

Psychological Medicine

Clinical Academic Group

King's Health Partners

- King's Health Partners brings together:
- three of the UKs leading NHS Foundation Trusts
- a university ranked 8th in the world for clinical, pre-clinical and health
- 4.2m patient contacts each year
- over 36,000 staff
- more than 25,000 students
- a combined annual turnover of £3.1bn
- services provided across central and south London and beyond, including nine mental health and physical healthcare hospitals and many community sites
- a comprehensive portfolio of high quality clinical services with international recognition in cancer, diabetes, mental health, regenerative medicine, transplantation, cardiac and clinical neurosciences
- a major trauma centre and two hyper-acute stroke units

About King's Health Partners

King's Health Partners Academic Health Sciences Centre brings together one of the world's top research-led universities, King's College London, and three of London's most prestigious and highly regarded NHS Foundation Trusts – Guy's and St Thomas', King's College Hospital and South London and Maudsley.

Our partnership provides a powerful combination of complex clinical specialties that cover a wide range of physical and mental health conditions and a breadth of research expertise that spans disciplines from medicine and biomedical sciences to the social sciences and humanities.

There are three parts to our mission: excellence in research, education and clinical care.

To support our mission, we are delivering programmes of work to:

- join up mental and physical healthcare so that we treat the whole person, mind and body

- increase the value of the care we provide and the outcomes we achieve for our patients and service users
- integrate care across local primary, secondary and social care services to make it easier for people to get the care and support they need
- improve the public health of our local community by tackling inequalities and supporting people to live healthy lives
- bring together our collective strength and expertise in a range of specialist areas to deliver world-leading care, research and education

We are uniquely structured to deliver our mission for excellence. Our 21 Clinical Academic Groups (CAGs) bring together all the clinical services and staff from the three trusts with the relevant academic departments of King's College London.

Foreword



At King's Health Partners we are committed to improving outcomes for our patients and service users and achieving maximum value for money in everything we do. We believe that being open and transparent about the care and outcomes we deliver results in a culture of improvement across our partnership.

This is why we are publishing a series of outcomes books that will help patients, service users, carers, referring clinicians and commissioners to make better informed decisions, and our staff to drive up the quality of the care we provide. The books report key outcomes for treatments provided by our 21 Clinical Academic Groups (CAGs). CAGs form the building blocks of our Academic Health Sciences Centre. By bringing together our clinical and academic staff across teaching, training and research, we can use their combined expertise to achieve better outcomes for our patients and service users.

Our books are designed for a clinical and lay audience and contain a summary of patient volumes and measures (e.g. length of stay, re-admissions, patient experience), clinical outcomes, educational activities, technological and research innovations and publications. They also focus on other important measures, such as staff satisfaction and wellbeing.

The primary purpose of King's Health Partners is to improve health and wellbeing locally and globally. We must deliver this goal in a challenging economic environment with rising demand for, and costs of, healthcare. We will only achieve sustainable health improvement if we strive always to increase value. We define value in terms of outcomes that matter to patients, over the full cycle of care, divided by the cost of producing those outcomes. By publishing outcomes books we have more information to support us measuring the value of the healthcare we provide.

Our goal is to increase the depth and breadth of reporting each year. Books will be updated regularly to demonstrate progress against our mission to achieve world-class research, education and clinical care. We hope you find these data valuable. Please send comments and suggestions to us at kingshealthpartners@kcl.ac.uk

For more information please visit our website at www.kingshealthpartners.org

Professor John Moxham, Director of Clinical Strategy, King's Health Partners

March 2017

A handwritten signature in black ink, appearing to read 'John Moxham'.

Foreword from CAG Leadership

The Psychological Medicine CAG is central to the King's Health Partners mission in having a major focus on delivering research and clinical care across mental and physical health. The CAG comprises of academic and clinical staff working within King's College London, clinical services within the secondary care setting providing front end crisis function and tertiary specialist services with a focus on physical/psychological interface of the South London & Maudsley NHS Foundation Trust. This book highlights the clinical outcomes of the diverse range of services across the CAG and more importantly the service user experiences based on information obtained from 2013 to 2015.

Apart from providing high quality of services, demonstrating clinical outcomes that are meaningful for service users and clinicians and that can be measured as part of the routine clinical activity forms an integral part of our governance strategy.

The CAG structure changed in July 2016 to form the new Psychological Medicine and Integrated Care CAG. This was the result of a merger of the Mood, Anxiety and Personality CAG and the Liaison and Specialist services of the old Psychological Medicine CAG. We hope the book gives an overview of our clinical services, research highlights and the strategic vision of our CAG within King's Health Partners and will provide a foundation for the future measurement of the progress and delivery of the Psychological Medicine and Integrated Care CAG.

Ranga Rao, Clinical Director

Matthew Hotopf, Academic Director

Steve Davidson, Service Director

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The value of partnership at King's Health Partners

The mind and body are inseparable, and mental and physical health conditions are often connected.

The average life expectancy for someone with a long-term mental health illness is much shorter than for someone without, often due in part to smoking, obesity, diabetes or alcohol misuse. Likewise, many people with long-term physical health conditions suffer from depression or other mental health conditions.

Despite this, health services separate care into physical and mental and often fail to share patient information.

At King's Health Partners we are working to overcome these barriers by treating the whole person. We are committed to caring for vulnerable patients with both physical and mental ill health in an integrated manner with better, faster diagnosis and treatment because we know that addressing

mental ill health improves physical health outcomes and vice versa.

Right across our partnership, we are committed to joining up and delivering excellent mental and physical healthcare, research and education so that we treat the whole person, by:

- screening all patients with chronic physical diseases for mental health conditions, and using the learning from this to improve the care we provide
- improving our understanding of the physical health needs of people with severe mental ill health
- addressing the traditional distinctions between the mind and body in research and education allowing us to train students and staff to deliver more integrated care

- better organising and expanding current training provision for physical and psychiatric comorbidity
- working with our local commissioners to find new ways of paying for integrated services
- linking IT systems across our partner trusts so that clinicians have access to a person's physical and mental care records
- investing in innovative programmes such as IMPARTS (Integrated Mental and Physical Healthcare: Research, Training and Services) and 3DfD (3 Dimensions of care for Diabetes)
- recognising the importance of employee mental and physical health and wellbeing.

Public health

Public health is one of our biggest challenges. At the root of much of the ill health in south London is a high incidence of smoking, alcohol abuse and obesity. With our health and social care partners, we are developing strategies to tackle these public health priorities. We are also developing plans for a new Institute for Urban Population Health, a collaboration with local partners to bring about transformational change to health in local communities. We want to achieve a measurable improvement and impact on health gain and local management of physical and mental health problems through new evidence based interventions.

Alcohol strategy – key aims

- developing appropriate resources for clinical staff and patients
- developing and implementing training for all staff on harmful drinking supporting early identification and intervention
- establishing ourselves as a centre of excellence for integrated research, training and practice in the management and prevention of alcohol misuse
- attracting funding for future alcohol clinical, training and research initiatives
- monitoring the impact of the strategy on indicators of alcohol related harm

Tobacco strategy – key aims

- supporting all clinical sites to be smoke-free
- developing an informatics structure for routinely and systematically recording smoking status
- support, referrals and treatment uptake for smoking cessation across the partnership
- co-producing clinical care pathway for nicotine dependence treatment

- developing and implementing training packages for smoking cessation interventions for all our healthcare professionals
- monitoring the impact of our smoking cessation strategy in relation to knowledge and uptake of skills by staff, uptake of smoking interventions, outcomes of interventions, user satisfaction, prevalence of smoking, cost-effectiveness of interventions

Informatics

Informatics is at the heart of our plans to join up care, research and education. Data is one of our most important assets at King's Health Partners. We are proud of our ability to control information systems for the purpose of **data creation, curation and analysis** with strong and transparent information governance processes throughout. This control enables our exploration of the relationship between clinical

and biological data, extending at one end to clinical decision support embedded in **electronic medical records** (EMRs), sharing of clinical data to enhance care and outcomes, through to research recruitment and participation, with **strong patient engagement** throughout. We have developed a clear strategy and action plan to maintain and develop leadership in the field of informatics.

Systems have been developed to enable electronic healthcare records to be shared across our partner organisations and with other healthcare organisations.

Our work includes the award-winning 'MyHealthLocker' programme, the Clinical Record Interactive Search (CRIS) and King's Health Partners Online. We are working with patients to make electronic patient information available in an anonymised format between partner trusts, primary care and social care. Together we have a powerful information resource for both practitioners and researchers.

Introduction

The Psychological Medicine CAG is central to the King's Health Partners' mission in having a major focus on delivering research and clinical care across mental and physical health and is world-class in research and clinical provision for eating disorders and chronic fatigue.

Our CAG comprises academic and clinical staff working within King's College London, King's College Hospital and Guy's and St Thomas' Hospital. We provide a front-end crisis function and tertiary specialist services, with a focus on physical and psychological care at the South London and Maudsley NHS Foundation Trust.

A particularly important part of the King's Health Partners' mission for our CAG is working in collaboration across mental health and physical health services. We are achieving this by working closely in those clinical and research pathways that straddle traditional physical and mental health divides.

We have a strong academic focus, with two high profile academic leaders within the Institute of Psychiatry, Psychology and Neuroscience (IoPPN). Professor Sir Simon Wessely heads the Academic Department of Psychological Medicine and is the

Vice Dean for Medical Education and a leading expert in military health.

Matthew Hotopf is Professor of General Hospital Psychiatry, theme lead and director of the Biomedical Research Centre Nucleus.

Our senior academics have specific research interests in the field of epidemiology, medically unexplained symptoms, neurology and long-term conditions.

Our academic portfolio includes basic research into psychological and social processes, including epidemiology and health psychology, as well as biological approaches. Some examples of academic activities include:

- work by Wessely and Chalder on chronic fatigue syndrome. In particular, detailed clinical studies to develop a cognitive behavioural model to understand the condition, developing interventions through a series of randomised control trials and providing evidence of impact for the development of National Institute of Clinical Excellence (NICE) guidance.

- similar work on unexplained symptoms has demonstrated their frequency in medical clinics and is, developing a model for treatment and demonstrated efficacy in randomised trials.
- work on physical diseases including diabetes and cancer has emphasised the need to improve physical health outcomes by addressing psychiatric disorders and psychological processes. This has led to a trial demonstrating the benefits of motivational interviewing and cognitive behavioural therapy (CBT) in glycaemic control of diabetes.

In order to promote the physical/mental health overlap, King's Health Partners has awarded a grant to our CAG to demonstrate the practicalities of identification of patients with mental health problems in the general medical setting. This includes informatics to screen for and identify depression and anxiety and to support staff training.

Collaborations with other clinical academic groups and GPs

Psychosis CAG

This work centres on developing the crisis / acute care pathway and the effective management of inpatient beds. Collaboration is steered through the inpatient development group

and through identification of joint business planning components.

Mood, Anxiety and Personality CAG

Collaboration is underway in the development of care pathways for people entering the service for the first time or in crisis. Overlapping pathway development between Mood, Anxiety and Personality assessment teams and A&E services was previously facilitated by the joint service director. From July 2016, a merger of the Mood, Anxiety and Personality CAG and the Liaison and Specialist services of the Psychological Medicine CAG created the new Psychological Medicine and Integrated Care CAG.

Links with GPs and GP consortia

Involvement in this work is via our collaboration with the Mood Anxiety and Personality CAG, who are leading on GP engagement.

CAG leadership



Matthew Hotopf
Academic Director



Rango Rao
Clinical Director



Steve Davidson
Service Director

Our vision and strategy

Aims and ambitions

Our CAG is delivering King's Health Partners' strategic objectives by:

- pioneering the integration of mental and physical healthcare through Integrating Mental and Physical Healthcare: Research, Training and Services (IMPARTs) and a range of services that offer treatment across the traditional mental/physical health divide
- delivering innovative models of local healthcare through triage wards and liaison psychiatry
- generating evidence to support effective population health interventions
- delivering world-class specialist services in eating disorders, mother and baby, psychosexual service, neuropsychiatry and memory disorders, and HIV in the context of mental health
- driving the quality of care by reviewing all clinical care pathways.

