In light of the recent refugee crisis, the World Health Organisation has commissioned to the Unit for Social and Community Psychiatry, WHO collaborating centre for mental health service development, a review of the evidence on mental health needs of refugees and good practice for their care. The main findings are presented in this article.

**Mental health needs of refugees**

Overall, the rates of mental disorders identified in refugees vary substantially across studies.

This heterogeneity is mainly due to three factors:

a) The characteristics of the groups studied – for example background, qualifications and motivations – vary widely.

b) The context and situation in the host country: generally speaking, the poorer the host country the higher the rates of mental disorders in refugees.

c) The quality of the studies: studies of higher methodological quality generally report much lower prevalence rates than poorer studies with small and non-random samples.

Considering these problems, the most comprehensive reviews of the literature showed that:

- major depression rates in refugees are similar to those in the general population in Western countries;
- the prevalence rate of psychosis in refugees is around 2%, similar to psychosis rates among the general population in western countries (Llosa et al., 2014);
- refugees are about ten times more likely than the age-matched general population to have post-traumatic stress disorder (PTSD);
- 9% of refugees in general and 11% of children and adolescents have PTSD.

Hence, the very fact of being a refugee seems not to be the most significant criterion for the potential risk of mental disorders.

However, refugees can be exposed to various stress and traumatic factors that can negatively affect their mental health. These are commonly categorised as pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty).

Once a mental disorder has become manifest in a refugee, post-migration factors are critical to whether the disorder (in particular depressive disorders) will become chronic. Lower mental disorder rates were linked to being in employment, having appropriate living arrangements, and feeling accepted in the host country.
Mental Health Care for Refugees: Evidence and recommendations for good practice

The Unit for Social and Community Psychiatry, established jointly by ELFT and Queen Mary University of London (QMUL) in 2009, is designed to focus on the mental health care of refugees from five European countries to discuss and explore options for how mental health care could be provided in the future. Mental health care has improved over the last five decades in line with increased funding, but there have been no major significant research discoveries or service models. Innovation is therefore required, and training and support for the workforce must be carried out, this is likely to be driven by social values and social models.

The Unit for Social and Community Psychiatry (USCP), within the East London and Essex Mental Health NHS Foundation Trust (ELEM), and the London School of Hygiene and Tropical Medicine (LSHTM), have been working alongside experts from across the refugee and mental health communities to develop a new technology-supported intervention in improving the care of refugees. The intervention is called the ICTMC (Interactive Communication Training for Mental Health Care), and it involves a series of workshops and webinars to help professionals understand and communicate with refugees. The workshops are designed to facilitate first contacts with professionals in the host country and to help refugees to overcome barriers in accessing mainstream services for physical and mental health care.

The project is focused on developing good practice guidelines for mental health care for refugees, with a particular focus on providing guidance on how to improve care in the context of refugee resettlement. The project is supported by the UK’s National Institute for Health Research (NIHR) and the European Commission’s Horizon 2020 program. The project team includes experts from the UK, the US, and Europe, and they have been working together to develop the guidelines.

The project team has identified several key areas for improvement in mental health care for refugees, including:

1. Increasing awareness of the cultural and linguistic needs of refugees
2. Improving communication skills among health professionals
3. Developing culturally sensitive care plans
4. Providing adequate support for refugees with mental health conditions
5. Ensuring that refugees have access to appropriate mental health services

The guidelines will be published in 2021 and will be available free of charge on the project website. The project team plans to disseminate the guidelines widely to stakeholders, including policymakers, clinicians, and training providers. The project team will also seek to implement the guidelines in clinical settings, with a view to improving the quality of care for refugees.

The project team is also working on developing an online training program for health professionals, which will be launched in 2022. The training program will provide a comprehensive overview of the guidelines and will be tailored to meet the needs of different stakeholders.

