out more and try this system out through the project website at http://www.pi-football.com.

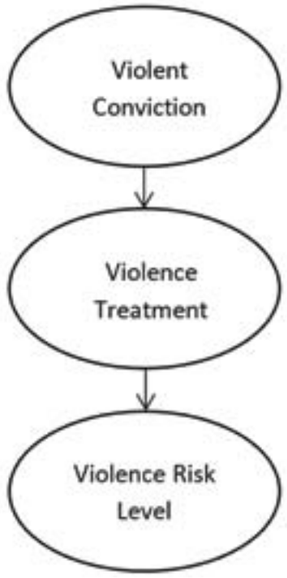

Figure 1: A simple moderation model for predicting future violence

In thinking about decision-making for high-risk offenders, our first step was to build a Bayesian Network that reflected the factors considered by forensic professionals, and model these in a way that reflected the likely causal mechanisms for an individual reoffending. We did this through a process called 'expert knowledge elicitation': a decision scientist from RIM would run through various 'risk' scenarios with a pair of forensic clinicians, who would then provide their 'expert' input in developing the scenarios from very basic associations between past and previous offending, to more complex networks that considered treatment and personality as risk and or mitigating factors for change. In *Figure 1*, we are considering how past violent convictions– a risk factor for future offending – might be moderated by treatment for violence; whereas in *Figure 2* we model the additional possibility that high levels of psychopathy might interfere with successful treatment, and also provide a causal model of violence that accounts for violence risk both before and after treatment. In this way it is possible to model complex outcomes, such as if someone begins treatment but fails to complete it, or does not complete it successfully (perhaps due to the presence of psychopathy). By building several sub-networks in this way, we were able to work up into a complex system of over 100 nodes that modelled the 'expert' decision process more accurately than any alternative SPJ or risk assessment system.

Once the completed network was constructed (see *Figure 3*), we could use existing data on violence risk factors derived from our previous study of 1396 high-risk prisoners in England and Wales – the Prisoner Cohort Study – to populate, or 'parameterise' the network. This means that for each node in the network, we had a set of probabilities relating it to every other node: we could then model future cases where there was only limited information about an offender, using existing information derived from our data. So, for example, if we did not know whether an offender had a previous history of substance misuse, we could use the data to infer the probability that he or she had used drugs in the past based on their offending history, social circumstances and mental illness. This is an ability unique to Bayesian Networks known as 'reverse inference': inferring information from effect to cause, as well as from cause to effect.

