Our research shows that mental health clinicians who are consistently rated as empathic and genuine by their patients get better results. The finding was based on a study in 157 patients being treated for depression by clinicians in the United States.

It’s been known for a while that some clinicians consistently achieve better results with their patients than others. However, why this was the case was not clear. At the same time, we know that if a patient feels that their clinician likes them and is genuine and empathic, the patient does better. Most people know what “empathy” means – it means making a person feel that you understand their emotions and perspective on a situation. Being “genuine” is less often discussed. It means coming across as your true self, not putting on a front, not being false and not just telling a person what you think they want to hear.

What isn’t clear is whether this is really due to something about the patient, rather than anything to do with the clinician. For instance, it could be that patients who perceive their clinician positively are better at forming social relationships generally or have a more positive outlook — and that’s why they’re doing better in treatment. If it all really just comes down to the perspective of the individual patient, then saying that more genuine and empathic clinicians get better results could be a red herring. After all, one patient may perceive their clinician very differently than another. On the other hand, it could be that some clinicians are generally better able than others to show empathy and to come across as genuine, and that it is this that produces positive results. If this was the case, it could have important implications for clinician selection and training.

To investigate this, we used a dataset from the National Institute for Mental Health Treatment for Depression Collaborative Research Program. This involved 157 patients being treated by 27 clinicians. Because the same clinician was treating multiple patients, this enabled us to see if some clinicians really were consistently able to be more genuine and empathic than others — and whether this was important for good results. After their second treatment session, each patient rated whether they felt liked by their clinician and how genuine and empathic their clinician came across. We then averaged the scores across different patients being treated by the same clinician, to get an average score for each clinician. We found that patients who had been treated by clinicians with high average ratings of genuineness and empathy had less severe depression during and at the end of their treatment.

Finally, we calculated for each patient how different their perception of their clinician was from how the clinic’s other patients perceived them. We found that, even after taking this into account, patients treated by clinicians with high average ratings of genuineness and empathy did better. This means that, even if an individual patient does not think their clinician is very genuine or empathic, if the clinician is someone who is generally able to come across as genuine or empathic, the patient is more likely to do well. The full methods and results of this piece of research have been published in the Journal of Affective Disorders, volume 167, pages 112-177.

The results suggest that some clinicians seem to be generally better than others at making their patients feel liked.
Psychiatric and psychosocial morbidity before and after surgical treatment for refractory epilepsy

By Dr Maurice Clancy, Specialty Trainee

Epilepsy is a common disease affecting 0.5–1% of the population. There is a high prevalence of mental illness associated with it, approximately 25%. In patients with severe epilepsy which is resistant to treatment with medication, surgery may be an option if an identified aberrant piece of brain tissue is found to be the cause of the epilepsy, this usually occurs in a type of epilepsy called temporal lobe epilepsy. Surgical intervention can reduce the number of seizures or stop seizures completely. However, surgery can have undesirable effects on mental health. Older research papers on this topic state that there is increased risk of psychosis, depression, anxiety, suicide and accidents after patients have epilepsy surgery. More recent papers have not found this. The contradictory results of the existing studies may be because of the small sample sizes of the studies. Studies that includes small cross sectional studies with limited follow up, do not use formal assessment instruments and the patients group are heterogeneous. Bearing these limitations in the literature in mind, I conducted a prospective cohort study looking at rates and severity of mental illness in patients before surgery for epilepsy and looked at the same group of patients one year after surgery to see whether there was any different following up. The study was carried out in the National Centre for Neurology and Neurosurgery at Beaumont Hospital, Dublin Ireland. All patients who were possible going to have surgery for their epilepsy in the future were operationally and 48 patients proceeded to surgery and had follow up 1 year later. I had a 100% follow rate in terms of patients who had surgery, 20 male and 28 female patients were followed up and the average age was 35. Most of the patient had operations on their amygdalas, hippocampuses or temporal lobes. 88% of the sample had a reduced number of seizures or no seizures following surgery therefore there was a good surgical outcome. Twenty-four patients (51%) had a psychiatric diagnosis before surgery but this fell to fourteen following surgery (28.2). This result was statistically significant (p=0.021). There was no increase in the numbers of patients with depression or anxiety following surgery. This result was not significant. There was a dramatic reduction in the number of psychotic type symptoms following surgery (p=0.001). This was because epilepsy auras which are warning signs that a seizure may happen had stopped as there were fewer seizures post-operatively. Auras can be psychical hallucinations such as olfactory (smell) hallucinations, gustatory (taste) hallucinations, visual, auditory, tactile (feelings on the skin or sensory) hallucinations (feelings inside the body) hallucinations. There was no significant difference between HADS scores pre-operatively versus follow up. There was an improvement in Quality of Life following surgery with the average QOLIE-89 score increasing from 70 to 75 following surgery (p=0.02). In conclusion, my study demonstrated that there are high rates of mental illness associated with severe epilepsy. Undergoing surgery had a neutral impact on mental health with no increased rates of depression and anxiety following surgery. Quality of life improved after surgery. There were very low rates of new onset psychiatric illness following surgery. Clinicians and patients should be reassured that having a mental illness does not mean patients with severe epilepsy should not have surgery for their epilepsy. By Domenico Giacco, Senior Research Fellow and Aysegul Dirik, Research Assistant

