Extract from an editorial published recently in *World Psychiatry*, in which Prof Stefan Priebe argues that psychiatry should advocate for the political changes needed to improve mental health.

What contributes to poor mental health is well known: adverse childhood conditions; experience of war, persecution and torture; social isolation; unemployment and social exclusion; poverty, poor education and low socio-economic status; and social inequality.

In order to achieve substantial improvements in public mental health, we require societies to change and implement all those factors that promote mental health: societies should provide safe and supportive upbringing conditions; secure peace within and between countries; eradicate poverty; guarantee good education; strive for full employment; promote social cohesion and functional communities; and have little social inequality. These requirements are clear and unequivocal, no more research needed.

Yet, there is little evidence that we are currently making much progress towards such societies. How can this be changed and societies improved? Changing the rules and processes within societies is clearly a political task. Politicians get elected to take decisions about military activities, expenditure on education and social welfare, employment rules, taxation and other means of redistribution. Politicians are democratically legitimized and authorized, mental health experts are not. Perhaps, we should therefore just provide our expert view and leave it there? This appears to have been the dominating attitude of mental health professional bodies during the last three decades. One may conclude that such abstaining from political involvement has been a major mistake, both for people with mental disorders and the profession itself.

If there is a will to engage politically and call for societal change on the basis of the evidence for public mental health, there are likely to be various and potentially strong allies, calling for similar changes based on expertise from other fields of medicine and social sciences. For example, social inequality is bad not only for mental health, but also for physical health and other social phenomena such as crime rates (Wilkinson & Pickett, *The Spirit Level*, 2009). Consequently, a World Health Organization European review of social health determinants (Marmot et al, Lancet, 2012) calls for action in the wider social and economic spheres, with less deprivation and a more balanced social gradient. Linking with such calls from experts in other fields may strengthen the impact of a political voice from mental health.

Political engagement of mental health professionals – even if aligned with experts from other fields as well as patient and carer groups – might still not be successful. Other societal forces and interests might drive societies in opposite directions, e.g., towards military engagements and even greater social inequality. Politicians are unlikely to change the welfare system or stop wars just because they are told by experts that this would be better for public mental health.

Despite this, raising our professional voice in the political arena might still be important. How can we – as mental health academics or clinicians – know the central importance of societal factors for mental health and not call for the political action to improve them – loudly and clearly? Whether effective or not, political engagement appears a moral imperative for a credible profession with coherent values (Priebe et al, *Br J Psychiatry*, 2013). As a minimum, it can underline the societal relevance of psychiatry and help to link psychiatry and other important societal groups.
Clinicians’ experiences of offering financial incentives to patients to increase their adherence to anti-psychotic medication

By Katie Moran, Research Assistant, Unit for Social and Community Psychiatry

People living with schizophrenia and other psychotic illnesses are often prescribed a "dual" medication containing anti-psychotic medication. This helps to control symptoms and prevent relapse. Depots may be given to patients between once a week and once a month, at home or in a clinic, as an alternative to medication in tablet form. However, for various reasons, not all patients take all of their prescribed depot. This is called "non-adherence." As a result of non-adherence, patients’ symptoms often worsen, resulting in risk to themselves or others. Past attempts to improve adherence to anti-psychotic medication have shown limited success. However, recent research trials have found that offering patients a financial incentive (money) to take their medication can be effective. Over one year, patients who were offered £15 for each depot showed improved adherence in comparison with patients who did not receive any incentives.

Offering financial incentives for depot adherence is contentious. Following the trial, we wanted to learn more about how offering financial incentives worked in practice. We conducted interviews with clinicians (psychiatrists, depot clinic nurses, care coordinators and team managers) to find out:

1. How did patients spend the money?
2. Did patients ask for more money, or more frequent depot injections?
3. Did other patients start asking to receive money for their depot injections, or become non-adherent to their depot to try and receive money?
4. What effect did the incentive have on patients’ interaction with the mental health team?
5. Did patients’ health improve as a result of the incentive?

There appeared to be no negative consequences when these requests were refused.

About one third of clinicians interviewed felt that relationships with patients improved because of the incentives, mainly through greater trust and better communication. This may have been the result of patients’ increased contact with clinicians through attending depot appointments more often.