Maudsley Eating Disorders Service

The Eating Disorders Service is a good example of a clinical model where the tripartite mission comes alive. All the frontline staff are aware of the current clinical trials and senior clinical staff deliver training packages within the speciality across the region. In addition, the service has a national referral base.

There are inpatient, outpatient and day care elements, and all components deliver high-quality clinical outcomes. From comparative data internationally, it appears as if the eating disorders service admits the most severely ill patients with very low BMI and is able to deliver consistently good outcomes.

Liaison psychiatry service at King's Health Partners

This service has:

- five liaison psychiatry teams working with four acute trusts

- very high demand for A&E liaison, especially at King's College Hospital
- excellent 'in reach' into general hospitals
- a well-developed model of specialist liaison clinics
- specialist expertise in deliberate self harm, meeting the tripartite mission
- good working relationships with other CAGs.

Mother and baby service and the National Society for Prevention of Cruelty to Children (NSPCC)

The Channi Kumar Mother and Baby Unit at the Bethlem Royal Hospital is recognised as a pioneering unit. Women suffering the onset or relapse of severe mental illness following childbirth are admitted with their babies.

Our multidisciplinary team of psychiatrists, psychologists, nurses, occupational therapists, social workers and nursery nurses combine treatment of the mother's mental illness with work to promote her relationship with her baby and develop parenting skills.

This includes the use of video interaction work where the psychologist supports a mother to interpret a baby's cues and enhance sensitive caregiving. (Ref: *NSPCC All Babies Count: Spotlight on Perinatal Mental Health, 2013*).

Psychological therapies

Psychological therapies are key components within all of the services provided by our CAG. The services within the complex care pathway are all specialist tertiary and national services and psychological therapists are engaged in developing new and innovative approaches to treatment for a wide range of complex problems, including chronic fatigue, eating disorders, dissociative seizures (non-epileptic), psycho-sexual difficulties, depersonalisation disorder, neuropsychological disorders, perinatal mental health and HIV mental health. Major clinical trials are underway for CBT for dissociative seizures and persistent physical symptoms.

Within the acute and crisis care pathway, clinical health psychologists work closely with colleagues within the acute hospitals, addressing the psychological aspects of physical health problems, contributing to improved general health and quality of life outcomes. The triage wards benefit from the input of clinical psychologists working closely with their multidisciplinary colleagues to provide expert assessment and brief psychological interventions to facilitate crisis resolution. Roles for psychology are currently being developed within the home treatment teams (HTT).

Routine monitoring of outcomes are undertaken by all psychological therapy services, focusing on symptom reduction, reducing functional impairment and improving psychological wellbeing.

Our services

Complex care pathways

Our complex care pathway includes a range of specialist services that deliver care linking with our overall psychological medicine brief. All of these services involve interfaces across mental health and physical health provision and include the following services:

Eating disorders service

Our Eating Disorders Unit is the main academic centre for eating disorders in the UK, with only one other competitor and with high-quality outcomes due to developing cognitive behavioural therapy (CBT) for eating disorders.

We are internationally renowned for our research and are at the forefront of treatment development, having generated much of the evidence underpinning contemporary eating disorder treatments.

Our outpatient service is recognised nationally and internationally for our clinical and research evaluation of psychological treatments for eating

disorders. We have expertise in both individual and group/family therapy.

We help patients and their families explore the nature of the eating disorder and the impact it has on them and their family. We explore ways in which the family can help the individual overcome their problems.

Our treatment is provided mainly on an outpatient basis by a multidisciplinary team, which includes psychiatrists, psychologists, nurses, family therapists, dieticians and individual support. We also offer multi-family therapy (MFT) for which we received a Positive Practice Award from the National Institute for Mental Health in England, 2004.

Mother and baby/perinatal services

The Mother and Baby Unit at the Bethlem Royal Hospital is a 13-bedded regional and national unit offering 24-hour psychiatric care to mothers of babies up to one-year-old. 11 of these beds are acute admissions beds and two are for parenting assessments. **There are very few units providing a similar service in the London area. The Unit is accredited by the Royal College**

of Psychiatrists College Centre for Quality Improvement (CCQI) process as part of a national accreditation process.

The Unit is linked to community and liaison perinatal mental health teams across the South London (London boroughs of Southwark, Lambeth, Lewisham and Croydon). It offers preconception counselling through to pregnancy and the postnatal period until the baby is one year old. Our community teams work closely with maternity services linked to King's College Hospital, St Thomas' Hospital, Lewisham and Croydon Mayday Hospitals, secondary mental health and primary care.

Chronic fatigue service

Our service is an internationally recognised research and treatment unit, which provides specialist diagnostic assessment and treatment for people with chronic fatigue syndrome (CFS).

We have developed models for understanding and treating CFS and continue to be at the forefront of research and development in this field.

We pride ourselves on our ability to engage with people who have complex and sometimes long-standing difficulties. Our treatment is time limited, focuses on recovery and aims to help patients develop skills and feel empowered to manage their problems independently.

The Chronic Fatigue Research and Treatment Unit offers two types of treatment for CFS: cognitive behavioural therapy (CBT) and graded exercise

therapy (GET). They are delivered by experienced clinicians and tailored to the needs of the individual patient.

Our service also offers treatment for fatigue in the context of chronic diseases and for those with medically unexplained symptoms like fibromyalgia and irritable bowel syndrome. We provide a family-based service for adolescents and a home-based treatment for those of all ages who are housebound.

CBT includes behavioural strategies for fatigue management, such as sleep and activity scheduling, and cognitive strategies such as modification of unhelpful thoughts and beliefs.

GET includes establishing a baseline level of activity and gradually increasing levels of activity. With the help of a therapist, patients are helped to gradually increase both the intensity and duration of their physical activity over the course of treatment.

Psychosexual and relationship service

This service treats people with a lack of sexual desire, erectile dysfunction, premature and/or retarded ejaculation, non-ejaculation, vaginismus, dyspareunia, vulvadynia, anorgasmia, sexual addiction, fetishism and gender dysphoria, as well as other disorders related to sexual functioning.

We are experts in dealing with psychosexual problems of all levels of complexity, and our

expertise helps patients with complex and enduring sexual problems, where counselling or medication alone has been insufficient.

Our service offers assessment and treatment for individuals and couples who are experiencing difficulties with their sexual functioning, where the primary cause is psychological or where the psychosexual problem has developed as a result of physical pathology.

CASCAID: mental health and HIV service

Our CASCAID team provides care and treatment for people with HIV and serious mental health problems. It aims to promote and enhance the wellbeing and quality of life of clients through the provision of an accessible and comprehensive HIV mental health service. **Our team aims to adopt a holistic approach that recognises diversity, values difference and contributes to the de-stigmatisation of HIV and AIDS.**

In addition to the objectives common with other community mental health services, our service also aims to:

- increase adherence to HIV medication and improve communication and liaison between the different agencies involved in the care of people with HIV and mental health problems
- increase understanding of children's needs in relation to HIV and their families
- improve cognitive and neuropsychological functioning where this has been impaired
- help to reduce transmission of HIV and other sexually transmitted diseases through safer sex information and guidance.

CASCAID interventions include key-working, psychiatric medication, managing side effects of anti-HIV medication, psychological support and therapy including therapy for children and families, gay affirmative psychotherapy, psycho-education, multi-agency links and working.

Crisis care pathways

Mental health liaison

Our Mental Health Liaison service provides care to people aged over-18 with mental health problems, who are patients at University Hospital Lewisham, King's College Hospital, Guy's and St Thomas' Hospital and Croydon University Hospital. There is a high demand for A&E liaison, especially at our King's College Hospital site.

Some of our strengths include:

- having excellent 'in reach' into general hospitals
- a well-developed model of specialist liaison clinics
- specialist expertise in deliberate self-harm
- meeting the tripartite mission
- good working relationships with other CAGs.

Our service was accredited as “excellent” under the Psychiatric Liaison Accreditation Network of the Royal College of Psychiatrists.

The network engages staff and service users in a comprehensive process of review, through which good practice and high-quality care are recognised and services are supported to identify and address areas for improvement. The accreditation is based on self- and peer-review.

Triage

Our triage wards are recognised as an innovative model of inpatient care provision in the UK and developed by South London and Maudsley. It is the sole admission (assessment) ward for the borough and has approximately nine hundred admissions per year, with 50% of patients discharged home directly from the ward. **Our service provides the shortest length of stay (five to seven days) in the country while safely managing a high turnover of patients and providing high quality of care.**

The new triage wards have been developed since the formation of CAGs at South London and Maudsley, one in Croydon at the Bethlem Royal Hospital in Croydon and the other in Lambeth.

Home treatment team (HTT)

Home treatment is a way of helping people at home rather than in hospital. This can help to avoid the stress, anxiety and upheaval that can happen with a hospital admission. Our service provides short-term treatment for people who are having a mental health crisis across the four London boroughs of Lambeth, Southwark, Lewisham and Croydon. Wherever possible, we avoid the need for hospital admission.

The service brings together different health and social care professionals, including nurses, social workers, occupational therapists and psychiatrists. We work closely with the patients, their carers, GPs, local day care centres and housing providers, as required. The Trust has four HTTs, one in each borough. Teams comprise of between 25 and 32 staff and are multi-professional, consisting of a consultant psychiatrist, speciality doctors, a team leader, experienced community nurses, social workers, occupational therapists, health care assistants and a business manager/administrator. We are recruiting clinical psychologists to the teams to further enhance the range of services and interventions we provide.

Teams operate between the hours of 8am and 10pm, 365 days a year. Their main aim is to provide a high intensity service to people with acute mental ill health or crises as an alternative to hospital admission,

enabling patients to receive care at home wherever possible. The team's staffing levels allow a high frequency of home visits, often twice daily, through to a minimum of two home visits per week.

Teams work in conjunction with Promoting Recovery Teams from the Psychosis CAG or the treatment teams from the Mood, Anxiety and Personality CAG, providing an additional level of support beyond what those teams normally provide. We provide a range of interventions from medication management and mental state monitoring through to practical and social support, carer support and specific therapeutic interventions, such as solution-focused therapy and recovery-focused care plans.

We also provide a service enabling patients who have had admission to hospital to be discharged as soon as practicable through high-intensity input, providing supervision and support through the often difficult phase from hospital back to community living. This is also done in conjunction with other community services. Some of our teams specialise in offering specific care packages to those who are being started on clozapine medication in the community as opposed to the alternative practice of this being carried out during a hospital admission. Our teams can provide a high level of medical and nursing supervision to such patients, visiting up to four times daily when required.

Neuropsychiatry service

Our neuropsychiatry service at King's College Hospital and South London and Maudsley Hospital manages the psychological complications of neurological disorders. This includes psychiatric complications of epilepsy, Tourette's syndrome, movement disorders and other neurological disorders, including: early onset dementias and other memory disorders, depersonalisation and conversion and dissociative disorders, including non-epileptic seizures and other somatoform disorders.

The Neuropsychiatry and Memory Disorders Clinic at St Thomas' Hospital provides a general neuropsychiatry service and specialist memory disorders service. It provides assessment and treatment of the psychiatric and behavioural manifestations of medical disorders (for example, systematic lupus erythematosus, HIV, Korsakoff's syndrome, Tourette's syndrome, neuropsychiatric inherited metabolic disorders, cerebral hypoxia, cardiac and neurological disease).

Within the specialist memory disorders service, we treat memory complaints and other cognitive impairments including language, reasoning, visuo-spatial skills, mental calculation and frontal-lobe functions. These may arise from hypoxia, head injury, alcohol, encephalitis, stroke, ageing or dementia.

This service has strong links with the Clinical Neurosciences CAG. SLAM provides the following services:

- brain injury inpatient and outpatients and neuropsychiatry inpatients and outpatients at the Maudsley and King's College hospitals
- neuropsychiatry and memory disorders outpatients at St Thomas's Hospital
- MRI/Neuro-radiology.