Relatives or friends of patients in mental health treatment often provide unpaid help such as “carers” or “care assistants”. Studies have acknowledged this important, even if “non-professional”, role. Calls to involve families in patients’ treatment can be found in national mental health policies and are supported by decades of research evidence. Family members or friends can be engaged in treatment plans, recognise and respond to early warning signs of relapse and assist patients in accessing services during crises. As a result, their involvement in treatment can lead to better outcomes from psychological treatments, fewer inpatient admissions, shorter inpatient stays, and better quality of life reports by patients. Despite these demonstrated benefits, evidence suggests that patients’ families and friends are often not involved in routine mental health care.

Why is family involvement in treatment under-applied?

A recent systematic review (Basran et al, BMJ 2014) of the available evidence in the scientific literature was carried out at the Unit for Social and Community Psychiatry in order to answer this question. We searched all of the studies that collected data about family involvement in mental health treatment. We then targeted the studies that discussed the factors which were shown to be helpful or unhelpful when trying to work with families in clinical settings. A search of scientific databases initially identified more than 15000 papers. Excluding papers that were not relevant (in paper type or country) being included in the final review. After analysing the data from the reviewed papers, we identified the following main themes:

a) There needs to be a whole team approach
b) If only a few professionals in a clinical team are trained to do family work and the other staff members do not participate, the practical burdens of family work (such as the extra time it takes) can be too difficult for individual staff members to overcome. This can result in the work not happening at all, or not being carried out in the best possible way. Aside from developing specialist family interventions, there also needs to be a general focus on finding ways to enable family work. On the one hand, for example, allowing staff to have flexible working hours may help to address the needs of families who are only able to attend therapy sessions at certain times, or that can happen at an operational level include writing family work into business plans, policies and the job descriptions of all staff.

What can facilitate (or hinder) family involvement in mental health care?

a) Staff need training and ongoing supervision
b) The absence of adequate training and supervision for staff carrying out family work was often reported as a major barrier. As traditional clinical practices are focused on one-to-one encounters with patients, mental health staff may lack the skills or confidence to work with families. For example, they might not know how to manage group meetings where there are differences of opinion. Allowing staff to access supervision and ongoing support can help to increase their confidence in working with families.

c) Building trusting relationships is key

SOME STUDIES FOUND THAT FAMILIES THEMSELVES CAN REFUSE INVOLVEMENT OR NOT TAKE PART FULLY, SUCH AS BY NOT ATTENDING MEETINGS. THIS CAN BE FOR MANY REASONS, INCLUDING HAVING NEGATIVE EXPERIENCES WITH SERVICES IN THE PAST OR BECAUSE THEY DO NOT SEE THE BENEFITS IN THEIR INVOLVEMENT. INVOLVING FAMILIES IN TREATMENT PLANNING IS ALSO PROBLEMATIC (FOR EXAMPLE ALLOWING STAFF TO HAVE FLEXIBLE WORKING HOURS"

OTHER NEWS

ANNUAL EAST LONDON RESEARCH PRESENTATION DAY

The Trust’s 12th Annual East London Mental Health Research Presentation Day took place on 1st October 2014 in the Robin Hood House Lecture Theatre. The event was open to all Trust staff and was well attended by staff, trainees, and respected external speakers such as the Governors Council. The format of the day was a series of very brief presentations on a wide range of topics, each followed by questions conducted in the Trust. Attendees were able to get information about 14 different projects, ranging from the results of recent clinical studies to trials and qualitative work.