While the majority of clinicians felt the incentives helped in some way, around one third of clinicians felt that they hindered their ability to manage patients’ care, mainly because providing them took more time and effort of their day. A small number of clinicians felt the incentives made it more difficult to manage patients’ care, as the patient spent the money on drugs and/or alcohol and became more disengaged. Some clinicians also talked about how the incentives had a negative impact on their relationship with the patient, as the relationship became more about the money. They said a minority of patients became aggressive if the incentive was not there for their appointment, which also affected the relationship.

A small number of patients were believed to have become dependent on the money, that they were able to spend the money on drugs and/or alcohol, or to increase the amount of money received. In contrast, a small number of patients were believed to have reduced their use of illegal substances as a result of the incentive. Overall, the impact on patients was considered to be positive.

Through turning up to their depot appointments and receiving their medication on time, patients showed improvements in their mental health and a reduction in using drugs and/or alcohol. Other clinicians found that their patients began to understand the benefits of their medication for their mental health. Moreover, clinicians also felt that patients had become less demanding socially, as the regular medication and contact helped them have more stable relationships with others.

On the other hand, around a fifth of clinicians felt that the incentives had a negative effect on their patients’ health. This was largely to do with patients spending the money on drugs and/or alcohol, which impacted negatively on their mental health. In a minority of cases, clinicians reported that some of their patients had become non-adherent because of the money, secretive about the money, or were at risk of being taken advantage of by others who knew about receiving the incentives. The overall experience of clinicians was positive, with the majority feeling that offering financial incentives had a positive effect on their patients in a number of ways. However, clinicians for a third of patients did feel offering the incentives to have a negative impact on the patient or their relationship with them. This seems to suggest that the use of incentives may not be suitable for everyone, and in some instances, patients were reported to have turned up for their depot appointment earlier than arranged.

Future work will look to expand this research to other patient groups, and to compare outcomes in different age groups.

ENRICH peer support for discharge
NIHR research programme

ENRICH is a £1.95 million, five year programme of applied research commissioned by the National Institute for Health Research (NIHR) to develop, pilot and trial a Peer Worker intervention to enhance discharge from inpatient to community mental health care.

The programme started in March 2015 and builds on the experience of a peer worker who conducted in EUT between 2009 and 2012. Professor Alan Simpson at City University London, who led the trial and Professor Stefan Priebe are collaborators in the new programme of research which is being led by Dr Steve Talbot at St George’s, University of London. The programme is unpiloted and focuses on the service user researcher involvement.

Approximately one third of people discharged from inpatient mental health care in England are readmitted within one year; the majority in the first three months post discharge. The period following discharge is also a particularly risky time with 15% of all suicides nationally taking place following discharge from mental health services. A number of recent studies show that people who had been discharged from inpatient care were more likely to readmit as a result of discharge, and there is a high risk of suicide during the first three months post discharge.

This study will be delivered in one year post-discharge and the total cost of services used, including the delivery of the peer support intervention to enhance discharge from inpatient to community mental health care, will be measured. The programme is underpinned by a comprehensive service user researcher involvement.

Would you like your colleagues and peers to learn more about the evidence-based peer support intervention to enhance discharge from hospital to community care? If yes, would you like to be part of this innovative research programme? For more information, please contact: Katie.Moran@kcl.ac.uk

Correction

Correction: The Winter 2015/16 N&DD newsletter incorrectly identified Adrian Marrid, Dr med. habil., as a Research Assistant in the Unit for Social and Community Psychiatry whereas he is a Research Fellow in the Unit.