We also used the data to validate the Bayesian

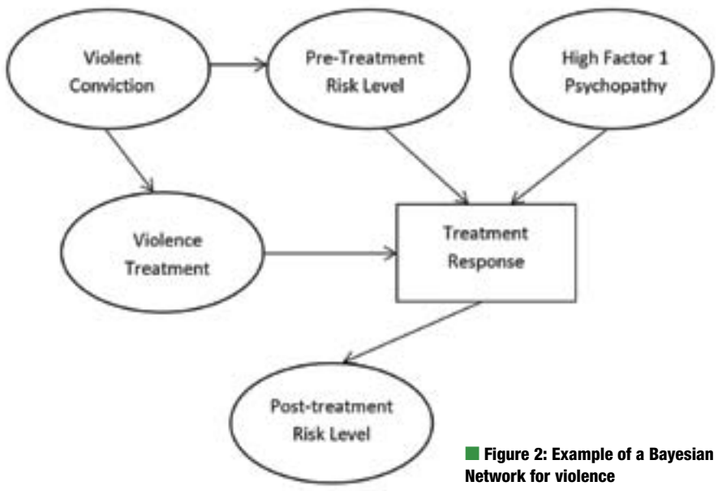

Figure 2: Example of a Bayesian Network for violence

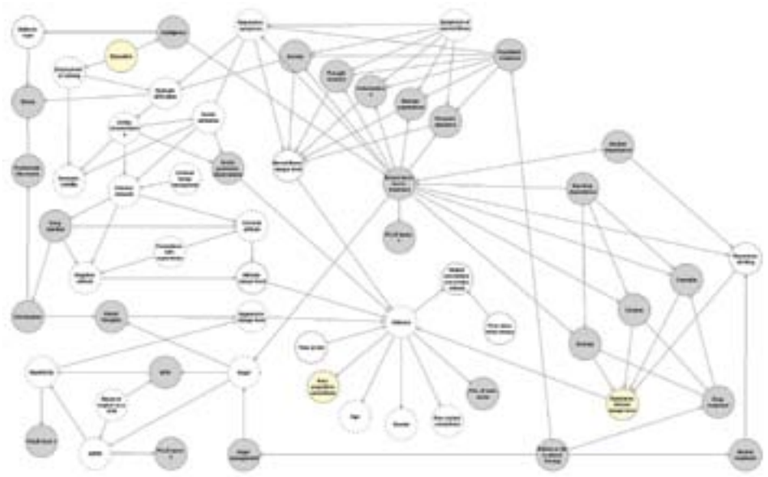

Figure 3: Completed network

Network as a risk assessment tool for future violence, and when used in this way it outperformed all the commonly used SPJ and assessment tools in successfully predicting violent reconvictions among high-risk prisoners. Yet the really exciting possibility in Bayesian Networks for violence lies in the ability to use the causal structure to identify not just if an offender is likely to reoffend violently, but what specific risk factors we should target with interventions to prevent that violent offence. With adequate data, we could even extend this model to accommodate other outcomes such as recall to hospital, self-harm, suicide or relapse.

Constantinou AC, Freestone M, Marsh W, Fenton N & Coid JW (2015) *Risk assessment and risk management of violent reoffending among prisoners. Expert Systems with Applications*, 42(21): 7511-7529. Constantinou AC, Fenton NE & Neil M (2013) *Profiting from an inefficient Association Football gambling market: Prediction, Risk and Uncertainty using Bayesian networks. Knowledge-Based Systems*, 50: 60-86.

OTHER NEWS

21ST INTERNATIONAL NETWORK FOR PSYCHIATRIC NURSING RESEARCH CONFERENCE

Research taking place in ELFT and led by members of the Mental Health Nursing research group in City University's Centre for Mental Health Research will be well represented at this, at one of the best mental health nursing research conferences in Europe, as we have had many abstracts accepted.

For more information please follow the link: http://elftintranet/events/royal_college_of_nursing_research_conference.asp

RESEARCH IN EAST LONDON – SAVE THE DATE!

Are you interested in the latest research taking place in ELFT? Then be sure to look into the 13th Annual East London Mental Health Research Presentation Day will be held from 14:00 to 17:00 in the Robin Brooks Centre at St Bartholomew's Hospital on the afternoon of Wednesday, 7 October 2015.

This is the usual teaching afternoon for doctors, but all staff and not only doctors will be most welcome. The presentation day will have the usual format of very brief presentations on a wide range of research projects that are being conducted in the Trust. Thus, you will get information on 14 different projects, ranging from epidemiological studies to clinical trials and qualitative work. Places are limited and will be allocated on first come first served basis. To register, please send your name and a contact email address to Research_Office@elft.nhs.uk

INVOLVING CHILDREN AND YOUNG PEOPLE IN RESEARCH

The INVOLVE website has recently been updated with information and resources on involving children and young people in research. See http://www.invo.org.uk/find-out-more/involving-children-and-young-people

FIFTH BI-ANNUAL CAMBRIDGE & BEDFORDSHIRE INTERNATIONAL CONFERENCE ON MENTAL HEALTH

Featuring high quality talks from internationally renowned experts, the conference will cover various topics, including, ADHD, Bipolar Affective disorder, Schizophrenia, Neuroscience and Imagining studies of Psychiatric disorders, Immunopsychiatry, Psychiatric Disorders in war regions and Transcranial Magnetic Stimulation in Psychiatry.

It will also feature student (medical and PhD) and trainees presentations from UK and Europe. The last day will include talks on humanities and psychiatry. The conference will be at Clare College, Cambridge 11-14 September 2015; registration fee for people who do not need accommodation is £75 a day. For more information and booking, see http://www.bcmhr-cu.org

FREE RESEARCH TRAINING COURSES

Noclor are running a set of FREE research training workshops this autumn. These include Good Clinical Practice (GCP), Informed Consent and some new courses including 'How to be a Principal Investigator' will be announced soon so keep checking back.

