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

The PROMO study selected two highly deprived areas in 14 different European capital cities (in London these were Tower Hamlets and Hackney) and explored the provision of mental health care for six socially marginalised groups: long-term unemployed; street sex workers; homeless; refugees/asylum seekers; irregular migrants; and members of the travelling communities.

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

In the first part of the study (see Priebe et al. in Eur J of Public Health) all health and social care services providing some form of mental health care for to these socially marginalised groups were contacted; data were obtained on service characteristics, staff and programmes.

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

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

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

Continued on page 2.
Mental health care for socially marginalised groups in Europe

Continued from page 1
explored in each deprived area. Semi-structured interviews with case vignettes were conducted to assess experiences of good and of problematic practice. The interviews were analysed using thematic analysis.

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

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

Specifically for East London, the findings show that a reasonable number of services have been established to provide care for marginalised groups, but their co-ordination could be improved. This might be achieved through simple measures such as annual meetings of all services providing mental health care to a marginalised group in a Borough, a joint policy regarding referrals; c) strengthening the collaboration and co-ordination between different services; and d) disseminating information on services both to marginalised groups and to practitioners in the area.

Factors predicting the outcome of psychotherapy for borderline personality disorder

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

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

The team is pro-active in researching ways to improve treatment uptake. For example, a current study is comparing standard treatment with nurse-initiated treatment. Patients with no contraindications are started on treatment within a short timeframe by the BBV nurses, without having to attend a liver clinic. The aim of the project is to see if reducing barriers increases uptake or engages more chaotic drug users in to HCV treatment.

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

Improving Access to Healthcare for a Difficult to Reach Group

By Mandie Wilkinson,
Blood Borne Virus Team

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Factors predicting the outcome of psychotherapy for borderline personality disorder

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

A systematic review by Barricot et al. published in Clinical Psychology Review, identified two consistent positive predictors of symptom change: pre-treatment symptom severity and patient-rated therapeutic alliance. Contrary to theories predicting increasing immutability with age, there was no evidence that age predicted poorer outcome.

More severely ill patients may have greater potential to achieve change during therapy, and should remain a focus for psychotherapy services. The therapeutic alliance is an important common factor predicting outcome in patients with BPD, even in highly disorder-specific treatments. Outcomes may be improved by further clinical and research focus on forming strong therapeutic alliances. The advancement of the field requires identification and testing of new predictors of outcome, especially those related to specific theories of therapeutic change in BPD.
Personality Disorder: Does It Exist in Adolescents?

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

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

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

One of our consultants therefore combed through the mental health records of adolescents discharged from the Coborn Centre since 2001. She reviewed them for symptoms that would match six indicators (self-harm; affective instability; impulsivity; relationship instability; self-image disturbance; feelings of emptiness) generally symptomatic for PD if at least four are evident. Her study showed that some young patients were diagnosed with PD though they met less than four of these indicators, whereas some met four or more of them yet were not diagnosed with PD but with an Axis-I disorder instead.

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

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

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

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

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

By Tomás Campbell,
Newham Psychological Services

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

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

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

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


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

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

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

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

Relief was a predominant emotion as a response to the relative’s admission and it was accompanied by feelings of guilt and worry. Carers frequently experienced difficulties in obtaining help from services prior to involuntary admission and some thought that services responded to crises rather than prevented them. Carers experienced increased burden when services shifted the responsibility of caring for their mentally unwell relatives to them.

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

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

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

AREC PUBLISH UPDATED ‘HEALTH RESEARCH AND YOU’ LEAFLET

The Association of Research Ethics Committees has started to update and reproduce information sheets. To keep costs to a minimum, and also to try and ascertain the demand for this information, AREC have made the first leaflet ‘Health Research and You’ available to download from the AREC website. If it does prove to be popular, they will add ‘Medical Research and YOU’ and ‘Genetic Research and YOU’, aiming eventually to provide a dedicated email address for enquiries, as well as audio cassettes. To download a copy, see: http://www.arec.org.uk/health/

HEALTH RESEARCH AUTHORITY COMES A STEP CLOSER

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

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

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

For more visit: www.hra.nhs.uk

OTHER NEWS

LONG-TERM IMPACT OF WAR ON HEALTHCARE COSTS

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

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

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

Survivors of the London Bombings with PTSD

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

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

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

Services may be part of wider political responses to terrorism but this did not preoccupy participants. In CBT, during elaboration of traumatic memories, attention might usefully be paid to clients’ experiences of collective action taken during a terrorist attack.
Group music therapy for patients with persistent PTSD

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

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

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

Mixed methods

Mixed methods were used comprising of an exploratory randomized controlled trial, qualitative content analysis of therapy, and patient interviews. Patients who had significant PTSD symptoms following completion of CBT were randomly assigned to treatment or control groups. The patients came from diverse backgrounds and had experienced very different types of trauma. The treatment group received ten weeks of group music therapy after which exit interviews were conducted. Control group patients were offered the intervention at the end of the study.

Within group music therapy, a wide range of instruments are provided with many requiring little or no prior musical knowledge. A combination of active music making and receptive listening are used, with an emphasis upon the group freely improvising music together. Music therapists support this process both musically and verbally, guiding the musical activities, providing musical support and encouraging verbal reflection on thoughts and feelings arising from the musical experience. For the purposes of this study, the intervention was manualised, with a particular focus on building trust and safety, offering opportunities for socialisation and support, providing supportive psychotherapeutic interventions and using music to lower anxiety, enhance self-esteem, and alleviate re-experiencing, avoidance, hyperarousal and associated depression.

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

Emotional responses

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

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

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

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

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

The study found that patient and clinician ratings of the TR were weakly inter-correlated ($r_s = 0.13$, $p = 0.004$), but each was independently linked with better adherence. After adjusting for patient-rated TR and symptom severity, each unit increase in clinician-rated TR was associated with an increase of the odds ratio of good compliance by 36.5% (95% CI: 34.6% to 39.8%).

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

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

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

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

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

Testing the Psychopathology of Psychosis

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

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

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

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

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

Recent Publications Continued

Continued from page 7

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