Our treatment is inpatient, outpatient and outreach and averages up to 12 weeks.

Introduction to service user and carer engagement and experience

Service user engagement

"We work with the senior managers to keep the views of service users and carers at the heart of all service developments and improvements."

Alice Glover, CAG PPI Lead

An advisory group of service users and carers works alongside the management of our CAG.

"Our meetings offer a forum for discussion and information sharing about service developments and improvements. Group members are

active between meetings, helping services to improve their feedback systems and to improve the quality of patient experience."

Head of Nursing,
Psychological Medicine CAG

During the last year, the advisory group has:

- visited wards and reported findings to the governance management meeting
- worked with managers on triage wards to develop a user-friendly care plan document
- worked with clinicians to co-produce a patient satisfaction survey for A&E psychiatric liaison
- helped with the development of a carers group on the Lishman Unit (brain injury)
- initiated and co-developed an audit about peoples experience of being brought to a place of safety
- worked with St.Thomas's A&E department on improvements to patient experience for mental health service users.

"After each meeting, a summary of the discussion is produced and circulated throughout the CAG, through local service user networks, to local user groups, voluntary and community organisations and via YouTube"

Alice Glover, CAG PPI Lead

Understanding patient experience

Collecting and analysing data about patients' experiences of healthcare is essential to achieving high quality care

Across King's Health Partners, we are committed to using patient experience data to improve the quality of the care we provide. Of great importance to us is the experience and active involvement of our service users. Since the formation of the Psychological Medicine CAG, teams within the CAG have been engaging with the Patient Experience Data Intelligence Centre (PEDIC), the mechanism by which we systematically give people the opportunity to feedback about their experience of services. Currently 87.5% of services in our CAG are using PEDIC. The data is also made available to be shared both locally and borough-wide.

In addition to reviewing compliments, complaints and Patient Advisory and Liaison Service (PALS) contacts, there are some specific activities that enable us to understand more fully what it is like to use our services:

- PEDIC services offer people the opportunity to give feedback via satisfaction questionnaires. There is a survey for inpatient services and a survey for outpatient services. The questionnaire comprises five standard questions and an opportunity for an additional five questions which relate to specific pathways or sets of services. The questionnaire also includes the new 'friends and family test'. Monthly and quarterly reports are generated through the PEDIC system and forwarded to individual teams, as well as managers. Services reflect on this feedback each quarter and generate actions to improve patient experience. Response rates and action planning are overseen through our governance systems
- **Linkworkers are people with experience of using services who are paid to attend wards for a few hours a week.** Their role is to be available to listen to patients and to feedback themes about how people are experiencing the service. Linkworkers are

currently working on triage wards and the Mother and Baby Unit.

"I have been a patient on a ward like this. I'm living proof that there is light at the end of the tunnel and things can get better. I come to the wards to listen to your experiences and to share my experiences. The feedback you give can help improve the quality of the service."

Message from linkworker to patients on the Linkworker leaflet

- Advisory group visits. Advisory group members have visited and reported back on triage wards and the Mother and Baby Unit. Action plans developed as result of their recommendations are overseen through our governance systems.

The patient experience outcomes and patient feedback can be seen in each of the care pathways throughout this outcome book.

Introduction to clinical outcome measures

Complex care pathway clinical outcome

Clinical outcomes are measurable changes in the health or quality of life of patients that result from the care they have received. The constant review of clinical outcomes establishes standards against which we can continuously improve all aspects of clinical practice.

Health of the Nation Outcome Scales (HoNOS)

Our CAG is able to evidence the clinical effectiveness of services with support from the Trust clinical outcomes team. This small team was founded by the South London and Maudsley NHS Foundation Trust in 2006, and has been led since inception by Professor Alastair Macdonald.

The team implements routine clinical outcomes measurement in adult and older adult mental health services provided by the Trust in the London boroughs of Lambeth, Southwark, Lewisham and Croydon. The team trains clinical staff in the use of 'The Health of the Nation Outcome Scales' (HoNOS) (Ref Wing et al 1998) and supports the Psychological Medicine CAG clinicians to engage in clinical research.

The Trust clinical outcomes team is a UK market leader influencing the implementation of clinical outcomes measurement in secondary mental health services across England

The team make recommendations to the Department of Health on outcomes and payment

by results policy developments and assists other mental health trusts with their outcomes implementation programmes. The South London and Maudsley NHS Foundation Trust possesses an extensive outcomes dataset developed over many years, which provides practice-based evidence of the clinical effectiveness of our services.

The 12 HoNOS scales

The HoNOS scales cover a wide range of health and social domains – psychiatric symptoms, physical health, functioning, relationships and housing:

1. overactive, aggressive, disruptive or agitated behaviour
2. non-accidental self-injury
3. problem drinking or drug-taking
4. cognitive problems
5. physical illness or disability problems
6. problems associated with hallucinations and delusions
7. problems with depressed mood
8. other mental and behavioural problems
9. problems with relationships
10. problems with activities of daily living
11. problems with living conditions
12. problems with occupation and activities

How they are scored

- 0 = no problem
- 1 = minor problem requiring no action
- 2 = mild problem but definitely present

- 3 = moderately severe problem
- 4 = severe to very severe problem

Dimensional change summary

Measuring change in total HoNOS score is the most common and easiest method to show outcomes. However, a patient might recover from depression but lose his or her home. The total score will show no change where in reality there is a lot of clinical change.

We can measure clinical outcomes by change in total HoNOS scores at admission and on discharge. The red confidence intervals show mean total HoNOS scores on admission (or first HoNOS recorded) and the green confidence intervals shows mean total HoNOS scores on discharge (or last HoNOS recorded). For examples, see pages 60 and 61.

Some caveats:

1. we rely on HoNOS ratings as a surrogate outcome for clinical symptoms and problems
2. by summing up twelve independent scales, total HoNOS scores can be a crude measure of changes in outcomes
3. looking at average HoNOS scores is also a crude measure because we are likely to overlook some potentially rich information and details, for example change within each HoNOS scales, episodes that get worse or episodes that get dramatically better.

Changes in mean score for each HoNOS scale

Presenting problems are reflected by the red line. Clinical effectiveness is shown by the difference between the red and the green line. The lower the scores on the green line the higher the clinical effectiveness for each scale. Each service area has a different profile and this reflects the needs of their targeted patient group, as well as their service delivery.

- CASCAID Mental Health and HIV services
- Psychosexual and Relationship Service
- Eating Disorders Service
- Mother and Baby / Perinatal Services
- Chronic Fatigue Service.

Other clinical outcomes

As well as the HoNOS scales there are several other outcomes that are associated with care pathways as described in this book. These scales are specific to the particular service with the aim of improving the patients' quality of life and helping to improve their mental state.



Complex care pathway

Our complex care pathway includes a range of specialist services that deliver care linking with our overall psychological medicine brief. All of these services involve interfaces across mental health and physical health provision and include the following services:

CASCAID service

Introduction

Our CASCAID team provides care and treatment for people with HIV and serious mental health problems. It aims to promote and enhance the wellbeing and quality of life of clients through the provision of an accessible and comprehensive HIV mental health service. Our team aims to adopt a holistic approach that recognises diversity, values difference and contributes to the de-stigmatisation of HIV and AIDS.

In addition to the objectives common with other community mental health services, our service also aims to:

- increase adherence to HIV medication and improve communication and liaison between the different agencies involved in the care of people with HIV and mental health problems
- increase understanding of children's needs in relation to HIV and their families
- improve cognitive and neuropsychological functioning where this has been impaired

- help to reduce transmission of HIV and other sexually transmitted diseases through safer sex information and guidance.

CASCAID interventions include key-working, psychiatric medication, managing side effects of anti-HIV medication, psychological support and therapy including therapy for children and families, gay affirmative psychotherapy, psycho-education, multi-agency links and working.

Patient experience

Complex and protracted adjustment to HIV

Anna is a 35-year-old single mother of two preschool children who discovered her HIV status during antenatal screening for her second child. Her relationship with her husband eventually broke down after her HIV status became known. Neither of her children are HIV positive. She is isolated and lonely, as her immediate family are not in the UK. Anna reports low mood and moderate levels of ruminative anxiety, with

occasional panic attacks. She is known to fall out of treatment at the HIV clinic, which is compromising her health status.

Last year, she was hospitalised with a bacterial respiratory infection for two weeks after stopping her HIV medications for nearly three months. Even though she is very active in her local church, no one knows about her HIV status as she is afraid of gossip amongst her close-knit community. She refuses to attend local HIV charities where she could possibly receive social support and connections with others out of fears that someone from her community might recognise her.

In psychological therapy, Anna was provided with some psycho-education about anxiety and panic and then was introduced to mindful meditation as a means of helping her cope with her ruminative anxiety. Behavioural experiments were then introduced to assist her in facing her fears in going out in public and coping with panic sensations. Principles of behavioural activation were then introduced to assist Anna in developing more rewarding, meaningful and pleasurable activities to lift her mood and improve her outlook on life.

When Anna started to show improvement, cognitive interventions were used to assist her in dealing with the shame of having HIV and facing her fears about attending support groups in the community to foster social connections. In time, she also started to identify, explore and work through some rather difficult and sad feelings about being a single parent with a life-threatening condition and her fears of leaving her children as orphans should something happen to her.

Complication and treatments for HIV and related comorbidities

John is a 47-year-old gay man who was diagnosed with HIV nearly 15 years ago. He was later diagnosed with Hepatitis C (HCV) three years ago. Unfortunately, his liver has become cirrhotic quite quickly, so he now needs to start treatment for HCV as soon as he can. However, his HIV medications need to be changed first as his current ones are contraindicated for the HCV treatment. Unfortunately, John begins to experience rather severe and difficult side effects from the new HIV medications, including gastrointestinal upset and uncontrollable diarrhoea. Given these untoward and difficult circumstances, John has become depressed with low mood, isolation and withdrawal. He fears going out in public, so he is missing work and is now under performance management with a threat of discipline. Since the HCV is known to be rather difficult with a propensity to cause emotional and psychological difficulties, John is referred to CASCAID for support.

In psychological therapy, a variety of cognitive-behavioural interventions are used to assist John in coping with the HIV medication side effects and their impact on his daily life. As improvements start to emerge in his daily functioning and quality of life, he is encouraged to start HCV treatment. Psychological support continues for the next few months as John adjusts to the emotional instability and diminished frustration tolerance that often accompanies this form of treatment. But it doesn't appear to work, as his HCV genotype is known

to not respond to this treatment. As a result, continued psychological support is necessary to help John mourn the loss of a 'promised cure' with the prospect of a decline in health, quality of life and possible longevity.

Chemsex

Frank is a 53-year-old gay man who was diagnosed last year with advanced HIV disease when he was hospitalised with pneumocystis carinii pneumonia and had to be intubated and in intensive care for nearly a month. He was referred to CASCAID for psychological support after discharge as he was struggling with the emotional sequelae of being close to death with intensive medical procedures. He also had to deal with his immediate family finding out he was gay as well as HIV positive.

His first few sessions of psychological therapy focussed on dealing with the events over the past few months. However, as the sessions progressed, Frank eventually disclosed that he was beginning to fall back into some risky activity that he had been involved with for more than three years. Frank had been engaging in drug-fuelled sexual activity that is becoming known as 'chemsex'.

In psychological therapy, Frank was able to develop an understanding of how this substance misuse and risky sexual activity developed and the circumstances which appeared to maintain it. However, he was initially ambivalent about changing this activity, as it had become his primary social activity and way of connecting with other

gay men. Like many others who engage in this activity, disconnecting drug use from sexual expression became a complicated and daunting task. But in therapy, Frank was able to start finding other ways of developing intimacy with men and enjoying safer sex. However, his urges for recreational stimulant drug use continued to surface at times. In therapy, Frank developed a better appreciation of how his difficult emotional states could trigger such urges and he found better ways to cope with them.