Full details here: http://www.noclor.nhs.uk/news-events/news/free-research-training-courses-autumn

Studies recruiting in your trust

Interested in volunteering as a companion to a person with mental illness?

Are you…

- Enthusiastic about providing support to a patient on a one-to-one basis?
- Happy to travel regularly to Newham to engage in social activities with them?
- Able to commit to volunteering at least one hour of your time, once a week, for a full year?

LFT, in collaboration with Queen Mary University, is piloting a new companion scheme (the 'VOLUME' programme) in Newham, East London, intended to reduce social isolation in patients with psychosis living in the community. The scheme involves matching patients with volunteer companions, who will help them to engage in social activities locally and become more active.

The VOLUME team will provide:

- Full training
- DBS check
- Expenses
- Ongoing support throughout the scheme.

To find out more contact Volunteer Coordinator Eoin Golden by phone 020 7540 4380 ext: 2338 or email: e.m.golden@qmul.ac.uk

VOLUME+ volunteer for mental health

Cognitive therapy for Paranoid, Schizotypal and Schizoid Personality Disorders

By **Dr Julia Renton**, Consultant Clinical Psychologist, Head of Inpatient/EI/AO Psychology (Bedfordshire and Luton)

Relatively few recognized cases of individuals with paranoid, schizotypal and schizoid personalities are seen within clinical services. The reason for this appears to be twofold. Firstly, these are not clients for whom seeking psychological therapy would be concordant with their belief sets and secondly, when they do present to mental health services, these clients may be allocated to inappropriate clinical pathways. Such individuals may be referred to psychosis services and may be either incorrectly diagnosed or discharged with no further treatment once perceived as not meeting diagnostic criteria for schizophrenia. Although these disorders have historically been regarded as "untreatable", evidence has been slowing growing that symptoms of severe personality disorders (PD) are treatable, particularly with cognitive therapy for the emotional distress and unhelpful beliefs associated with these PDs.

Clients with these diagnoses often present considerable difficulties in developing engagement within psychological therapy. They generally do not take on the conventional 'sick role' in which they are compliant, obedient and grateful as patients or therapy clients. As a result, conventional and collaborative therapeutic relationships are less likely to develop. Therefore, the cardinal principle of cognitive therapy with such personalities must be the formation of a therapeutic alliance with the client. This process needs to commence at the very beginning of the therapy through a development of mutual understanding of the individual's difficulties (formulation), which should lead to establishing an initial sense of trust and collaboration.

Basic treatment goals for any of these three disorders may include the following:

1) Engage trust within therapy by exploring ambivalence, respecting the patient's autonomy and emotional limits, and remaining non-defensive.

2) Explore the impact and accuracy of unhelpful beliefs about others and to work collaboratively to develop alternative, more functional beliefs

3) Experiment with more adaptive social behaviors and skills to support more functional beliefs and to reduce predominance of suspicion and mistrust.

Paranoid Personality Disorder

The essential diagnostic feature of Paranoid Personality Disorder (PPD) is a persistent interpretation of the intent of others as malevolent, coupled with an array of distrust and suspiciousness (DSM-5). Individuals with this disorder assume that other people will exploit, harm, or deceive them even if no evidence exists to support this expectation. They are preoccupied with doubts about the trustworthiness of friends (if they have any) or colleagues without justification, and scrutinize the actions of others for evidence of malevolent intentions, often reading hidden meaning. The World Health Organization's ICD-10 Classification of Mental and Behavioral Disorders diagnostic guidelines for PPD are largely similar to those of DSM-5. Distrust and suspiciousness constitute the main diagnostic themes, although these characteristics are not as explicitly central to the diagnosis of PPD as in the DSM-5. Additionally, ICD-10 discusses the preoccupation with unsubstantiated 'conspiratorial' explanations to events, a combative and tenacious sense of personal rights and a tendency to experience excessive self-importance, which manifests in a persistent self-referential attitude.