Other News

JOIN DEMENTIA RESEARCH LAUNCHES AS A NATIONWIDE SERVICE

‘Join Dementia Research’ delivers new opportunities for people to play their part in beating dementia, connecting researchers with people who want to participate in studies. Details for and how you can take part in the initiative, please go to the ‘Join dementia research’ website at www.research.dementiaresearch.nihr.ac.uk

BENEFITS ADVICE SERVICE FOR RESEARCH INVOLVEMENT

A new confidential service has been launched which offers personal advice and support on how payment of fees and expenses for public involvement might affect people in receipt of state benefits. The service will be provided on behalf of the NIHR by Better Choices Advice Bureau, initially as a pilot for one year, and offers a confidential service to members of the public involved with NIHR or organisations funded NIHR funded research projects and NHS staff. To find out more contact the members of the public to get involved. Visit www.nihr.ac.uk/resources-centre/benefits-advice-service

SPECIAL OFFER

SOCIAL MEDIA USAGE GUIDANCE

INVolE have published new guidance on the use of social media to actively involve the public in research. This guidance provides examples of ways in which different types of social media are currently being used to involve the public in research, the benefits, challenges, risks and ethics of using social media for public involvement. A support pack with guidance and a template in line with international SPIRIT guidelines. The guidance and template clearly define the expected components of a protocol and help ensure researchers cover all the elements required by sponsors, research-active organisations and regulators provided extended guidance on the use of social media.

HEALTH RESEARCH AUTHORITY PROTOCOL TEMPLATES

In response to feedback from researchers, sponsors and stakeholders, the Health Research Authority (HRA) is developing a suite of templates and guidance for writing protocols. A multi-disciplinary group of individuals from research-active organisations and regulators provided extended guidance on the use of social media to actively involve the public in research. This group has produced detailed guidance and a template in line with international SPIRIT guidelines. The guidance and template clearly define the expected components of a protocol and help ensure researchers cover all the elements required by sponsors, research-active organisations and regulators.

The ENRICH team's previous research shows that peer workers bring about change by building strong, therapeutic relationships based on shared lived experience: risk modelling, recovery, working, and living well in the community, and engaging service users with mental health services and the wider community. Individually, service users overcome obstacles to support from a peer worker include increased levels of hope in the future and personal empowerment; decreased experience of stigma within services; improved relationships with others; and increased self-esteem. These improvements are not limited to individuals who are directly involved in the programme and have access to a peer worker. Other clinicians found that peer workers bring about change in a focused set of individual recovery, service use and cost outcomes. The key aim of ENRICH is to significantly reduce readmissions in the year post-discharge and the total cost of services used, while improving individual wellbeing and recovery. Discussions with local partners are already taking place and will develop over the rest of the year.
Continuity across inpatient and outpatient mental health care or specialisation of teams?

By Serif Omer, Research Assistant, Unit for Social and Community Psychiatry

There is ongoing debate in mental health policy regarding the best system for organising secondary mental health care services. A central area of this debate is whether there should be continuous treatment teams across inpatient and outpatient settings or separate specialised teams within each of the two settings. These two types of system can be referred to as continuity systems and specialisation systems of care.

In the United Kingdom we have traditionally adopted a continuity system, in which the same consultant psychiatrist provides care for a patient in both inpatient and outpatient settings. However, following the Royal College of Psychiatrists report on the New Ways of Working for Psychiatrists, the NHS is moving toward adopting a specialisation system with separate consultants, providing inpatient and outpatient care. Interestingly, this contrasts with reforms taking place elsewhere. In Germany, for example, there are initiatives to move from a specialisation system toward a continuity system of care.

These conflicting reforms are occurring throughout the world and are based on little or no evidence regarding their effects on patient care. As a result, we conducted a systematic review recently published in European Psychiatry to identify previous research on the topic and synthesise the findings. We searched 5 bibliographic databases using a comprehensive combination of search terms, contacted key researchers in the field, and tracked citations of relevant articles. We then analysed the included papers using narrative synthesis, a systematic method to draw conclusions from a range of different studies.

Our systematic search identified 17 unique research studies relevant to our research question. This included 13 comparative studies that investigated outcomes in continuity and specialisation systems of mental health care and 4 qualitative studies that investigated the detailed views of patients and staff members.