Childhood trauma and sexual risk taking

Joey is a 29-year-old gay man who was diagnosed with HIV about seven years ago. He was referred for psychological therapy at CASCAID from a local sexual health clinic. He was presenting to them on a regular basis with various sexually-transmitted infections associated with unsafe sexual activity. In psychological therapy, Joey was able to talk about some difficult, if not traumatic, events from his personal background. He was kicked out of his home when he was 16 years old, when his sexuality was discovered by his family. For the next three years, he lived on the streets, engaged in sex work and started to take recreational stimulant drugs.

After his HIV diagnosis, Joey managed to turn his life around by going back to school and getting a job. However, he continued to engage in relatively risky sexual activity, usually under the influence of drugs. He saw this activity as self-

destructive, especially because he had just started to date a young man who was not aware of his HIV diagnosis. In therapy, Joey eventually disclosed a barrage of traumatic incidents whilst he was homeless and engaging in sex work. Even though his life was now relatively stable, Joey felt an urge to 'get off his face' whilst being subjugated to demeaning, unwanted and risky sexual activity with strangers.

In psychological therapy, Joey was able to work through some of the emotional trauma associated with these difficult events from his youth. However, it took some time for a safe therapeutic working alliance to develop as Joey had difficulties in trusting his psychologist. In time, Joey started to control his recreational substance use which, in turn, helped him in reducing his risky sexual encounters. He was also able to face the fears of rejection in disclosing his HIV status to his new boyfriend. In doing so, he was now in a better position to start developing this relationship.



Fears of HIV-related cognitive decline

Sam is a 61-year-old gay man who was diagnosed with HIV many years ago. Back in the 1990s, he witnessed the rapid decline and deaths of many of his friends and lovers to HIV-related causes. Some of these cases involved HIV-related dementia, which were not only sad but traumatic to witness.

Sam stopped working many years ago when he was ill with HIV but now he is on medication and his immune system is in good shape. In many respects, Sam is doing well in life as he enjoys the company of good friends, volunteers at a local charity and takes singing lessons. He sometimes dates other men with HIV, but he never lets it develop into anything special or intimate because he prefers to keep it that way.

Sam was referred to CASCAID for an assessment of his cognitive functioning because he reported to the HIV clinic that he was concerned about his memory. He was beginning to become distracted, sometimes misplaced things and forgot appointments. He had a recent embarrassing moment when he turned up at a friend's house for a dinner party on the wrong evening.

Screening of his cognitive functioning with standard psychometric tests did not suggest any significant problems in Sam's attention, learning or memory. Some aspects of his cognitive functioning were above what would be expected for someone of his age and educational/occupational background.

However, in the assessment it became apparent that Sam was stressed, with an upcoming medical assessment for his benefits and was worried about the prospect of having to return to work after nearly 15 years of being on benefits. He was also very aware of and could remember the horror stories of watching his friends mentally deteriorate with uncontrolled HIV disease in the 1990s. He had admitted that he had always been somewhat scared and 'on the lookout' for any signs of cognitive decline.

In feedback, Sam was able to appreciate that any difficulties that he might have had in clear, quick and accurate thinking was probably within the normal range for someone of his age. He was also able to learn how emotional distress and ruminative anxiety could impact on concentration and memory, something which he did not appreciate before.

Sam was offered a limited number of sessions to learn how to modulate stress with various cognitive behavioural strategies. He was also encouraged to access various community-based services for alternative means of managing stress, involving complementary therapies and mindful meditation.

HIV-related encephalopathy

Rebecca is a 42-year-old woman who was diagnosed with advanced HIV disease last year after being diagnosed with lymphoma. The circumstances of how she may have contracted HIV are still unclear to her, but it

is suspected that she may have been living with the disease for many years. Rebecca wants to start a graduated return to work as a cashier in retail as she has been off work for more than a year now. But the HIV clinic is concerned about her presentation. They find her rather slow in responding to questions, emotionally flat and not spontaneous in conversation. She was referred to CASCAID for a neuropsychological assessment and an MRI was requested for diagnostic imaging of her brain.

Rebecca's sister accompanied her to the neuropsychological assessment to provide some corroborating evidence and impressions of Rebecca's functioning. She agreed that Rebecca was not the same person compared to a couple of years ago when she was much more alive and energised.

Results from a battery of neuropsychological tests suggested a general slowness in the speed of processing information, which is a hallmark sign of encephalopathy. Rebecca also demonstrated difficulties in working memory, in that she found it difficult to quickly organise and manipulate large amounts of information. These difficulties were more pronounced for verbal information than non-verbal, pictorial information.

However, another set of difficulties observed were her higher-order, executive functions which are associated with the frontal lobes. Based on a variety of psychometric tests, Rebecca demonstrated difficulties in dividing her attention, switching and sequencing tasks, and in modifying her performance based on feedback.

Based on the test result, it appeared that Rebecca was experiencing some difficulties in adapting and responding to changing conditions, especially when the situations were unstructured with no clear goals and/or immediate feedback.

These test results were supported by the findings from the MRI which suggested HIV-related encephalopathy.

Rebecca was encouraged to receive additional support in managing her daily life. While she needed to have some kind of positive and meaningful activity in her life, a return to work was not recommended at this time. As a result, Rebecca was referred to a local day programme for cognitive rehabilitation. A variety of community-based services were recommended for general support, as well as some time-limited psychological support to help her in coping with her difficulties and slow recovery.

A 30-year-old man working in a hospital was not diagnosed until he presented with HIV encephalopathy (confusion, stroke-like left-sided weakness) and a florid manic-like episode requiring both physical and psychiatric hospitalisation. MRI brain scans showed Progressive Multifocal Leukoencephalopathy, a serious and previously pre-terminal complication. CASCAID worked with him intensively for over a year on the consequences of all this, including the impact on his job and on his wife (HIV negative) and children. His physical/psychiatric condition improved. Work of the service included liaison with the Occupational Health department of the hospital he worked

in and other agencies, like housing. Eventually he returned to work. All-in-all, a remarkable rehabilitation success.

A 38-year-old man with late diagnosis HIV presented with encephalopathy in King's College Hospital requiring transfer to a Maudsley Hospital inpatient ward with evidence of significant cognitive damage. At that point, CASCAID took over and managed a trial of return to his flat with a carer. With considerable input from the consultant and community psychiatric nurse (CPN), this lasted six months. However, issues of risk associated with grandiosity/ lack of insight into his cognitive impairment required readmission to the Maudsley Hospital under the Mental Health Act (MHA). Further assessment determined it is unlikely that another trial in the community would work. Thereafter, there were protracted negotiations to enable funding and after more than a year in the Maudsley Hospital he moved to a local care home (where CASCAID has responsibility for eight or nine men and women with HIV dementia/ cognitive damage). He has required continued close monitoring because of a tendency to refuse medicines, including HIV drugs and antipsychotic medication, with increasing psychotic arousal and deterioration in behaviour/ manageability, threatening the placement itself. The issue at this point was whether we could avert readmission under the MHA to the Maudsley Hospital to legally reinstate psychiatric and physical treatment regimes. To date, this has been managed using covert administration of an antipsychotic in his food at a dosage insufficient to reduce the arousal but one that does not over-sedate him or give him Parkinsonian side-effects.

A 19-year-old boy with vertically-transmitted HIV, previously not known, presented in psychiatric crisis two years ago. Prior to diagnosis, he had shown behavioural problems and had been diagnosed with Asperger's/ autism. He experienced a highly-disordered manic-like episode which led him to significantly damage the psychiatric unit, requiring transfer to a Paediatric Intensive Care Unit (PICU). He has now transitioned to adult services and has been taken up by CASCAID because he suddenly stopped taking HIV medication, started to maintain he was HIV negative and withdrew from college to his room with the curtains drawn. He requires ongoing persevering engagement in liaison with his HIV consultant/clinic.

A 23-year-old woman with vertically-transmitted HIV whose mother died of AIDs had previously been in the Young Persons clinic in King's College Hospital. She has two small children (both negative) but has recently separated from partner/father of her children. She had been on HIV combination medication but she has stopped them for unclear reasons. She presented with a grandiose manic-like episode requiring admission and was difficult to control, CASCAID became involved both while she was in King's College Hospital for investigations and whilst a psychiatric inpatient. Formally homeless and with her children with their father, she was offered emergency accommodation only briefly and as she was not provided with benefits, she was looked after temporarily by an aunt. Ongoing psychiatric assessment of her mental state was not straightforward, though

anti-psychotics were phased out. She remains flat, self-neglecting and doesn't engage with her children when she sees them, tends to say no to follow-up (though we see her anyway) and refuses to attend HIV clinic and take HIV medication, despite a very low CD4 count and the risk of imminent major HIV-associated illness.

Clinical outcomes

The following data present demographic information and outcomes for clients who have been given the CORE-OM or CORE-10 and is only applicable for CASCAID clients who complete the CORE.

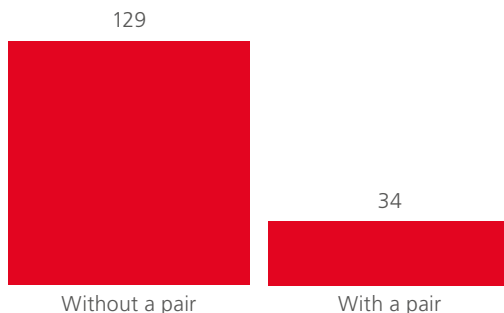
Introduction

Data is taken from the electronic patient journey system (ePJS) in an 'episode of care' format. Each episode of care that the client receives is registered as distinct, so one client may appear several times in the data – once for each episode of care. A client will appear in the CORE database once they meet the criteria of being in psychological therapy. This happens when a client has three (or more) therapy events that have the note type 'psychological therapy', are 'attended', and are either 'face to face' or 'group' contact.

Once a client is identified by the above rule, the scores from two COREs are retrieved (the first CORE and the most recent CORE in that episode of care). Between 1st of January 2011 and 1st May 2014:

- 163 clients had at least three psychological therapy events in the CASCAID team
- 75 (46%) of these clients had a valid pre-therapy CORE registered on ePJS
- 34 (21%) of those who have had at least three psychological therapy events had valid completed 'pre' and 'post'-therapy paired ratings.

Figure 1 | The frequency of those with and without a pair of valid CORE scores



Client Profile

Since characteristic information (eg. gender and ethnicity) is recorded on ePJS, it is possible to investigate the demographic profile of clients who both had a pair of COREs and those who did not. There were no statistically significant differences between the number of those without a pair of COREs and those with a pair of COREs when looking at:

- mean age

- proportion of male and female clients
- proportion of clients from white British, Irish or other ethnic backgrounds
- mean pre-therapy global distress (GD) score
- diagnosis.

From looking at demographic information recorded on ePJS, it can be seen for CASCAID clients with paired ratings that:

- at the start of therapy, the average (mean) client age was 43
- 71% of clients were male
- 53% of clients whose ethnicity had been recorded were White or White British, and 30% were recorded as 'Black or Black British'.

CASCAID offers treatment to clients with a wide range of diagnosis. The two most common diagnosis are:

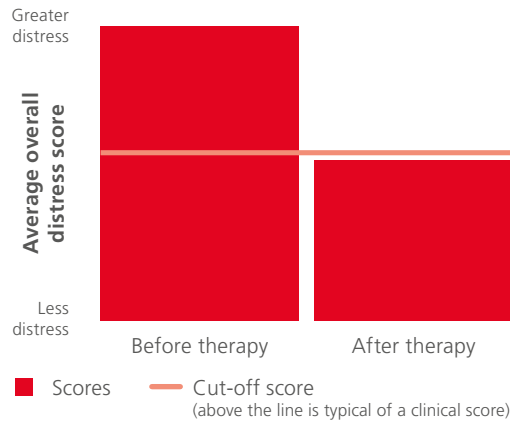
- 40% mood [affective] disorders (F30-39)
- 17% neurotic, stress-related or somatoform disorders (F40-48)

Outcome analysis: global distress

A client's mean global distress (GD) score is a rating on a scale of 0-4. A higher score means

that the client is more psychologically distressed. Mean GD scores were significantly lower post-therapy, with a large effect size.