Schizotypal Personality Disorder

The main feature seen in individuals with Schizotypal Personality Disorder is their acute discomfort with, and reduced capacity for, close relationships, alongside cognitive or perceptual distortions and eccentricities of behavior. They often have subclinical psychotic symptoms or experiences, such as suspiciousness, believing people are talking about them or intend them some harm alongside ideas of reference or odd/magical beliefs with little or no insight regarding the distorted aspects of these cognitions. They also lack friendships, feel anxious in social situations, and may behave in ways that others perceive as odd. The predominant diagnostic theme for Schizotypal Personality Disorder (StPD) in DSM-5 appears to be persistent deficits in social and interpersonal functioning alongside subjective experience of considerable distress with, and ability to engage in, close interpersonal relationships. Conversely, ICD-10 does not recognize a diagnosis of StPD, but rather schizotypal disorder. This is classified as a clinical disorder associated with schizophrenia rather than a personality disorder. Thus, the DSM-5 designation of schizotypal as a personality disorder might be seen as controversial with those favoring ICD-10 in their clinical practice.

Schizoid Personality Disorder

The main feature seen in individuals with Schizoid Personality Disorder (SPD) is lack of, and indifference to, interpersonal relationships. Such individuals often present as withdrawn and solitary, seeking little contact with others and gaining little or no satisfaction from any contact they do have, irrespective of its focus. The DSM-5 diagnostic criteria for SPD specify a longitudinal pattern of detachment from and indifference to interpersonal relationships accompanied by considerably limited range of expressed emotions in social situations as primary diagnostic features. The individual with SPD is not usually distressed by the absence of relationships, but may be distressed by pressure from others such as family members over their lack of involvement. Those with SPD rarely seek treatments of their longer-term difficulties, but should they engage, it is only for a brief period of work, often to tackle heightened levels of psychological distress brought on by a change in their environment. Once this immediate difficulty appears resolved, therapy rarely extends onto revision of the underlying cognitive factors.

Conclusion

Whilst there are many differences between Paranoid, Schizotypal and Schizoid personality disorders, it appears that all of these subscribe to the view that they are different, unlikable and unable to fit into the social world, and that interpersonal relationships should be avoided. However, the rationales behind such decisions differ accordingly to a belief set specific to the particular disorder, i.e. because others want to hurt them (paranoid), others don't care or don't appreciate their uniqueness (schizotypal), or that others are cruel and rejecting (schizoid). Because of such unhelpful appraisal of interpersonal activities and social situations, the development of a collaborative and trusting therapeutic relationship is particularly difficult with these individuals. Hence, addressing this through the means of guided discovery needs to be the initial focus of therapeutic work, which will eventually provide a safe place to test these beliefs and an opportunity for in-vivo modeling for the development of future interactions.

■ Excerpted from Renton J & Mankiewicz P (2015) *Paranoid, Schizotypal and Schizoid Personality Disorders* In: Beck AT, Davis DD & and Freeman *A (Eds) Cognitive Therapy of Personality Disorders* (3rd Edition) (pp. 244 – 275) Guildford Press

Upcoming Events

Autumn Research Seminars in the Unit for Social & Community Psychiatry

The S&CP regularly holds seminars to present to work of its members. These seminars are free, open to the public and held from 14:00-15:00 in the Lecture Theatre, Academic Unit, Newham Centre for Mental Health. For more information, call Carolanne Ellis on 020 7540 4210.