The project team believes that the guidelines and training program will help to improve the quality of mental health care for refugees in the UK and abroad. They hope that the guidelines and training program will be widely adopted by health professionals and used to improve the care of refugees in the future.

Can mental health interventions change social networks?

It is widely understood that people with severe mental illnesses, such as psychosis, often have social network problems: many have an average of 6 contacts. These contacts are usually made up of family members, friends, and work colleagues. The number of contacts tends to decrease over time, and this is likely to be driven by social values and social models. Multiple reasons have been recognised for the difficulty in establishing social relations, some being illness related, such as symptoms or being socially disadvantaged, while being employed may reduce the likelihood of establishing new contacts. The challenge in mental health is to overcome the issues surrounding patients with small social networks. Previous interventions have focused on social skills training, to equip patients with enough social skills to socialise, but results have found that they mainly fail in helping patients to create real life contacts. There has been little research into whether specifically targeting small social networks leads to an increase in social contacts.

A systematic review (Anderson et al. BMC Psychiatry 2015) included reviewing all randomised controlled trials (RCTs) whose primary aim is to improve the social networks of patients with psychosis, to determine the effectiveness of existing psychosocial interventions. A total of five papers met the inclusion criteria, as their primary aim was to increase social contacts. These studies were conducted in Italy, Ireland, Netherlands, Japan and Israel. The interventions offered to patients across these studies were varied, patients working closely with staff to identify areas of interest and how they could get involved in corresponding activities. In some cases a mentor or a volunteer + stipend, meeting with a volunteer to do activities or a social scenario could drive forward the science and practice of mental health care.

The intervention involved delivering groups, namely guided peer support, where a nurse would initiate a discussion related to illness within a group and allow group members to contribute. Another study involved delivering social cognition training, where patients worked in groups to discuss their social cognitive impairments. Both the control and intervention group received social training, which involved weekly meetings with a mentor to help set goals related to the patient’s social life, as well as offering social skills training.

Some of the interventions were cognitive psychological therapy (PT) intervention, where they used a structured group which focused on cognitive differentiation, social perception, verbal communication and social skills training and problem solving. The experimental group also had a therapy dog, where it was believed the presence of a therapeutic animal can have a positive effect on social interaction. It was found that four of the five interventions, successfully increased social network sizes.

Peer support groups, social cognition training, intervention training and social skills training can all be successful in helping patients to increase their social networks. It is important to identify which interventions are most effective for different groups and how they can be tailored to fit the needs of the patients.
Care Planning and Care Coordination in Community Mental Health:
What makes it collaborative, recovery-focused and personalised?

By Professor Alan Simpson
City University of London

This is a summary of the findings from a research study, in collaboration with researchers from three universities: City University London in England, and Cardiff and Swansea Universities in Wales.
The research involved the study of care planning and coordination: Collaborative Care Planning Project (COCAPP) which was carried out in six NHS mental health service provider organisations: four in England and two in Wales. One of the reasons for carrying out the research in both England and Wales is that Wales has a mental health service provider organisation called the Mental Health Measure, introduced in 2010. This is intended to ensure that where mental health services are delivered, they focus more appropriately on people’s individual needs. In England, care planning is often guided by and is not legally required. However, there are different systems in England and Wales and the way that people receiving mental health services should have a care coordinator, a written care plan and regular reviews of their care. With the introduction of the Mental Health Measure, it is now expected that care planning and coordination should be focused on and that people will be taking more control over their own support and treatment.

We wanted to find out what helps and what hinders care planning for people with severe mental illness. The study was collaborative, personalised and recovery-focused. By collaborative, we mean that care planning was completed in partnership with the service user: the coordinator works with the service user to plan their care. By personalised, we mean that care is designed with the involvement of the service user and designed to meet their individual needs. By recovery, we mean ‘a personal journey ... one that people will experience’. By collaborative we mean that care planning is agreed by the service user and their carers. We reviewed 33 care plans with the permission of the service users concerned.