Figure 2 | Pre and post therapy mean GD scores



Outcome analysis: clinical and reliable change

Of the 34 clients who had a pair of valid CORE scores, 28 (82%) had a pre-therapy score falling within the clinical range.

- 24 (85.7%) clients with a pre-therapy score within the clinical range demonstrated a reliable improvement between their pre- and post-therapy CORE global distress scores
- 13 (46.4%) also showed 'clinical recovery', moving from a 'clinical' to a 'non-clinical' category following therapy
- only one (3.6%) client deteriorated non-reliably, with no clients deteriorating reliably.

Psychosexual service

Introduction

This service treats people with a lack of sexual desire, erectile dysfunction, premature and/or retarded ejaculation, non-ejaculation, vaginismus, dyspareunia, vulvodynia, anorgasmia, sexual addiction, fetishism and gender dysphoria, as well as other disorders related to sexual functioning.

We are experts in dealing with psychosexual problems of all levels of complexity and our

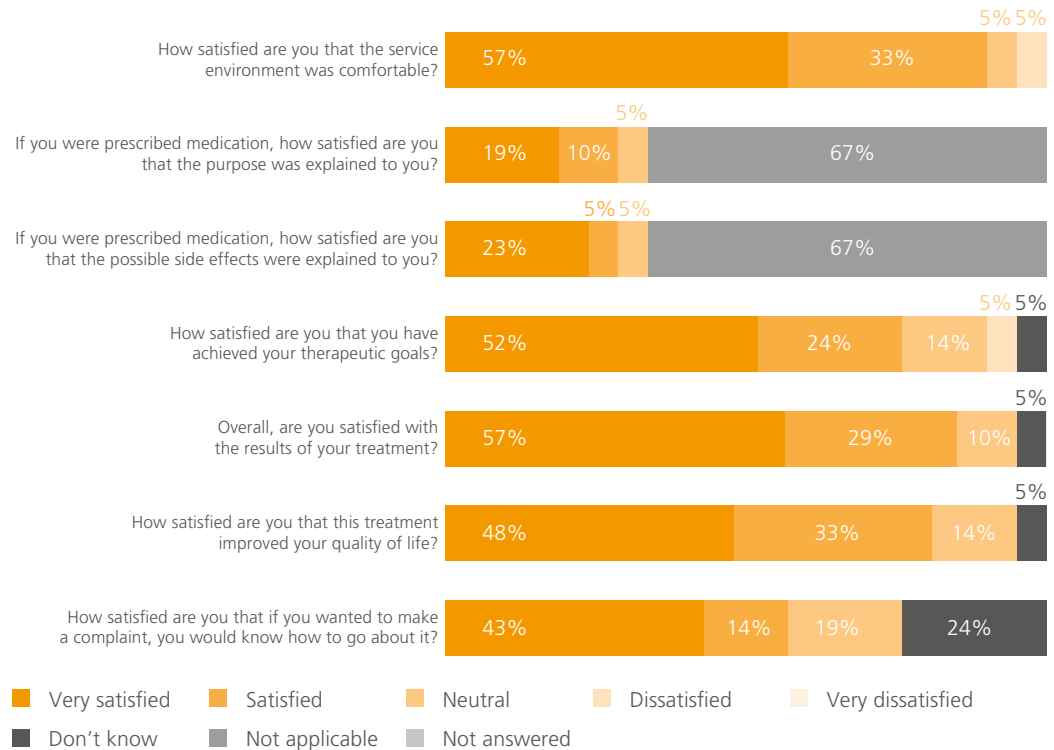
expertise helps patients with complex and enduring sexual problems, where counselling or medication alone has been insufficient.

Our service offers assessment and treatment for individuals and couples who are experiencing difficulties with their sexual functioning, where the primary cause is psychological or where the psychosexual problem has developed as a result of physical pathology.



Patient experience

Figure 3 | Patient experience survey for Psychosexual service



Patient experience in the psychosexual service

Sara had developed a pattern whereby she always develops sexual aversion, fear and anxiety about engaging in sexual activity in her relationships resulting in avoidance of sexual activity with her partners and her relationships ending. She did

not want her current relationship to end and was keen to sort her problem out. She attended psychosexual therapy where a holistic approach using behavioural exercises, CBT and couple work resulted in a resumption of a healthy sex life in her

current relationship and a pregnancy. The couple were delighted with this outcome. This was thoroughly rewarding for the therapist too.

John attended the psychosexual service for problems he was having with being unable to regulate his sexual desire. He had struggled alone with this problem, feeling too guilty to seek help. What had seemed like a pleasant pastime to begin with, accessing sexual images online had grown into something far too difficult to control. John found using the internet for sexual purposes had resulted in him engaging in some risky behaviour and it had ruined his relationships, financial stability and work prospects. Worst, he found coping with the emotional impact of feeling he had let down those close to him all too much to deal with. Attending for psychosexual combination therapy enabled him to receive psychiatric medical help, identifying appropriate medication to help regulate his impulsive behaviours and CBT to help him adjust to where his life had taken him, to be compassionate to himself and to look towards a brighter future. John has now moved on and is adjusting to his new life and the psychosexual team are pleased they were able to help someone who believed no help was big enough to beat the 'net'.

Tom had experienced difficulties with his erectile functioning most of his adult life. He had masked these problems well. The ending of his long-term relationship and some ill health made him understand he needed some help if he was to enjoy normal sexual activity with partners in the future. We introduced Tom to psychosexual combination therapy, which brings together medical and psychological interventions aimed

at achieving his goals. He underwent several medical reviews and he found an injection treatment which suited him and enabled him to achieve good erections. This, together with CBT, increased his self-esteem and gave him the confidence to engage in sexual activity and he can now look forward to a healthy sexual future. The consultant, therapist and patient enjoyed working together in a flexible way using this fully-integrated treatment to help the patient achieve his goals.

Clinical outcomes

The results below show a reduction in sexual and relationship difficulties in 2012/13 and also a reduction in male erectile disorder.

Due to changing our sexual functioning outcomes measure in 2012/13, the current data is based on a very small number of patients who commenced and finished treatment in May 2012 which limits the conclusion you can draw from this year's results. This may account for the small reduction seen in the results for female sexual functioning in 2012/13.

Figure 4 | Relationship difficulties (Females)

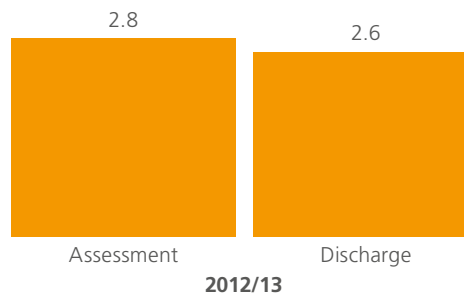


Figure 5 | Sexual function sub-scale (Females)

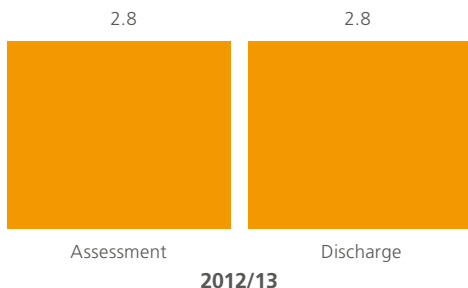


Figure 6 | Sexual difficulties (Males)

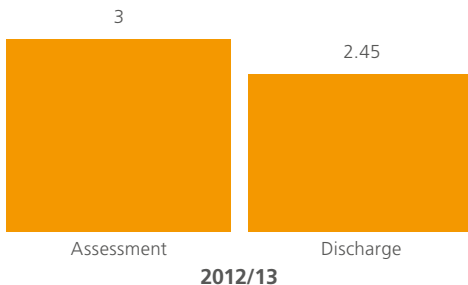
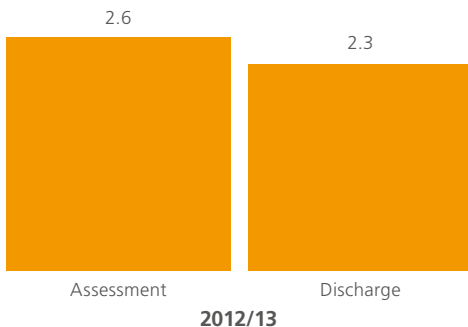


Figure 7 | Male erectile disorder (Males)



Research in focus

Mapping the brain in younger and older asymptomatic HIV-1 men: Frontal volume changes in the absence of other cortical or diffusion tensor abnormalities

Cortex, 2012

Towgood, K.J., Pitkanen, M., Kulasegaram, R., Fradera, A., Kumar, A., Soni, S., Sibtain, N.A., Reed, L., Bradbeer, C., Barker, G.J., Kopelman, M.D.

Introduction: Over the past decade the developments made in treating people with human immune deficiency virus (HIV) have greatly improved quality of life and life expectancy. However, the nature of asymptomatic HIV-associated minor neurocognitive disorder (HAND) remains unclear. In this study we explored the occurrence of neuropsychological and neuroimaging changes in medically and psychiatrically stable HIV-1 infected patients on highly active antiretroviral treatment (HAART) from two separate age groups.

Methods: Participants included 20 HIV-1 infected younger (aged 20–40) and 20 HIV-1 older patients (aged 50–75). Comparisons were made with 20 age- and education-matched younger and 22 matched older healthy seronegative males. Participants were stable on treatment and asymptomatic at study onset with undetectable HIV-1 viral loads, and free of medical or psychiatric co-morbidity, alcohol or substance misuse. A detailed neuropsychological assessment was

used and volumetric-magnetic resonance imaging (MRI) and diffusion tensor imaging (DTI) performed to assess grey and white-matter integrity.

Results: We found significant effects of ageing on memory, grey and white matter measures. Comparison of the HIV-positive and HIV-negative groups did not show significant differences on the neuropsychological tests after Bonferroni correction, and there were no significant age-by-HIV status interactions. However, we did find reduced grey matter volume on MRI in our HIV-positive participants within the medial and superior frontal gyri. We also found significant ageing effects in fronto-temporal grey and white matter, independent of the effect of HIV.

Conclusions: The results from this study suggest that HIV-1 disease by itself does not significantly impair cognitive function when patients are otherwise asymptomatic. Nevertheless, the imaging techniques were sensitive enough to detect subtle grey matter changes not normally evident until much later in the disease. If confirmed in a longitudinal study, this frontal grey matter change could represent an important biomarker for trials in HIV disease.

Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: Systematic review

PLoS Medicine, 2012

Oram, S., Stöckl, H., Busza, J., Howard, L.M., Zimmerman, C.

Background: There is very limited evidence on the health consequences of human trafficking. This systematic review reports on studies investigating the prevalence and risk of violence while trafficked and the prevalence and risk of physical, mental and sexual health problems, including HIV, among trafficked people.

Methods and findings: We conducted a systematic review comprising a search of Medline, PubMed, PsycINFO, EMBASE, and Web of Science, hand searches of reference lists of included articles, citation tracking and expert recommendations. We included peer-reviewed papers reporting on the prevalence or risk of violence while trafficked and/or on the prevalence or risk of any measure of physical, mental or sexual health among trafficked people. Two reviewers independently screened papers for eligibility and appraised the quality of included studies. The search identified 19 eligible studies, all of which reported on trafficked women and girls only and focused primarily on trafficking for sexual exploitation. The review suggests a high prevalence of violence and of mental distress among women and girls trafficked for sexual exploitation. The random effects pooled prevalence of diagnosed HIV was 31.9% (95% CI 21.3%–42.4%) in studies of women accessing post-trafficking support in India and Nepal, but the estimate was associated with high heterogeneity ($I^2 = 83.7\%$). Infection prevalence may be related as much to prevalence rates in women's areas of origin or exploitation as to the characteristics of their experience. Findings are limited by the methodological weaknesses of primary studies and their poor comparability and generalisability.