Feedback from the day was overwhelmingly positive. It was an “enjoyable and useful” way to hear about the ongoing research projects taking place across East London. There were “some really interesting things covered” by a “variety of presentations” that were “very informative and useful”.

Despite these demonstrated benefits, evidence suggests that patients’ families and friends are often not involved in routine mental health care. It is highly important for patients, carers and staff to have a respectful, equal partnership, which is enriched but not dominated by professional expertise.

Some studies found that families themselves can refuse involvement or not take part fully, such as by not attending meetings. This can be for many reasons, including having negative experiences with services in the past or because they do not see the benefits in their involvement. Involving families in treatment planning is also problematic (for example, allowing staff to have flexible working hours may help to address the needs of families who are only able to attend therapy sessions at certain times). This can happen at an operational level by including family work into business plans, policies and the job descriptions of all staff.

b) Approaches to family involvement were sometimes described as rigid and even culturally insensitive. If staff find it too closely to the “guidebook” they sometimes failed to meet the needs of particular groups. Whilst both staff and families valued having a clear structure for family involvement, it was helpful for staff sometimes changed things to accommodate the needs of individual families. For example, some families preferred to receive information face to face, as they found written materials too difficult to understand. In some instances, involving families and friends in patients’ mental health care requires support and changes in existing ways of working. Whilst management and staff at an operational level are very important, it is not enough on its own. There also needs to be support within teams – involving families should not be seen as the responsibility of just a few members of staff.

If you would like further information, please contact Domenico GIACCO at: d.giacco@qmul.ac.uk or a dirig@hrl.nhs.uk
A sweet future of patient & public involvement in research ensured

A component of independent research commissioned by the National Institute for Health Research (NIHR) in 2009, the long-term future of SUGAR (Service User and Carer Group Advising on Research) has been ensured through a partnership agreement established between City University London and the East London NHS Foundation Trust. Professors Alan Simpson and Len Fellowes have recently won a national award for presentations and posters. Two examples are:

- **SUGAR** has hosted a number of international visitors and recently won a national award for facilitating members of the research team. SUGAR members discuss and contribute to various aspects of research projects and the research process and have also written journal papers and given conference workshops and presentations. SUGAR has hosted a number of international visitors and recently won a national award for

**European Federation of Psychiatric Trainees: a key stakeholder for psychiatric training in Europe**

**What is the EFPT?**

The EFPT is a federation of national psychiatric trainees’ associations. EFPT was founded in 1992 in London, based on a spontaneous initiative of a group of 16 trainees from 9 European countries. Other countries have joined in the following years and currently EFPT includes 35 member countries. The number of member countries is constantly increasing. In 2010, EFPT became the first association of postgraduate medical trainees to become a recognized non-governmental organisation with headquarters in Brussels (Belgium).

The objectives of the EFPT are to:
- 1. promote the highest standards for psychiatric training and harmonization of training programmes in Europe;
- 2. facilitate the exchange of information, collaboration and networking between trainees in different countries;
- 3. represent trainees in the international bodies which are responsible for defining and overseeing training curricula in Europe; and
- 4. support the establishment of national psychiatric trainees’ associations in all European countries.

**How is the EFPT organised?**

**Annual Forums**

The central moment of EFPT activities is the Annual Forum, in which country delegations meet. It is organized by the sitting President in his/her country, therefore it takes place in a different country each year.