Date	Title	Presented by
13 April	***Group processes in therapeutic groups***	Stavros Orfanos
14 September	***DIALOG + in depression***	Victoria Bird
21 September	***VOLUME – Volunteer recruitment, training and coordination***	Eoin Golden
28 September	***QuEST – experiences and views on the effectiveness of supported accommodation services***	Sima Sandhu
5 October	***Developing, refining and testing intensive group music therapy for acute adult psychiatric inpatients***	Catherine Carr
12 October	***Alternatives to 'forced treatment' on mental health wards***	Paul McLaughlin
19 October	***Patient and carer involvement in acute psychiatric care***	Domenico Giacco
26 October	***Social network assessments for schizophrenia***	Claudia Gulea
2 November	***COFI – Comparing functional and integrated systems of mental health care***	Eleni Natala
9 November	***Retention of participants with mental health problems in non-pharmacological clinical trials***	Paulina Szymczynska
16 November	***Development of a mobile health intervention using positive psychology for common mental health disorders***	Sophie Walsh
23 November	***The involvement of family and friends in mental health treatment***	Aysegul Dirik
30 November	***Discussions around intimacy in routine clinical encounters***	Neelam Laxhman

SUGAR Invites You To Enter the Dragons' Den!

By **David Thomas** & **Alex Thornton**, SUGAR Administrators

SUGAR are delighted to be able to announce that we have had our workshop accepted for the International Network for Psychiatric Nursing Research (NPNR) Conference in Manchester on 17-18 September 2015.

This year our workshop will have a Dragons' Den theme. Researchers will have an allotted amount of time to pitch their research idea to SUGAR. The winner will be invited to meet with SUGAR to receive a full consultation on their proposal.

SUGAR (Service User and Carer Group Advising on Research) currently consists of 16 members: 13 service users and three carers recruited through East London NHS Foundation Trust (ELFT) using a 'role description' and person specification designed for the role.

The group reflects the rich diversity of London in terms of age, gender, sexuality and ethnic mix and includes people with a range of mental and physical illness and life experiences. It meets once a month and is facilitated and supported by Professor Alan Simpson and colleagues at City University London, to discuss and collaborate on all aspects of the research process.

Joint presentations and workshops have previously been given at a number of international and national mental health nursing research conferences and events.

Last year SUGAR members attended the NPNR conference at the University of Warwick where our workshop included some fun but also inspirational topics. Themes addressed included contemporary practice in mental health nursing research; innovation in teaching, learning and practice; involving people – where has it got us?; building new knowledge for effective practice; methodologies, methods and magic; and reflections and reminders.

The atmosphere was buzzing and the SUGAR workshop, which included presentations, video clips, a glossy cartoon-led booklet and giant sugar cube dice, was praised by many attendees, receiving good coverage on Twitter via #NPNR2014 and @ SugarSolution.

So after last year's successful workshop we are aiming to spread our message about the benefits of service user and carer involvement in research further by demonstrating what an important part the SUGAR group play in the field of mental health research. We are very excited about this year's theme of the Dragons' Den and hope it will be a huge success.

The group have just recruited four new members, who have already brought with them fresh ideas and perspectives. Our monthly meetings are now being fully booked months in advance, so researchers wanting to present to SUGAR are advised to get in touch as early as possible to book a slot. SUGAR is going from strength to strength and the future looks very exciting for all involved.

If you would to learn more, check out our blog at blogs.city.ac.uk/sugar or follow us on Twitter @ SugarSolution

OTHER NEWS

PHD STUDENT WINS PRIZE

Sophie Walsh, a first year PhD student at the Unit for Social and Community Psychiatry, won the prize for best presentation at the Wolfson PhD Day for her work Development of a mobile health intervention using positive psychology for common mental health conditions. After winning Sophie said "There are so many exciting projects going on across the Wolfson, from health conditions as diverse as cancer to haematology to mental health. It was fantastic to hear the progress of my peers and see the quality of research being conducted here. I was very pleased to be awarded a prize for the best presentation and I look forward to hearing about others' progression at next year's event!"

CLINICAL TRIALS GUIDE FOR TRAINEES

Clinical trials, compared to observational studies, are considered by many to be the gold standard method for evaluation of healthcare interventions. However, clinical trials are complex and many researchers, particularly those in the early stages of their career, find it challenging to know where to start, either to contribute to or lead a trial. The NIHR have released a guide with questions aspiring trialists need answering ahead of starting their journeys into clinical trials, as well a list of useful links. It can be downloaded at http://www.nihr.ac.uk/trainee-clinical-trial-guidance.htm

DEVELOPING A CLINICAL ACADEMIC CAREER

The National Institute for Health Research (NIHR) has worked with Health Education England (HEE) to create a short informative animated video about research opportunities available as part of the Clinical Academic Career pathway, including the new ICA programme. Watch it at: https://www.youtube.com/watch?v=4KevHrdxQ1M&feature=youtu.be

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.