Conclusions: Although limited, existing evidence suggests that trafficking for sexual exploitation is associated with violence and a range of serious health problems. Further research is needed on the health of trafficked men, individuals trafficked for other forms of exploitation and effective health intervention approaches.

Associations between intimate partner violence and health among men who have sex with men: A systematic review and meta-analysis

PLoS Medicine, 2014

Buller, A.M., Devries, K.M., Howard, L.M., Bacchus, L.J.

Background: Intimate partner violence (IPV) among men who have sex with men (MSM) is a significant problem. Little is known about the association between IPV and health for MSM. We aimed to estimate the association between experience and perpetration of IPV and various health conditions and sexual risk behaviours among MSM.

Methods and findings: We searched 13 electronic databases up to 23 October 2013 to identify research studies reporting the odds of health conditions or sexual risk behaviours for MSM experiencing or perpetrating IPV. Nineteen studies with 13,797 participants were included in the review. Random effects meta-analyses were performed to estimate pooled odds ratios (ORs). Exposure to IPV as a victim was associated with increased odds of substance use (OR = 1.88, 95% CIOR 1.59–2.22, I₂ = 46.9%, 95% CI_{I2}

0%–78%), being HIV positive (OR = 1.46, 95% CIOR 1.26–1.69, I₂ = 0.0%, 95% CI_{I2} 0%–62%), reporting depressive symptoms (OR = 1.52, 95% CIOR 1.24–1.86, I₂ = 9.9%, 95% CI_{I2} 0%–91%) and engagement in unprotected anal sex (OR = 1.72, 95% CIOR 1.44–2.05, I₂ = 0.0%, 95% CI_{I2} 0%–68%). Perpetration of IPV was associated with increased odds of substance use (OR = 1.99, 95% CIOR 1.33–2.99, I₂ = 73.1%). These results should be interpreted with caution because of methodological weaknesses such as the lack of validated tools to measure IPV in this population and the diversity of recall periods and key outcomes in the identified studies.

Conclusions: MSM who are victims of IPV are more likely to engage in substance use, suffer from depressive symptoms, be HIV positive and engage in unprotected anal sex. MSM who perpetrate IPV are more likely to engage in substance use. Our results highlight the need for research into effective interventions to prevent IPV in MSM, as well as the importance of providing health care professionals with training in how to address issues of IPV among MSM and the need to raise awareness of local and national support services.

Hepatitis C infection, antiviral treatment and mental health: A European expert consensus statement

Journal of Hepatology, 2012

Schaefer, M., Capuron, L., Friebe, A., Diez-Quevedo, C., Robaey, G., Neri, S., Foster, G.R., Kautz, A., Forton, D., Pariente, C.M.

Mental health problems frequently occur in chronic infection with the hepatitis C virus (HCV) and during antiviral treatment with pegylated interferon-alpha (PegIFN α) and ribavirin. Depression is one of the most important complications during antiviral treatment of chronic hepatitis C infection. However, an increased prevalence of depression, fatigue, and cognitive disturbances has also been reported in untreated HCV-positive patients. Patients with psychiatric disorders or drug addiction also have an increased risk of HCV infection. Furthermore, because of possible drug-drug interactions, new antivirals administered together with PegIFN α and ribavirin may complicate psychiatric side effect management, even if no specific psychiatric adverse events are known so far for these new drugs. The European liver patient's organisation, ELPA, organised a European expert conference to review the literature and develop expert recommendations for the management of mental health problems in HCV infected patients. This paper results from the output of the 2011 EASL meeting and subsequent dialogue with patient groups and relevant experts in Europe. It summarises the current knowledge of HCV infection and the brain; prevalence, course, and neurobiology of IFN- α -associated psychiatric side effects; possible risk factors for IFN- α -associated depression and suicide attempts; psychiatric management of HCV infected patients before and during antiviral treatment; prevention of IFN- α -associated psychiatric side effects; and psychiatric aspects of the new antivirals. The summarised current knowledge about mental health changes before and during antiviral treatment should improve interdisciplinary management of HCV infected patients.

Am I normal? A systematic review and construction of nomograms for flaccid and erect penis length and circumference in up to 15,521 men

BJU International, 2015

Veale, D., Miles, S., Bramley, S., Muir, G., Hodsoll, J.

Objective: To systematically review and create nomograms of flaccid and erect penile size measurements.

Methods study key eligibility criteria: Measurement of penis size by a health professional using a standard procedure; a minimum of 50 participants per sample.

Exclusion criteria: samples with a congenital or acquired penile abnormality, previous surgery, complaint of small penis size or erectile dysfunction.

Synthesis methods: Calculation of a weighted mean and pooled standard deviation (sd) and simulation of 20,000 observations from the normal distribution to generate nomograms of penis size.

Results: Nomograms for flaccid pendulous [$n = 10,704$, mean (sd) 9.16 (1.57) cm] and stretched length [$n = 14,160$, mean (sd) 13.24 (1.89) cm], erect length [$n = 692$, mean (sd) 13.12 (1.66) cm], flaccid circumference [$n = 9,407$, mean (sd) 9.31 (0.90) cm], and erect circumference [$n = 381$, mean (sd) 11.66 (1.10) cm] were constructed. Consistent and strongest significant correlation was between flaccid stretched or erect length and height, which ranged from $r = 0.2$ to 0.6 .

Limitations: relatively few erect measurements were conducted in a clinical setting and the greatest variability between studies was seen with flaccid stretched length.

Conclusions: Penis size nomograms may be useful in clinical and therapeutic settings to counsel men and for academic research.

**HIV-related posttraumatic stress disorder:
Investigating the traumatic events**

AIDS Patient Care and STDs, 2010

Theuninck, A.C., Lake, N., Gibson, S.

This study examined the relationship between the experience of various HIV-related events (receiving the diagnosis, receiving treatment, experiencing physical symptoms, self-disclosing HIV positive status, and witnessing HIV-related death) and

posttraumatic stress symptoms in a sample of 100 gay men living with HIV. Self-report data revealed that 65% met criteria for having experienced a traumatic event in accordance with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) posttraumatic stress disorder (PTSD) criterion A. The experience of shame, humiliation or guilt during an event was measured but not found to be a significant indicator of having been traumatized. A total of 33% qualified for a PTSD diagnosis. Stepwise multiple regression analysis showed that receiving medical treatment, experiencing physical symptoms and witnessing HIV-related death were most associated with HIV-related PTSD symptoms. Given that multiple HIV-related events are potentially traumatic, the screening, assessment and treatment for HIV-related PTSD may need to be considered by HIV services.

Eating disorders care pathway

Introduction

Our Eating Disorders Unit is the main academic centre for eating disorders in the UK, with only one other competitor with high-quality outcomes.

We are internationally recognised for our research and are at the forefront of treatment development, having generated much of the evidence underpinning contemporary eating disorder treatments.

Our outpatient service is recognised nationally and internationally for our clinical and research evaluation of psychological treatments for eating disorders. We have expertise in both individual and group/family therapy.

We help patients and their families explore the nature of the eating disorder and the impact it has on them and their family. We explore ways in which the family can help the individual overcome their problems.

Our treatment is provided mainly on an outpatient basis by a multidisciplinary team, which includes psychiatrists, psychologists, nurses, family therapists, dieticians and individual support. We also offer multi-family therapy (MFT) for which we received a Positive Practice Award from the National Institute for Mental Health in England, 2004.



Patient experience

Eating disorder services receive a high number of thank-yous and compliments:

"Just a note to say thank you for spending all that time with us at the beginning of the week. It was most useful and I am sure during the coming days, weeks and months we will draw on what we did and find support from it."

Thank you note from a carer

"Thank you for all your help and support over the years. I feel like I have come a long way since the first day that we met. I now know that everything will be okay and don't feel like I need to control my life with food. I am very happy and settled in my job and I am really excited about what my future has in hold for me. I am really sad to say goodbye but I know this is also a good thing."

Service user feedback

To improve patient experience the inpatient unit are currently working to increase information about the side effects of medication and making the ward feel safer. They are also making sure that people know how to make a complaint if they need to.

Figure 8 | Eating disorders outpatient

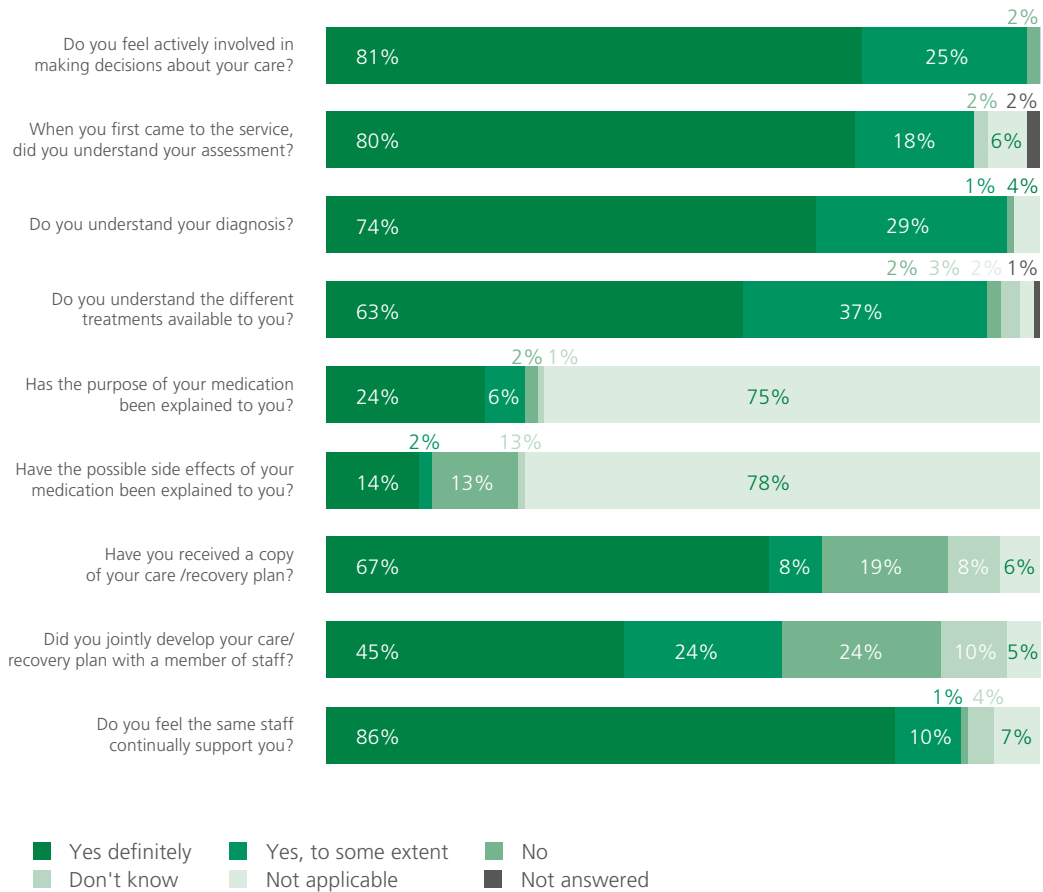
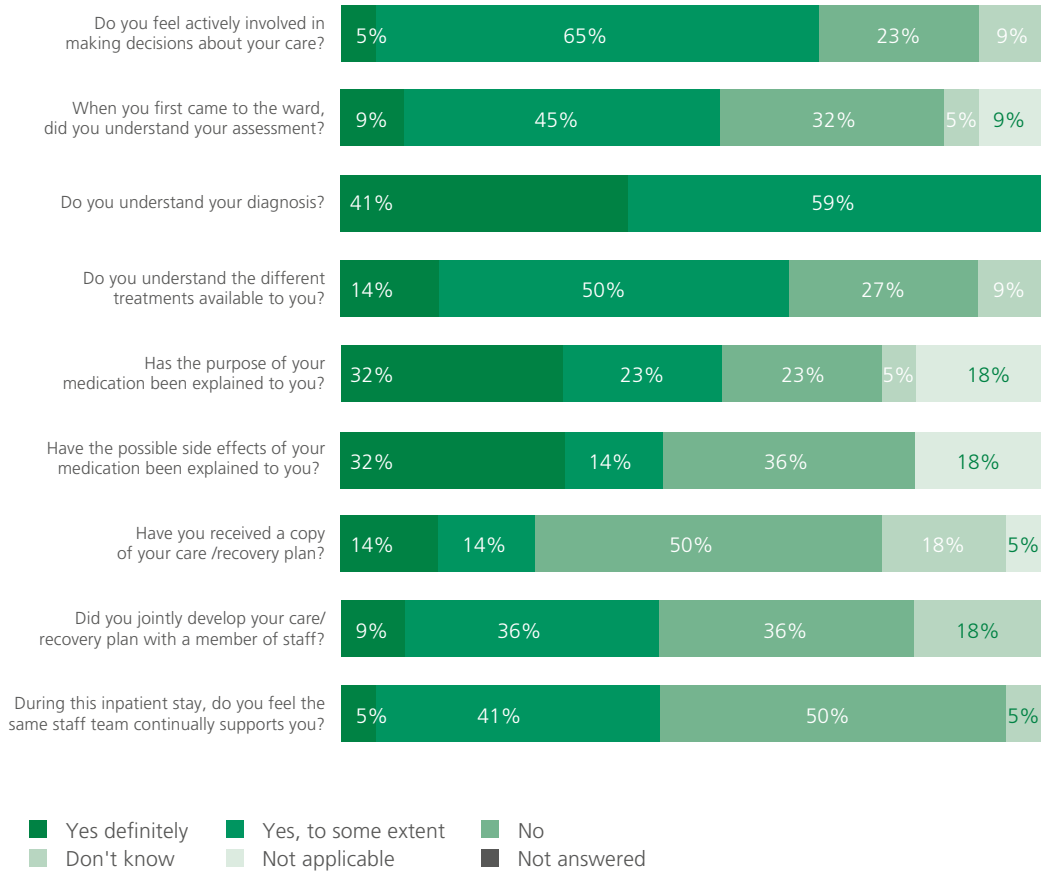