Our narrative synthesis of the studies found the following:

- Continuity systems are associated with shorter lengths of patient stay in hospital.
- There were mixed findings on the number of hospital admissions. However, when restricting our analysis to only those studies that were deemed of higher quality, continuity systems were associated with lower hospital admissions.
- Continuity systems are associated with faster and more flexible transitions between inpatient and outpatient services.
- Patients and staff members have identified advantages and disadvantages of both types of system, but they seem to prefer a continuity system of care.
- We also found that the quality of the previous studies was poor. Only two studies would meet the quality criteria for an acceptable level of evidence set by the Cochrane Effective Practice and Organisation of Care Group. Many of the studies failed to control for potential confounders and included only one site per intervention group, which could bias the findings. There was also a tendency for the novel system (i.e. the more recently introduced system of care) to have more intensive treatment and better outcomes, regardless of whether it was a continuity or specialisation system.

The findings of our systematic review suggest that a continuity system, whereby the same clinicians provide care for a patient across inpatient and outpatient settings, is associated with better outcomes and is preferred by patients and staff members.

This could be due to improved communication between services which ensures smoother transitions between settings. Having the same clinicians across settings could also be beneficial as clinicians can develop a better therapeutic relationship with patients, which is of crucial importance in mental health care, and a better knowledge of their patient.

However, the quality of the available evidence is currently very poor and we should be careful when interpreting the findings. Even so, there are a large number of reforms taking place throughout the world which can be costly both financially and in terms of staff morale. At the very least, these findings should raise questions regarding the appropriateness of reforms where a continuity system is being replaced by a specialisation system of care, as is the case in the United Kingdom. There is an urgent need for further, high quality research that overcomes the limitations identified in our review. The CGI study (Comparing Functional and Integrated Systems of Mental Health Care), coordinated by the Unit for Social and Community Psychiatry in East London, is currently being carried out across 5 European countries over 5 years. The study aims to answer some of these important questions.
The inter-relationship between mood, self-esteem and response styles in adolescent offspring of bipolar parents

By Hana Pavlickova, Research Assistant, Unit for Social and Community Psychiatry

It has been well documented that children of parents with Bipolar Disorder (BD) have an increased risk of psychiatric disorders in comparison to offspring of parents without psychiatric problems; almost 30% of offspring of parents with BD have been found to meet diagnostic criteria for affective disorders, compared to less than 10% of children of well parents. However, little research has been carried out investigating whether children of bipolar parents already show some psychological and/or behavioural dysregulations similar to adults diagnosed with bipolar disorder. Identifying such psychological vulnerability mechanisms might have implications for theoretical models of the disorder as well as for early psychotherapeutic interventions for high-risk populations.

One way of addressing this question is by examining the core domains of psychological dysregulation in bipolar disorder that is instability of affect and intense shifts in self-concepts, within the context of response style theory (Nolen-Hoeksema, 1991). The response styles theory proposes that individuals differ in the way they respond to feeling of low mood, with serious consequences for the duration and severity of depressive or other kinds of dysphoric episodes. Three coping strategies have been described within this framework. First, (a) rumination has been defined as passively directing one’s attention and thoughts to current depressive feelings, to its causes and effects. In contrast, (b) active coping has been described as directing one’s attention away from depressive symptoms by engaging in pleasant activities to relieve symptoms. Finally, (c) Risk-taking, which is particularly important in the context of BD, involves engaging in dangerous behaviours without regard to the consequences.

Using this theoretical framework, we asked 23 adolescent children (i.e. 13-19 years old) of parents diagnosed with bipolar disorder and 25 adolescent children of well parents with no psychiatric problems (further referred to as control children) to complete a diary for 8 days (this method is referred to as the Experience Sampling Method (ESM): Czikszentmihalyi and Larson, 1987). Adolescents were asked to rate their mood, self-esteem, and response styles (i.e. rumination, active coping, risk-taking) 10 times a day at a random period throughout the day as a reminder by a wristwatch they wore. This data allowed us to examine the way mood, self-esteem and response styles affect each other over time, and the differences in these between offspring of bipolar and well parents. We expected that low mood would lead to greater engagement in rumination in the offspring of bipolar parents, whilst high mood would lead to a greater engagement in risk-taking. Second, we also expected that in children of bipolar parents rumination would lead to more pronounced decreases in mood and self-esteem, whilst risk-taking would lead to a greater increase in mood and self-esteem.