■ Auty KM, Farrington DP, Coid JW (2015) *Authors' reply*. **The British journal of psychiatry : the journal of mental science**. 206(4): 343.

■ Bhui K (2015) *From the Editor's desk*. **The British journal of psychiatry: the journal of mental science**. 206(4): 353-4.

■ Bhui K, Aslam RW, Palinski A, McCabe R, Johnson MR, Weich S, et al. (2015) *Interventions designed to improve therapeutic communications between black and minority ethnic people and professionals working in psychiatric services: a systematic review of the evidence for their effectiveness*. **Health technology assessment**. 19(31): 1-174.

■ Bhui KS, Owiti JA, Palinski A, Ascoli M, De Jongh B, Archer J, et al. (2015) *A cultural consultation service in East London: Experiences and outcomes from implementation of an innovative service*. **International review of psychiatry**. 27(1): 11-22.

■ Butler M, Warfa N, Khatib Y, Bhui K (2015) *Migration and common mental disorder: An improvement in mental health over time?* **International review of psychiatry**. 27(1): 51-63.

■ Campbell T, Rohleder P, Beadle S & O'Keefe T (2015) *Psychological interventions in people with HIV disease: Considering the challenges in the fourth decade of the epidemic* In: **Watson RR (Ed). Health of HIV Infected People: Food, Nutrition and Lifestyle with Antiretroviral Drugs**, Vol. I, 551-569. Academic Press, Elsevier

■ Coid JW, Ullrich S, Zhang T, Sizmur S, Farrington DP, Freestone M, Rogers RD (2015) *Improving Accuracy of Risk Prediction for Violence: Does Changing the Outcome Matter?* **International Journal of Forensic Mental Health**. 14(1).

■ Constantinou AC, Freestone M, Marsh W, Fenton N & Coid JW (2015) *Risk assessment and risk management of violent reoffending among prisoners*. **Expert Systems with Applications**, 42(21): 7511-7529.

■ Cottney A & Innes J (2015), *Medication-administration errors in an urban mental health hospital: A direct observation study*. **Int'l J of Mental Health Nursing**, 24(1): 65–74.

■ Doyle M, Coid J, Shaw J (2015) *Authors' reply. Discharges to prison from medium secure psychiatric units*. **The British journal of psychiatry : the journal of mental science**. 206(3): 254.

■ Eylem O, van Straten A, Bhui K, Kerkhof AJ (2015) *Protocol: Reducing suicidal ideation among Turkish migrants in the Netherlands and in the UK: Effectiveness of an online intervention*. **International review of psychiatry**. 27(1): 72-81.

■ Giebel CM, Jolley D, Zubair M, Bhui KS, Challis D, Purandare N, et al (2015) *Adaptation of the Barts Explanatory Model Inventory to dementia understanding in South Asian ethnic minorities*. **Aging & mental health**. 1-9.

■ Highton-Williamson E, Barnicot K, Kareem T, Priebe S (2015) *Offering financial incentives to increase adherence to antipsychotic medication: the clinician experience*. **Journal of clinical psychopharmacology**. 35(2): 120-7.

■ Le Boutillier C, Chevalier A, Lawrence V, Leamy M, Bird VJ, Macpherson R, et al (2015). *Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis*. **Implementation science** IS. 10(1): 87.

■ McGilloway A, Ghosh P, Bhui K (2015) *A systematic review of pathways to and processes associated with radicalization and extremism amongst Muslims in Western societies*. **International review of psychiatry**. 27(1): 39-50.

■ Mir J, Kastner S, Priebe S, Konrad N, Strohle A, Mundt AP (2015) *Treating substance abuse is not enough: Comorbidities in consecutively admitted female prisoners*. **Addictive behaviors**. 46: 25-30.