What did we find?
There were no major differences between the six sites on the empowerment or recovery scores on the service user questionnaires.
We found some significant differences between sites on some recovery scores for the care coordinators: where they saw a greater range of treatment options, the service was rated as more recovery-focused.
We found a strong positive correlation between scores on the recovery scale and the therapeutic relationship scale for service users; this suggests that organisations perceived to be more recovery-focused were also perceived as having more therapeutic relationships.

Some common themes across sites:
Austerity and re-structuring: Cuts and merging of services, increased workloads, integration of health and social care services, refocusing of services, increased use of voluntary services;
Bureaucratic factors: Administrative burdens, inflexible computer systems, unwieldy documentation, poor communication, limited training in coordinator role/recovery approaches, high caseloads preventing recovery-oriented work;
Contractory policies: Some policy developments appeared to go against a recovery focus (e.g. Payment by Results, Community Treatment Orders); whereas others supported the recovery focus (e.g. personal budgets);
Care planning was varied across the perspectives of service users, carers and care coordinators within and across all six sites with no distinct reasons for these variations identified.
There is a tension between the standardisation of documentation and the ability for the care planning approach to focus on the individual’s needs.

Care Planning:
Overall, there were major challenges in trying to make care planning and coordination meet the different needs of service users, practitioners, managers and commissioners:
Care plans were seen as largely irrelevant by most service users who rarely consult them;
Care coordinators regarded care plans as a useful record but also an inflexible administrative burden that restricts time spent with service users. Once written, they rarely consulted them.

Care planning and therapeutic relationships:
Service users value their conversations and relationships with care coordinators more than they do care plans;
Relationships with care coordinators, support workers, family and other carers are seen as far more important to recovery.

Risk and safety:
Risk is a very significant concern for managers and clinicians. However, it did not appear to be openly discussed when we reviewed the care plans of people who were often unaware that risk assessments had taken place;
This appears to limit the involvement of service users (and carers) in exploring and managing their own risk and prevents positive risk-taking from becoming a part of people’s recovery.

Recovery and personalisation:
We found great variation in understandings of recovery and personalisation, both within and across sites and within groups of staff, service users and carers.

Conclusions:
Positive therapeutic relationships appear to be the most important factor in helping care planning and care coordination to be personalised and recovery-focused.
Excessive administrative tasks and inflexible systems, though sometimes necessary, should be addressed in order to increase the time staff can spend with service users and carers;
Everyone involved needs to have a shared understanding of the ideas behind recovery and personalisation, developed in partnership with service users, carers, and frontline practitioners;
Training may not be enough to bring about the necessary changes and without also addressing the wider political and organisational issues.

We recommend research to investigate new ways of working and training to increase staff contact time with service users and carers and to improve on a focus on recovery.

Adolescent Sibling Groups within a CAMHS Disability Service: Service User Perspectives

By Bethan Manford (Assistant Psychologist)
& Dr Carolyn Gracey (Clinical Psychologist)
Hacking Ark, Homerton University Hospital NHS Foundation Trust & Jeans Appeal, A宁 (Clinical Psychologist), Royal Holloway, University of London.

Adolescence is a period where many developmental changes take place. Identity, belonging, puberty, position of self in families and society pose many questions for young people to understand. Sibling groups provide a space where young people can meet other siblings, discuss common joys and concerns and learn to manage situations often experienced (D’Arcy et al. 2006). Sibling group participation supports self-esteem and knowledge of disability (Smith & Perry, 2004). Literature suggests that siblings of children with a disability have additional responsibilities and benefit from time and space for psychological self-adjustment (Feetalas et al, 2009). This research was conducted to assess how an adolescent sibling group was able to meet the needs of young people with a sibling with a moderate or severe learning disability.
The CAMHS Disability team is a specialist tier 3 NHS provision for children with disabilities and mental health/behavioural problems. Much of our work is with children with significant learning disabilities. We facilitate groups for siblings aged 6-11 and 11-19. Feedback has shown that these groups are valuable for young people to think about their wellbeing. Sibling group opportunities to play, learn and explore relationships and narratives both within and outside of family life. Our adolescent sibling group’s attendance was poor and we wanted to think together with young people about ways to make the groups a better fit and to improve future attendance. There is also a paucity of services for siblings of young people with moderate-profound disabilities. There is also a paucity of service user involvement research where young people are able to influence how services are provided. We aimed to take into consideration systemic family needs where there is a child or young person in the family with a significant disability.