Figure 9 | Eating disorders inpatient



Research and innovation

MANTRA (Maudsley Model of Anorexia Nervosa Treatment for Adults)

This model is a manualised, cognitive-interpersonal treatment for adults with anorexia nervosa (AN) informed by a psycho-biological maintenance model of AN (Schmidt and Treasure, 2006). Given the low motivation often encountered when working with this patient group, early modules incorporate motivational interviewing techniques to assess and work with issues of motivation. At the heart of the treatment manual is an individualised formulation depicted as a 'vicious flower' which maps out the 'petals' or factors that maintain an individual's illness.

The treatment change techniques are then divided into four core modules, each of which targets a factor known to maintain the disorder (Schmidt and Treasure, 2006; Treasure and Schmidt, 2013; Schmidt et al., 2014). These are positive beliefs about the illness, one's dominant thinking style, difficulties managing emotions and relationships and the response of others to the illness. At the end of treatment, individuals are encouraged to depict progress via a 'virtuous flower' of factors that promote and maintain positive health and wellbeing.

So far, two pilot trials (Wade et al., 2012; Schmidt et al., 2013) and a definitive trial

(Schmidt et al., in preparation) comparing MANTRA with a routine care style of treatment for AN yielded promising results for MANTRA. Patients showed improvement in their core eating disorder symptoms and there were indicators that MANTRA may be particularly beneficial for presentations at the severe end of the spectrum. Furthermore, both therapists and patients like using MANTRA (Waterman-Collins et al., 2014; Lose et al., 2014; Zainab et al., submitted).

Interviews exploring therapist experiences of using the manual described it as affording a good balance of structure and flexibility, along with offering a breadth of 'tools' to flexibly and successfully weave into a time-limited treatment. Patients' reports of working collaboratively through the manual with their therapist also highlight the benefits of the structured approach, the value of gaining new perspectives on their difficulties and of acquiring skills to manage their eating disorder, as well as to enhance confidence and overall quality of life. Thus, results from studies using this manual strongly support the case for accessibility of a time-limited and potentially cost-effective cognitive-interpersonal package for adults suffering with AN.

Clinical outcomes

For all eating disorders services, there is some overlap in the first and last confidence intervals which suggests that there is not a statistically significant difference in first and last HoNOS scores.

Figure 10 | Eating disorders outpatient

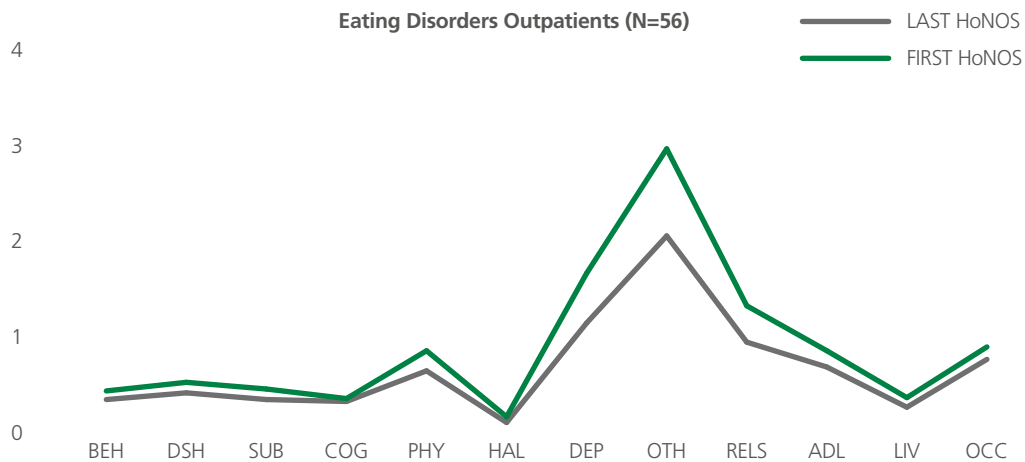
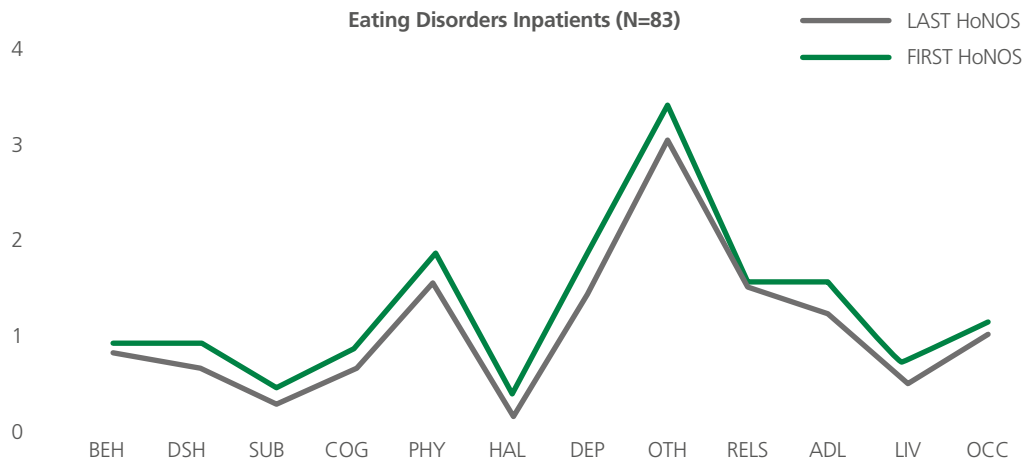


Figure 11 | Eating disorders inpatient



Change in mean score for each HoNOS scale

Figures 10 and 11 show average first and last HoNOS scores for each of the 12 independent HoNOS scales for the inpatient and outpatient eating disorders service. They are more descriptive, as we can see change within each HoNOS scale.

Clinical improvements are shown by the gaps between the first and last HoNOS lines. We can see that depression and other problems tend to show greater improvements for patients in outpatients.

The green line shows improvement over the 12 different HoNOS scores as the values are lower than at first HoNOS.

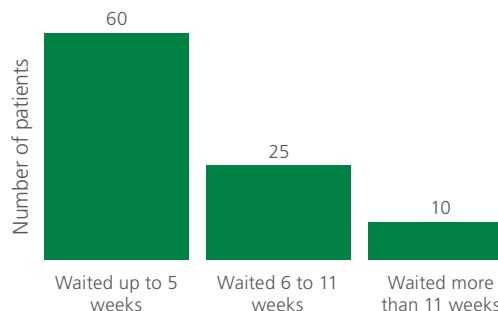
Performance measures

Waiting times

Figure 12 | Waiting times for inpatient services



Figure 13 | Waiting times for outpatient services



Research in focus

The MOSAIC study – comparison of the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA) with Specialist Supportive Clinical Management (SSCM) in outpatients with anorexia nervosa or eating disorder not otherwise specified, anorexia nervosa type: Study protocol for a randomized controlled trial

Trials, 2013

Schmidt, U., Renwick, B., Lose, A., Kenyon, M., DeJong, H., Broadbent, H., Loomes, R., Watson, C., Ghelani, S., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Beecham, J., Treasure, J., Landau, S.

Background: Anorexia nervosa (AN) is a biologically-based serious mental disorder with high levels of mortality and disability, physical and psychological morbidity and impaired quality of

life. AN is one of the leading causes of disease burden in terms of years of life lost through death or disability in young women. Psychotherapeutic interventions are the treatment of choice for AN but the results of psychotherapy depend critically on the stage of the illness. The treatment response in adults with a chronic form of the illness is poor and drop-out from treatment is high. Despite the seriousness of the disorder, the evidence-base for psychological treatment of adults with AN is extremely limited and there is no leading treatment. There is therefore an urgent need to develop more effective treatments for adults with AN. The aim of the Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC) is to evaluate the efficacy and cost effectiveness of two outpatient treatments for adults with AN, Specialist Supportive Clinical Management (SSCM) and the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA).

Methods/Design: 138 patients meeting the inclusion criteria are randomly assigned to one of the two treatment groups (MANTRA or SSCM). All participants receive 20 once-weekly individual therapy sessions (with ten extra weekly sessions for those who are severely ill) and four follow-up sessions with monthly spacing thereafter. There is also optional access to a dietician and extra sessions involving a family member or a close other. Body weight, eating disorder-related symptoms, neurocognitive and psychosocial measures and service use data are measured during the course of treatment and across a one-year follow up period. The primary

outcome measure is body mass index (BMI) taken at twelve months after randomisation.

Discussion: This multi-center study provides a large sample size, broad inclusion criteria and a follow-up period. However, the study has to contend with difficulties directly related to running a large multi-center randomized controlled trial and the psychopathology of AN. These issues are discussed.

Poor decision-making in male patients with anorexia nervosa

European Eating Disorders Review, 2012

Tchanturia, K., Liao, P.-C., Forcano, L., Fernández-Aranda, F., Uher, R., Treasure, J., Schmidt, U., Penelo, E., Granero, R., Jiménez-Murcia, S., Sánchez, I., Campbell, I.C.

Objective: Decision-making is impaired in female patients with anorexia nervosa (AN) but it is unclear if the same impairment is present in male patients with AN.

Method: Decision-making was assessed in 48 AN individuals (19 male and 29 female patients) and 61 healthy controls (20 male and 41 female patients) using the Iowa Gambling Task (IGT).

Results: Both male and female patients with AN performed significantly worse than healthy controls on the IGT. No gender differences in IGT performance were found across groups. Male patients had higher impulsivity scores

but impulsivity had not predicted poor decision-making performance.

Discussion: Impaired decision-making is present in male and female patients with AN. These data suggest that male patients with AN are very similar to female patients in decision-making and, as a result, treatment approaches that seek to improve this ability should be similar in both genders.