The Forum includes different sessions, each of them lasting for one day:

- a) Working groups: delegates meet in small groups that address specific aspects of training (e.g. in training on psychiatry, exchange programs or working conditions of trainees);
- b) Assembly day; the General Assembly is the main governing body of the EFPT. Each country has one vote and participates with two delegates (ideally a trainee in Adult Psychiatry and a trainee in Child and Adolescent Psychiatry). During the General Assembly the main decisions on EFPT Functioning are made.
- c) EFPT Board of Directors: The EFPT Board of Directors is the executive body of the Federation and it is responsible for the management of its overall and administrative functioning. It includes seven members, elected each year among the delegates participating at the Forum: President, Immediate Past President, President Elect, General Secretary, Child and Adolescent Psychiatry Secretary, Information Technology Director (IT Secretary) and Treasurer. Duration of the mandate for all Board members is one year, until the subsequent Annual Forum.
- d) Working groups day; delegates meet in small groups that address specific aspects of training (e.g. in training on psychiatry, exchange programs or working conditions of trainees).

**What are the main EFPT outputs?**

- **Statements**: The policy of the EFPT is described in the EFPT “Statements”. The Statements represent the official standpoint of European trainees on a wide range of topics (e.g. psychiatry training; working conditions of trainees, etc.). They are proposed by Working groups, approved by the General Assembly of the EFPT and regularly revised. EFPT statements are available on the EFPT website.

**Country reports and research projects**

All delegates of EFPT member countries present at the Annual Forum a brief description of psychiatric training in their country, the “country report”, with a focus on main challenges and issues in the previous year.

The EFPT has also a specific Research Working Group with the aim of evaluating training needs and implementation of training in different European countries. Projects of the research working group have assessed preferences on medication prescribing of trainees, their relationships with pharmaceutical companies, their use of Information Technology tools for training, their attitudes about training and their views on the future of psychiatry. Reports from these studies have been published in major international journals such as Lancet, World Psychiatry, European Psychiatry and BMJ Psychiatry.

Data from country reports and research project by the EFPT constitute a valuable source of information on improvements and problems for psychiatric training in different European countries. This evidence is used by EFPT Board members to advocate changes in training associated to the associations involved in definition of training standards (e.g. European level and at national levels, such as European Psychiatric Association and National Associations of Psychiatry).

**Influence on training standards at a European level**

The EFPT is active member, with voting rights, of the European Union of Medical Specialists (UEMS) Board of Psychiatry and Child and Adolescent Psychiatry and, as such, contributed to the development of European guidelines for training and on the monitoring of training guidelines implementation. Through EFPT, the opinions of psychiatric trainees have been incorporated in the main documents that set the standards in Europe for psychiatric training curricula. Two examples are:

- The “UEMS Framework for competences in psychiatry”, which lists the competences that all European psychiatrists should have; and
- The “Charter for Medical Specialist training – Chapter for Psychiatry” that provides guidelines for national policies on psychiatric training.

Both documents are accessible on European Union of Medical Specialists – Section of Psychiatry website (uempsychiatry.org).

**Promotion of networking and collaboration among European psychiatric trainees**

The creation of a “community” among European trainees is very important in order to avoid professional isolation, facilitate exchange of positive (and negative) experiences and stimulate a debate on how to improve psychiatric training.

The Annual Forums are a great opportunity for networking with other colleagues from different countries. In the next year, the Annual EFPT Forum will be held in Lisbon, Portugal.

Determined from the beginning of the year the EFPT supports and contributes to educational activities organised by the European Psychiatric Association and the European Federation of Psychiatric Training and to national/local events organised by the national associations of psychiatric trainees and psychiatric trainees.

The information presented here is only intended to give a “flavour” of what EFPT is and what the organisation has represented for psychiatric trainees around Europe in the last 22 years. For regularly updated information on the EFPT activities and if you are interested to become a member, please consult the EFPT website (www.efpt.eu).
Millfields Unit: The only quantitative evidence of efficacy to emerge from the DSPD programme?

By Dr Celia Taylor, Lead Clinician & Head of Service, and Dr Andrew Farnell, Research Director, Millfields Unit with Mark Freestone, Consultant Clinical Research Fellow, Violence Prevention Research Unit

Millfields Unit, the Trust’s inpatient medium secure personality disorder (PD) unit, recently published the first quantitative evidence of the efficacy of its treatment model to emerge from the Dangerous and Severe Personality Disorder (DSPD) programme (Wilson et al., 2014). This was an initiative of the previous UK Government, and its aim was to address a lack of services for PD offenders through the development of a network of units for the assessment and treatment of an estimated 1,400 men in prisons and a further 400 in high and medium secure psychiatric hospitals. DSPD offenders were defined through a combination of DSM-V diagnoses and psychopathic traits.