In contrast to our expectations, there were no differences in the magnitude of rumination each group displayed. Further, both groups showed improved mood as a consequence of risk-taking, and dampened self-esteem after engaging in rumination. However, whilst control children employed active coping strategies to cope with low mood, children of bipolar parents did not. Finally, we found that in children of bipolar parents low self-esteem triggered risk-taking at the subsequent time point. Whilst our findings did not support the role of cognitive abnormalities (i.e. negative thinking) as a vulnerability factor for BD, they are in line with previous studies linking increased risk of anxiety and anxiety disorders with behavioural inhibition, and recent suggestions of a clinical staging in the development of bipolar disorder (Duffy et al., 2009; Duffy & Carlson, 2013). Furthermore, our finding that rumination led to decreases in self-esteem, rather than mood (although with no differences between groups) is contrasting our previous findings in patients with bipolar disorder, where rumination dampened affect, but was unrelated to self-esteem. It is possible that these findings reflect differential relationship between cognition and affect, changing as a function of the capacity of top-down emotion regulation, decreasing with severity of the illness.

Finally, whilst high-risk-taking increased positive mood in both groups, only offspring of bipolar parents showed an increased engagement in risk-taking in response to low self-esteem. This finding is in line with previous studies of manic patients, and has been previously explained in the context of the manic defence mechanism arguing that some individuals develop mania to cope with experiences that threaten self-esteem (Abraham, 1911/1927). Given that no bipolar offspring in the current sample met diagnostic criteria for BD, this finding might indicate early behavioural dysregulation specific for vulnerability to BD, with important implications for early psychological interventions. Although more research is needed to reliably inform our understanding of the development of bipolar disorder as well as early psychological interventions for high-risk individuals, the present findings have identified some areas that might be of relevance both theoretically and clinically.

Further reading

If you have a medical condition and are undergoing treatment, we would like to ask your family doctor, nurse or consultant about clinical research, and whether it might be right for you.

Last year, more than half a million NHS patients chose to take part in nearly 5,000 clinical research studies. Thanks to those patients, we are learning more all the time about how to deal with a whole range of medical conditions – and make some real breakthroughs that will improve thousands of lives. This year, you could help us to do even more if you remember it’s OK to ask.

You can send us your responses by:
• Twitter: @CICRCAAHF / @NRHoktoask
• Facebook: facebook.com/ NRHOKTOASK
• oktoask@nih.ac.uk

It’s OK to ask about clinical research

Clinical research is the way in which we improve treatments in the NHS. Doctors use clinical research studies to compare current treatments with potentially better ones, so that we can keep improving the care we offer NHS patients. People who take part in studies often feel that they are taking an active part in their health care and helping others, by helping to identify the best treatments.

Who and what should you ask?

In many cases doctors will let patients about research. But we also want to encourage patients and their carers across the country to ask their family doctor or consultant about clinical research, and whether it might be right for them or their loved one.

In a consumer poll, only 21% of patients and the public said that they would feel confident asking their doctor about research opportunities – a low number. That is why the National Institute for Health Research (NIHR) is promoting the fact that it’s OK to ask about clinical research.

Upcoming Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
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<tbody>
<tr>
<td>13 April</td>
<td>Group processes in therapeutic groups</td>
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<tr>
<td>20 April</td>
<td>Built environment and mental health</td>
</tr>
<tr>
<td>27 April</td>
<td>Intimacy and wellbeing in people with mental illness: ethical challenges</td>
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<tr>
<td>11 May</td>
<td>Social networks</td>
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<tr>
<td>18 May</td>
<td>VOLUME – Valorising in mental health</td>
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<tr>
<td>1 June</td>
<td>Video clip study and trend expectations</td>
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<tr>
<td>8 June</td>
<td>The nature of the befriending relationship: findings from qualitative interviews</td>
</tr>
<tr>
<td>15 June</td>
<td>Discussions around intimacy in routine clinical encounters</td>
</tr>
<tr>
<td>22 June</td>
<td>COVIP – Satisfaction with treatment</td>
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Studies recruiting in your trust

NIHR is recruiting studies in your trust

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

You can send us your responses by:
• Twitter: @CICRCAAHF / @NRHoktoask
• Facebook: facebook.com/ NRHOKTOASK
• oktoask@nih.ac.uk
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.