Methodology:
A qualitative approach was adopted using a focus group and a semi structured interview format. Questions centred on how siblings gained from the group, what they found difficult and ideas for improvements. The session was audio recorded and notes taken by facilitators and siblings for shared ownership. Participants were siblings who had previously attended group interventions for adolescents at Hacking Ark. We discussed the research with these young people who had attended previous groups and invited 7 to participate. 2 young females (aged 12) took part in the focus group. Some adolescents who were invited did not attend and we were able to ascertain factors for drop out from sending a short questionnaire by post. Reasons for not attending included: being on holiday and being the only boy in the groups. Our inclusion criteria invited young people of a similar age group (those aged 11-19), who had attended a Hacking Ark adolescent sibling group in the last two years. They also have a sibling with moderate/profound disability. In regards to ethical considerations, an information sheet was given to the adolescents and their parents. Informed consent was given by parents and young people. Right to withdraw, confidentiality and anonymity were explained to the young people.

Several key themes and sibling narratives emerged:
Improved understanding and coping
“I gave me ideas about how to cope with my brother and helped me to communicate better with him; our relationship bond is stronger”

Shared experiences and stories (normalising)
“Sometimes my brother shouts and I don’t know why”
“You feel like you’re the only one that feels this way, like you are the only one in the world. But when you realise that other people feel the same way, it kinda actually makes you feel glad and quite grateful. I can understand similar experiences”

Safe place
Access to a place siblings felt empowered and could trust group members to share thoughts and feelings “I felt I could trust you guys”

Roles and responsibilities
Personal and shared, within the group, families and society “I’m kinda like the younger mum”

Learning and teaching
Experiences of learning, knowledge and teaching facilitators, each other and those in the community their siblings “At first it’s hard to understand their communication and actions, how they react to stuff but eventually you will get used to it all and it will get easier”

Making connections
Connections made with each other, with families and their families. A desire for broader society to understand. “I think what stops other people coming is probably they might feel embarrassed having a sibling with a disability. I used to be embarrassed but now cos like I understand, I don’t feel that way…”

Championing
Speaking on behalf of their sibling wanting to broaden understanding to reduce stigma in the community

Hope and resilience
Future positive change and an overall sense of self awareness, adaptability and various abilities to cope with stressful situations

Conclusion:
In line with previous findings, the focus group outcomes suggest that siblings benefit from attending groups at CAMHS. These groups increased adolescents’ understanding of their brother/s sisters disability provided a space for understanding how to manage their own emotions and reinforced strategies to improve coping. An overall theme resonating from the young people was resilience. In terms of implications, the groups built positive identities and networks for young siblings. Sibling groups can help create a broader network in the local community, thus supporting the journey of coping with disability in the family. There is a need to implement service user ideas to increase attendance to the groups for adolescent siblings being led by their needs.
Burnout syndrome among psychiatric trainees

By Nikola Jovanovic, Clinical Lecturer & Psychiatrist Unit for Social and Community Psychiatry

What is burnout and why is it important?

Recruitment and retention in psychiatry have been two issues of major concern in recent decades. While negative perception of psychiatry may discourage medical graduates from entering the field, reports from doctors leaving psychiatry have indicated reasons such as high numbers of challenging patients, depressing work conditions, job stress and low morale among staff.