■ Mundt AP, Chow WS, Priebe S (2015) *A More Robust Test of the Penrose Hypothesis-Reply*. **JAMA psychiatry**. [in press].

■ 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.

■ Nawka A, Kuzman MR, Giacco D, Pantovic M, Volpe U (2015) *Numbers of early career psychiatrists vary markedly among European countries*. **Psychiatria Danubina**. 27(2): 185-9.

■ Orfanos S, Banks C & Priebe S (2015) *Are Group Psychotherapeutic Treatments Effective for Patients with Schizophrenia? A Systematic Review and Meta-Analysis*. **Psychotherapy and Psychosomatics** 84(4): 241-249.

■ Owiti JA, Greenhalgh T, Sweeney L, Foster GR, Bhui KS (2015) *Illness perceptions and explanatory models of viral hepatitis B & C among immigrants and refugees: a narrative systematic review*. **BMC public health**. 15(1): 151.

■ Owiti JA, Palinski A, Ajaz A, Ascoli M, De Jongh B, Bhui KS (2015) *Explanations of illness experiences among community mental health patients: An argument for the use of an ethnographic interview method in routine clinical care*. **International review of psychiatry**. 27(1): 23-38.

■ Paclickova H, Bremner S, Priebe S (2015) *The Effect of Financial Incentives on Adherence to Antipsychotic Depot Medicaiton: Does it Change Over Time*. **Journal of Clinical Psychiatry**. [in press].

■ Piette A, Muchirahondo F, Mangezi W, Iversen A, Cowan F, Dube M, Grant-Peterkin H, Araya R & Abas M (2015) *Simulation-based learning in psychiatry for undergraduates at the University of Zimbabwe medical school*. **BMC Medical Education**. 15(1):23.

■ 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.

■ Renton J & Mankiewicz P (2015) *Paranoid, Schizotypal and Schizoid Personality Disorders* In: **Beck AT, Davis DD & and Freeman A (Eds) Cognitive Therapy of Personality Disorders** (3rd Edition) (pp. 244 – 275) Guildford Press

■ Rousseau C, Jamil U, Bhui K, Boudjarane M (2015) C*onsequences of 9/11 and the war on terror on children's and young adult's mental health: A systematic review of the past 10 years*. **Clinical child psychology and psychiatry**. 20(2): 173-93.

■ Savill M, Priebe S (2015) *Concepts and methods when considering negative symptom course: a reply*. **Psychological medicine**. 1-2.

■ Schrank B, Moran K, Borghi C, Priebe S (2015) *How to support patients with severe mental illness in their parenting role with children aged over 1 year? A systematic review of interventions*. **Social psychiatry and psychiatric epidemiology**. [in press].

■ Sweeney L, Owiti JA, Beharry A, Bhui K, Gomes J, Foster GR, et al (2015) *Informing the design of a national screening and treatment programme for chronic viral hepatitis in primary care: qualitative study of at-risk immigrant communities and healthcare professionals*. **BMC health services research**. 15(1): 97.

■ Theobald D, Farrington DP, Coid JW, Piquero AR (2015) *Are Male Perpetrators of Intimate Partner Violence Different From Convicted Violent Offenders? Examination of Psychopathic Traits and Life Success in Males From a Community Survey*. **Journal of interpersonal violence**. [in press]

■ Valenti E, Banks C, Calcedo-Barba A, Bensimon CM, Hoffmann KM, Pelto-Piri V, et al (2015) *Informal coercion in psychiatry: a focus group study of attitudes and experiences of mental health professionals in ten countries*. **Social psychiatry and psychiatric epidemiology**. [in press].

■ van der Krieke L, Bird V, Leamy M, Bacon F, Dunn R, Pesola F, et al (2015) *The feasibility of implementing recovery, psychosocial and pharmacological interventions for psychosis: comparison study*. **Implementation science**: IS. 10(1): 73.

■ Wherton J, Sugarhood P, Procter R, Hinder S, Greenhalgh P (2015) *Co-production in practice: how people with assisted living needs can help design and evolve technologies and services*. **Implementation Science**:10(75): doi 10.1186/s13012-015-0271-8