Despite the large sums invested in these services – in the order of £200 million between 2000 and 2010 (Tyrer et al., 2012) – independent evaluations were not favourable. The IMPALOX study of the assessment process for the high-secure prison units (Tyrer et al., 2011) found it to be too long, poor at selecting suitable prisoners, and frustrating for offenders who felt that their expectations were not being met; although some prisoners did report fundamental and positive changes in the way they were managed (Ramsey et al., 2009). Subsequent research into high secure prison and hospital DSPD programmes identified no positive change (Burns et al., 2011), and a lack of cost-effectiveness in the multi-methods used to assess effectiveness. From an effectiveness perspective, these have been modified such that only those are not well managed in a prison setting; a small number are on ‘step-down’ pathways from high security hospital (for a breakdown, see Freestone et al., 2012). Treatment is delivered through a modified TC approach comprising community meetings three times a week, with a focus on interpersonal dynamics and community living, and twice weekly small psychotherapy groups, which allow for the processing of childhood trauma and attachment difficulties, and their relationship to risk and offending. Modifications to the core TC consist of the incorporation of Cognitive Behavioural Therapy approaches addressing specific criminogenic needs such as substance misuse and violence. Millfields is the first NHS service to run the accredited Self Change Programme for violence reduction (Offending Behavioural Therapy Unit, 2001). Psychodynamic interventions such as individual and art psychotherapy are also offered. Community leave is facilitated for those eligible, and is underpinned by research into factors that most support desistance from offending by building social capital (Farrall, 2005).

Millfields staff set out to examine the effectiveness of its modified TC approach by considering:

- Whether there was evidence of change in violence risk during treatment.
- Whether there was evidence of change in psychological distress during treatment.
- Whether there were significant individual or treatment-related factors that predicted successful outcome.

This was a retrospective panel study of patient progress. The service routinely collects process monitoring and outcome data using measures of violence risk – the classical Clinical Risk-20 (HCR-20; Webster et al., 1997) and the Violence Risk Scale (VRS; Wong & Gordon, 2001). These are scored at annual intervals by a multi-disciplinary team of clinical and research staff, to ensure triangulation of perspectives on risk and management. Annual assessments of psychological distress are also undertaken, using the Symptom Check-list 90-R (Derogatis, 1994). Data analysis was performed on an ‘intention-to-treat’ (ITT) basis in which, if the patient was discharged (or transferred successfully or unsuccessfully) before the three-year mark, the final available value of the assessment was carried forward and used as a proxy for three-year outcomes.

The results showed evidence of reliable, and clinically significant decreases in risk and psychological symptoms as patients progressed with treatment. VRS dynamic scores showed consistent statistically significant decreases each year from initial assessment, whilst SQL90-R Global Severity Index scores decreased significantly between initial assessment and the third year of treatment. Analysis of HCR-20 scores was not conclusive, with an apparent improvement over two years of treatment followed by a non-significant increase in violence risk for patients in the third year of treatment. This result coincides with some individuals commencing community leave, which necessitates a change in scoring the HCR-2 and, by its very nature, the world outside the secure environment contains a multitude of unknown variables and therapeutic risks for patients, which are not measured until the patient reaches the point of scoring. Further, the now-accepted practice of dual-rating HCR-20 assessments simultaneously for both inpatient and community settings was not introduced in the service until mid-2011 (five years into the study). Some support for this hypothesis is lent by the fact that VRS dynamic items – with one exception relating to ‘security level of accommodation on release’ – are scored in the same manner throughout treatment.

The high proportion of reliable and significant reduction in psychological distress is supportive of the effectiveness of the Millfields treatment programme in reducing symptoms, which otherwise have the potential to elevate violence risk and complication management and treatment (Tyrer et al., 1996). In contrast to previous studies, this research was not limited by confounds that had the potential to impact upon follow-up assessments, because all measures were undertaken whilst patients were in the Unit. A further strength of this study lies in the multi-methods used to assess effectiveness of treatment, including both self-report and clinical assessment tools.

Millfields staff, in collaboration with the Violence Prevention Research Unit, plan to build on these findings by conducting a follow-up study, exploring the experiences of patients’ experiences of treatment.
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.