Work-related burnout syndrome is characterised by high levels of emotional exhaustion, cynicism, and low sense of professional efficacy. Staff burnout has been associated with impaired patient care, reduced levels of well-being, increased rates of turnover, and decreased levels of employee satisfaction. This presents a considerable burden to the workforce of mental health services.

The effect of working hour limitations has been studied extensively and it was found that trainees who worked more than 48 hours had higher rates of burnout than those who worked more than 32 hours. In the study, the authors reported an average of 53.7 working hours per week divided between the workplace and work assignments. However, the sample size was not clearly defined. The impact of burnout on clinical performance and patient outcomes has been extensively studied, with associations between burnout and poorer patient outcomes observed.

Supporting patients with Medically Unexplained Symptoms (MUS): an innovative care pathway piloted in primary care

By Frank Röhricht, Consultant Psychiatrist & Associate Medical Director

Currently, patients with MUS who are treated based on somatization disorder or “functional symptomatology” disorder in new classification systems, may have unmet health needs as a result of incorrect diagnosis; it is likely that they do not engage these patients in a holistic care and consequently treatment is often ineffective. This is despite frequent presentation at primary and secondary care services, resulting in high cost pressures on the health economy. Existing models have not met the complex needs necessary to achieve positive health outcomes for this group.

The Health Foundation gave ELFT a SHINE award of £75,000.00 to pilot a new programme in primary care for patients with MUS in a new care pathway, over a period of 18 months (June 2014 to December 2015) in east london. Professor Frank Röhricht was the lead researcher and project lead and the project was the manager, supervisor and trainer.

This report can serve as a starting point for wider discussions on the condition and its management. It is hoped that this project will be repeated elsewhere and that the findings of this project can be used to disseminate the results. We applied and we were awarded a further £30k for spreading innovation, support dissemination, a new project which will take place between January 2016 to January 2017. The objectives of this project are to:

- disseminate the findings of the Health Foundation project
- raise awareness amongst major stakeholders in respect of the scale of the problem, associated burden to the health economy, specific needs of the population
- consider possible solutions in terms of care pathway developments
- enthuse commissioners in respect of setting up a novel and innovative care pathway that combines clinical and cost effectiveness and stands good chances of reducing expenditure
- gather a group of interested and dedicated GP mental health leads in order to develop champions for their spreading implementational efforts
- contribute to upskilling primary care practitioners (GPs, nurses and dance-movement psychotherapists)
- develop the workforce for the delivery of the novel body-oriented interventions for MUS sufferers
- develop an information and networking platform for local and staff services
- ensure timely and appropriate access to dedicated enough time to running the proposed care finding algorithm; their day-to-day running of surgeries is so tightly managed that it leaves hardly any room for research into additional treatments.

For more information contact Frank Röhricht at Frank.rohricht@elft.nhs.uk
Double take on research quality

Combined expertise on two key aspects of Noclor’s services – Regulatory Compliance and Sponsorship – ensures that support is given only to research of the highest scientific and ethical standards. Any research study at an NHS site requires the appropriate permission before it can start, so Noclor offers specialist advice to guide researchers smoothly through the procedural web of legal requirements and forms to be completed. For all research, local permission must be sought directly from the NHS organisation where the research is to be conducted. Noclor arranges this permission for any research conducted at its NHS partner sites.

Studies that are awarded a research grant can be accepted to the NHR Portfolio, which enables access to support staff and facilities from the local Clinical Research Network. Another key requirement for any research study in the NHS is that it has a sponsor, who acts as guarantor that the research is designed, conducted and reported to internationally-recognised principles of Good Clinical Practice (GCP) and relevant legislation.

Ideally, a sponsorship request should be made at the time the research protocol is being developed, or at least at the grant application stage. Formal declaration from the designated sponsor is required before any application to the Health Research Authority (HRA) and any other regulatory authorities can be made.

Commercial trials have commercial sponsors. For non-commercial research, the appropriate sponsor may be the funding organisation, the organisation that will administer the funding, the employer of the Chief Investigator, or the lead care organisation where the research is to take place. Noclor provides sponsorship support services to its partners. If researchers require a Noclor partner to act as sponsor, then they should request it prior to applying for any other permission.

Research can get results that benefit the public through innovation.

Mabel Salii, Noclor’s Research Project Management and Governance Manager, heads the team responsible for the research governance approval process. She helps resolve any issues that the team may be experiencing, and responds to complex queries from researchers. For support or information, contact: mabel.salii@noclor.co.uk

Without high-quality research, treatment cannot improve.

Emmanuel Rollings-Kamara, Noclor’s Regulatory Compliance Manager, is responsible for training his team members to ensure that they give researchers an excellent level of service, and also reviews applications for sponsorship. For support or information, contact: emmanuel.rollings-kamara@nhls.net

Social networks of patients with psychosis

By Aleksandra Matanovic, Research Assistant, Unit for Social and Community Psychiatry

Social networks are important for both mental and physical health as they can help individuals to cope with stress. Large studies have shown that social isolation is a major factor for morbidity and mortality. Individuals with psychosis may have specific difficulties in establishing and maintaining social relationships. This could impact on their well-being and quality of life. Previous research on patients with severe mental illness has shown that their social networks tend to be smaller and mainly composed of family members. Illness-related neurocognitive deficits, but also various social stressors may result in difficulties in social interactions and lead to social isolation. For example, stigma attached to a diagnosis of schizophrenia and associated disorders can significantly reduce opportunities to form relationships.

Social disadvantage resulting from loss of employment and financial problems may increase isolation further. The lack of symptoms, length of illness, and frequency of hospitalisation also impact on the number and quality of patients’ social ties. Some authors argue that demographic and family structure changes in modern societies may reinforce social deficits experienced by people with psychosis. Increasing numbers of people live away from their family, or are alone. Ability to form new social relations outside the family circle is becoming increasingly important in contemporary society, particularly in large cities.

Assessing characteristics of social networks in a systematic manner has been advocated as a priority for mental health research. In particular, their size is important both as a relevant outcome criterion of psychosocial interventions, and as a factor influencing quality of life and service use. Against this background, the aim of our study was to systematically review the papers reporting the size and composition of social networks of individuals diagnosed with psychotic disorders, as well as the papers reporting the size of their friendship networks. The resulting paper (recently published in BMC Research Notes) contributes to information on social needs of this population, and also provides an insight on advantages and limitation of current assessment methods.

We conducted a systematic search of three bibliographic databases and scrutinised the reference lists of relevant scientific papers to identify any further literature. We also carried out a hand search for studies in key journals, reviews on the topic and conference abstracts. Papers were included if they described studies conducted on adults (i.e. ≥18 years of age) suffering from a psychotic disorder (i.e. including a standardized diagnosis of either schizophrenia, schizoaffective disorder, “narrow schizophrenia” spectrum disorder, or ‘psychosis’).

Available data on the size of the total social networks and friendship networks were summarized

Continues over on page 10

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 1-4:00-15:00 in the Lecture Theatre, Academic Unit, Newham Centre for Mental Health. For further information, please contact carolanne.ellis@elft.nhs.uk or Ruth.Cooker1@elft.nhs.uk

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<td>Domenica Giacco</td>
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<td>Catherine Carr</td>
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<td>Retention of participants with psychosis in non-pharmacological clinical trials</td>
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<td>EED/57 WFU Update</td>
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<td>RADAR Update</td>
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OTHER NEWS

Researchfish: Demonstrating the benefits of NIHR funded research

In the current economic climate the NIHR has declared that it is vital that it can prove its worth in hard data. Researchfish (www.researchfish.com) is the main way this information is gathered and it relies on information provided by investigators during the submission period. This data contributes to reports and decision-making such as the comprehensive spending review.

All recipients of NIHR research or training awards are required to report on an annual basis through Researchfish. If you have any questions please contact evaluation@nhr.ac.uk

Professor Dame Sally C Davies responds to ‘Going the Extra Mile’

Professor Dame Sally C Davies has responded to ‘Going the Extra Mile’, the report she commissioned in March 2014 from the Breaking Boundaries Review Panel to provide an independent review of public involvement in research in the NHS.

‘Breaking boundaries’ is a reference to the removal of barriers between service users and researchers. Nearly ten years after the NIHR was established, it was thought timely to consider how far the NIHR and related activity had come on in terms of public involvement, engagement and participation journey and where we would like to be in another ten years’ time.

Having reviewed the report’s recommendations, Dame Sally has agreed that the NIHR takes them forward. This important work will be led by Simon Denegri, who is the NIHR’s National Director for Public and the Public in Research, with support provided by the INVOLVE Coordinating Centre. The NIHR community will work in partnership to deliver the recommendations of the report.

New guidance on NHS excess treatment costs

The NHS has published new guidance on Excess Treatment Costs (ETCs) for research covering both how to meet these costs and the responsibilities of commissioners, providers and researchers in the funding of ETCs.

This guidance (which can be found at www.england.nhs.uk/commissioning/research/etc) reflects the already existing policies and principles, but is intended to provide guidance on how such costs should be identified and how the payment of these costs can best be managed by NHS bodies, in accordance with the established policy.

Correction

The article on Modelling clinical decision-making for high-risk offenders using Bayesian Networks, which appeared in the Summer 2015 edition of this newsletter was incorrectly attributed; the correct author of this work is Dr Mark Freestone, Clinical Research Fellow, Violence Prevention Research Unit. Our apologies to Dr Freestone for this error.
Mental Health Research in East London

Half day Conference Wednesday 5 October 2016

Are you interested in the latest mental health research? A showcase of more than a dozen projects emerging from epidemiological studies to clinical trials and qualitative work undertaken in East London.

From 14:00 to 17:00

Robin Brooks Centre
St Bartholomew’s Hospital
West Smithfield London EC1A 7BE

Details and registration at https://www.eelfts.nhs.uk/Research/ELFTResearch

Social networks of patients with psychosis

Continued from page 10

As weighted arithmetic means to account for the different number of participants across the included studies.

Our systematic review identified 20 papers which reported the size of whole social networks (20 papers) and/or the size of friendship networks (7 papers).

In our review, the networks with more than one category of social figures were reported in 20 studies for a total of 1184 patients. The number of friends was reported in 7 studies for a total of 1163 findings. Our findings show that for patients with psychosis, on average 11.7 individuals in their social networks, while the average number of friends was 2.4. These figures varied substantially across studies, i.e. for whole social network sizes ranged from 4.6 to 44.9. The social networks were family-dominated with on average 63.1 % of network members being relatives, in contrast to 26.5 % of members categorised as friends. As for the patients’ characteristics associated with network size, having higher levels of negative symptoms and not being married may be associated with smaller social networks. Our findings on the average social network size and composition in patients diagnosed with psychosis are similar to those reported by previous systematic reviews on social networks of patients with severe mental illness. Their social networks are smaller than in non-clinical populations, and also family-dominated. This is in contrast to, for example, networks of patients with HIV, where family and friends are equally represented. With regard to the size of friends networks, the average number of 3.4 friends found in our review was much lower than the figures reported for the general population in the UK (N = 10.6, for men and N = 7.6 for women). Previous research has found that more than half of people with severe mental illness report friends who attended groups and people to whom they also linked to small social networks. It needs to be stressed that the studies that included showed significant conceptual and methodological heterogeneity which limited the comparability of the results. It is necessary to develop comprehensive and conceptually-driven methods and assessment tools which could be used to access social relations of people with psychosis. In depth explorations of specific difficulties that people with schizophrenia experience in establishing and maintaining social contacts and how their social relationships differ from unfolded controls should be carried out. These are required steps to allow the development of effective strategies to increase social support for people with psychosis and to be able to test the effectiveness of interventions. Finally, many of the examined studies were conducted in times when the internet and social media were not part of our daily interactions, and future research may benefit from exploring virtual networks of people with psychotic disorders.

To befriend or to be a friend

Friendship is commonly held to be one of the key relationships defining schizophrenia and meaning to life. However, it is widely established that people with severe mental illness struggle to maintain meaningful relationships. This leads to high levels of social isolation, which in turn is linked with poor illness outcomes. One way of addressing patients’ isolation through volunteers who offer to spend their free time with people with severe mental illness offering one-on-one support to improve their social network is commonly known as befriending. In England alone, there are approximately 500 NHS independent befriending services. The assumption is that befriending relates to some form of friendship, however, there is little understanding how the term is understood and practiced by different organisations, and the impact of the different definitions on both patients and volunteers. We therefore carried out a systematic review with a narrative synthesis to explore how befriending is conceptualised and practiced. We reviewed articles found in grey literature (20 papers) and explored the practical implications of the different concepts of befriending. The key understanding of the phrase ‘to befriend’ is ‘to be a friend to’. However, the literature suggests that this definition of befriending is based on a range of relationships from very similar to natural friendships with no pre-defined goals, time restrictions, or boundaries, and one that could be conceptualised as a professional therapeutic relationship with clearly attached definitions. Understandably, there are advantages and disadvantages in defining befriending as ‘true friendship’ allows for development of a close of a relationship where one feels protected. At the same time, there are risks associated with personal boundaries being crossed or emotional lattices that might occur in natural friendships. Befriending as a ‘friendship’ implies that the term befriender will differ clear goals to be achieved and well defined boundaries between the patient and volunteer, which minimises the risks of emotional lattices. On the other hand, in these instances the term befriender becomes misleading for both patient and volunteer, and might lead to disillusionment and disappointment. Some patients may benefit from being approached as ‘true friendships’, as emotional implications, while others may prefer some form of supported companionship with clear boundaries as well. The two frameworks schemes might be useful for different contexts. Using appropriate labels – perhaps new labels – would avoid misleading the understanding and commitment of both patients and volunteers.

Studies recruiting in your trust

Volunteering in the Unit for Social and Community Psychiatry for People with Mental Illness

We are conducting a trial at the Unit for Social and Community Psychiatry into volunteer schemes for people with mental illness. We are interested in finding out whether people who are paired with a volunteer companion for one year up to being less isolated, doing more activities and having more social contacts than those who don’t have a volunteer. We need help identifying eligible patients who might be interested in taking part.

Patients will be considered if they

- Have a diagnosis of schizophrenia (ICD8:168) (Schizophrenia or related disorder)
- Do not need an interpreter
- Currently not receiving peer support/befriending in the last 2 years

What does it involve?

Patients will be randomly assigned to one of two groups. Patients in the first group will be matched with a volunteer companion who they will meet once a week for 1 year. Patients in the second group will not be matched with a companion, but will be given information on local activities. Both groups will be invited to take part in questionnaires at intervals throughout the study and will receive £15 each time.

If you would like to find out more about the trial, please contact Hussein Khaman by phone 020 7540 4380 ext: 2012 or email hussein.khaman@elhtfts.nhs.uk

Recent Publications

Notification of the following publications has been received since circulation of the last newsletter. Don’t be left behind! Please send copies of papers or reference details to ResearchOffices@elhtfts.nhs.uk so they can be included in this list and made available to interested staff.

Recent Publications Notification that 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.

- White PD, Chalder T, Sharpe M. (2016) Comment on: ‘Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’. Reports of recovery in chronic fatigue syndrome may present less than meets the eye’.