A randomized controlled trial of an Internet-based cognitive-behavioural skills package for carers of people with anorexia nervosa

Psychological Medicine, 2011

Grover, M., Naumann, U., Mohammad-Dar, L., Glennon, D., Ringwood, S., Eisler, I., Williams, C., Treasure, J., Schmidt, U.

Background: Anorexia nervosa (AN) poses a major burden on families. Carers (e.g. parents or partners) of people with AN are often highly distressed and may inadvertently respond in ways that can contribute to the maintenance of the disorder, e.g. through high levels of over-involvement and criticism [also known as expressed emotion (EE)]. This study aimed to evaluate the efficacy of a novel web-based systemic cognitive-behavioural (CBT) intervention for carers of people with AN, designed to reduce carer distress and teach skills in how to offer effective support.

Method: Carers of people with AN (n=64) were randomly allocated to either the web-intervention, Overcoming Anorexia Online, with limited clinician supportive guidance (by email or phone) or to ad-hoc usual support from the UK patient and carer organisation Beat. Carer outcomes were assessed at post-treatment (four months) and follow-up (six months).

Results: Compared with the control intervention, web-based treatment significantly reduced carers' anxiety and depression (primary outcome) at post-treatment with a similar trend in carers' EE. Other secondary outcomes did not favour the online intervention. Gains were maintained at follow-up.

Conclusions: This is the first ever study to use an online CBT program to successfully reduce carer distress and improve carers' ability to support the person with AN.

Poor cognitive flexibility in eating disorders: Examining the evidence using the Wisconsin Card Sorting Task

Plos One, 2012

Tchanturia, K., Davies, H., Roberts, M., Harrison, A., Nakazato, M., Schmidt, U., Treasure, J., Morris, R.

Background: People with eating disorders (ED) frequently present with inflexible behaviours, including eating-related issues which contribute to the maintenance of the illness. Small scale studies point to difficulties with cognitive set-shifting

as a basis. Using larger scale studies will lend robustness to these data.

Methodology/Principal findings: 542 participants were included in the dataset as follows: Anorexia Nervosa (AN) n = 171; Bulimia Nervosa (BN) n = 82; Recovered AN n = 90; Healthy controls (HC): n = 199. All completed the Wisconsin Card Sorting Task (WCST), an assessment that integrates multiple measurement of several executive processes concerned with problem solving and cognitive flexibility. The AN and BN groups performed poorly in most domains of the WCST. Recovered AN participants showed a better performance than currently ill participants; however, the number of preservative errors was higher than for HC participants.

Conclusions/Significance: There is a growing interest in the diagnostic and treatment implications of cognitive flexibility in eating disorders. This large dataset supports previous smaller scale studies and a systematic review which indicate poor cognitive flexibility in people with ED.

The cognitive-interpersonal maintenance model of anorexia nervosa revisited: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors

Journal of Eating Disorders, 2013

Treasure, J & Schmidt, U.

Aim: To describe the evidence base relating to the Cognitive-Interpersonal Maintenance Model for anorexia nervosa (AN).

Background: A Cognitive-Interpersonal Maintenance Model for anorexia nervosa (AN) was described in 2006. This model proposed that cognitive, socio-emotional and interpersonal elements acted together to both cause and maintain eating disorders.

Method: A review of the empirical literature relating to the key constructs of the model (cognitive, socio-emotional, interpersonal) risk and maintaining factors for anorexia nervosa was conducted.

Results: Set shifting and weak central coherence (associated with obsessive compulsive traits) have been widely studied. There is some evidence to suggest that a strong eye for detail and weak set shifting are inherited vulnerabilities to AN. Set shifting and global integration are impaired in the ill state and contribute to weak central coherence. In addition, there are wide-ranging impairments in socio-emotional processing including: an automatic bias in attention towards critical and domineering faces and away from compassionate faces; impaired signalling of, interpretation and regulation of emotions. Difficulties in social cognition may in part be a consequence of starvation but inherited vulnerabilities may also contribute to these traits. The shared familial traits may accentuate family members' tendency to react to the

frustrating and frightening symptoms of AN with high expressed emotion (criticism, hostility, overprotection) and inadvertently perpetuate the problem.

Conclusion: The cognitive interpersonal model is supported by accumulating evidence. The model is complex in that cognitive and

socio-emotional factors both predispose to the illness and are exaggerated in the ill state. Furthermore, some of the traits are inherited vulnerabilities and are present in family members. The clinical formulations from the model are described as are new possibilities for targeted treatment.

Publications

Published books		
Author	Title	Publisher
Kate Tchanturia	Cognitive Remediation Therapy for Eating Disorders	Routledge Taylor & Francis Group (November 2015)
Eating disorders		
List of publications	Journal	
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Tchanturia K, Smith E, Weineck F, Fidanboylyu E, Kern N, Treasure J, Baron-Cohen, S (2013) Autistic traits in anorexia	Molecular Autism	
Fonville L, Giampietro V, Williams S, Simmons A, Tchanturia K. (2013) Alterations in Brain Structure in Adults with Anorexia Nervosa and the Impact of Illness Duration	Psychological Medicine	
Lao-Kaim NP, Giampietro V, Williams SCR, Simmons A, Tchanturia K. (2013) Functional MRI investigation of verbal working memory in adults with Anorexia Nervosa	European Psychiatry	
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Lock J, Agras S, Fitzpatrick K, Bryson S, Booil J, Tchanturia K (2013) A Randomised assessment of Novel Treatment for anorexia nervosa addressing inefficient cognitive process	International Journal of Eating Disorders	
Tchanturia K, Davies H, Harrison A, Fox J, Treasure J, Schmidt U. (2012) Altered social hedonic processing in eating disorders	International Journal of Eating Disorders	
Tchanturia K, Davies H, Harrison A, Roberts M, Nakazato M, Schmidt U, Treasure J, Morris R (2012) Poor cognitive Flexibility in Eating Disorders	Examining the Evidence using the Wisconsin Cart Sorting Task PLoS one	

Tchanturia K, Hambrook D, Curtis H, Jones T, Lounes N, Fenn K, Keys A, Stivenson L, Davies H (2013) Work and Social Adjustment in patients with Anorexia Nervosa	Comprehensive Psychiatry
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Lose A, Davies C, Renwick B, Kenyon M, Treasure J, Schmidt U (2014). MOSAIC trial group. Process evaluation of the maudslay model for treatment of adults with anorexia nervosa trial. Part II: Patient experiences of two psychological therapies for treatment of anorexia nervosa	European Eating Disorders Review
Robinson P, Barrett B, Bateman A, Hakeem A, Hellier J, Lemonsky F, Rutterford C, Schmidt U, Fonagy P (2014). Study Protocol for a randomized controlled trial of mentalisation based therapy against specialist supportive clinical management in patients with both eating disorders and symptoms of borderline personality disorder	BMC Psychiatry
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Horrell L, Goldsmith KA, Tylee AT, Schmidt UH, Murphy CL, Bonin EM, Beecham J, Kelly J, Raikundalia S, Brown JS; CLASSIC trial group (2013). One-day cognitive-behavioural therapy self-confidence workshops for people with depression: randomised controlled trial	British Journal Psychiatry
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Giel KE, Kullmann S, Preißl H, Bischoff SC, Thiel A, Schmidt U, Zipfel S, Teufel M (2014). Understanding the reward system functioning in anorexia nervosa: crucial role of physical activity	Biological Psychology
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Hoyle D, Slater J, Williams C, Schmidt U, Wade TD (2013). Evaluation of a web-based skills intervention for carers of people with anorexia nervosa: a randomized controlled trial	International Journal Eating Disorders

Mother and baby/ Perinatal services

Introduction

The Mother and Baby Unit at the Bethlem Royal Hospital is a 13-bedded regional and national unit offering 24-hour psychiatric care to mothers of babies up to one year old. 11 of these beds are acute admissions beds and two are for parenting assessments. There are very few units providing a similar service in the London area.

The unit is linked to community and liaison perinatal mental health teams across South London (London boroughs of Southwark, Lambeth, Lewisham and Croydon). It offers preconception counselling through to pregnancy and the post-natal period until the baby is one year old. Our community teams work closely with maternity services linked to King's College Hospital, St Thomas' Hospital, Lewisham and Croydon Mayday Hospitals, secondary mental health and primary care.

We are also able to take mothers without their babies and offer a programme of gradual

reintroduction to the mother. We provide a unique inpatient parenting assessment service for local and national authorities across the United Kingdom. We undertake assessment of women or couples and their infant, where there is potential risk or safeguarding issues arising from the parents' mental health problems.

Our team is committed to providing cost-effective, evidence-based treatments for mothers with mental health problems and their babies, including a holistic treatment programme and encourage the involvement of fathers or partners in the process.

We aim to reduce risk and establish a relationship between mother and baby, which prepares them for a lasting return to the community.

Our aim is to provide early identification and treatment of antenatal and postnatal mental health problems. Our service helps to maintain the mother's mental health, develop a relationship between the mother and her baby, reduce the impact of the mother's mental illness on the child and provide support for the mother in her community.

We believe for each of our patients, in childbirth and parenthood, there are fundamental changes in their role, environment and relationships and the health of the mother and infant depends largely on the maturation and adaptation to these changes. We recognise mental health problems related to childbirth may have a profound impact on the lives of women, their infants and families and we aim to help them improve their mental wellbeing and understand their health problems through an eclectic approach to their treatment.

We acknowledge cultural differences in parenting practices and the contributions to the health of the mother and infant made by partners, families and important others. We work in conjunction with patients and carers and encourage liaison with external agencies throughout admission formulating cohesive discharge plans with the professionals who will be involved in the patient's care in the community. We acknowledge that in accordance with the Children's Act (1989), the welfare of the child is paramount. We also strive to work closely with child and family social services.



Patient experience

"The mother and baby unit is brilliant. I stayed in 2012 shortly before the birth of my son and about three months after. To begin with it's a scary place and everyone naturally moans about things especially the food and the supervision. However... 24-hour care from nursery nurses, mental health nurses helped me bond with my baby and overcome some of my fears. I was given brilliant psychology sessions which I was allowed to complete even after I left. I was able to do occupational therapy as part of my recovery.

I learned pottery, jewellery making, cooking, art therapy, drama therapy, baby massage, and there was tons of other options I could have done. I had weekly sessions with the "baby whisperer" (baby psychologist) which were so reassuring, she videoed my interactions and played them back explaining the interactions between my baby and I, which boosted my confidence and also helped prevent me building up false beliefs about my baby's development (I was unwell with severe anxiety over it).

I had somebody there at every hour of the day able to help. From as simple as helping change a nappy or watching and cuddling him for a few hours while I rested during my recovery to telephone support on my visits home and experienced psychiatric

and psychological care. I totally get why people complain, as the situation is not a pleasant one to be in, but in hindsight they saved my life probably and my child's. Instead of me being in and out of psych wards and my baby in foster care...we are a family and I believe it's down to the care I had there helping me bond with my child"

Comparing admission and discharge scores using the Crittenden CARE Index demonstrates significant clinical improvement in both the maternal and infant interactions. (Ref: Mother-infant interaction in mother and baby unit patients: Before and after treatment. Kenny, M., Paginate, C., Conroy, S., Seneviratne, G. & Pawlby, S. September 2013 In: Journal of Psychiatric Research. 47, 9, p. 1192–1198. Patient experience in the mother and baby unit).



Perinatal services

Members of the service user and carer advisory group visited the Mother and Baby Unit:

"The unit had a lovely atmosphere and we were made very welcome. Mums need to have better access to a pharmacist. This may then increase the amount of mums that will breastfeed, as there are concerns about the medication being transferred to the baby..."

Visit report to governance executive

The Mother and Baby Unit acted on these recommendations, and reported one month later that:

"The Mother and Baby Unit has an allocated pharmacist who makes themselves available for appointments with patients at their request. Ward doctor to provide medication information leaflets to patients after their first ward round."

To improve patient experience, the perinatal outpatient service is currently working on introducing a clearer treatment plan document and ensuring service users have a copy of this.



Figure 14 | Mother and baby outpatient

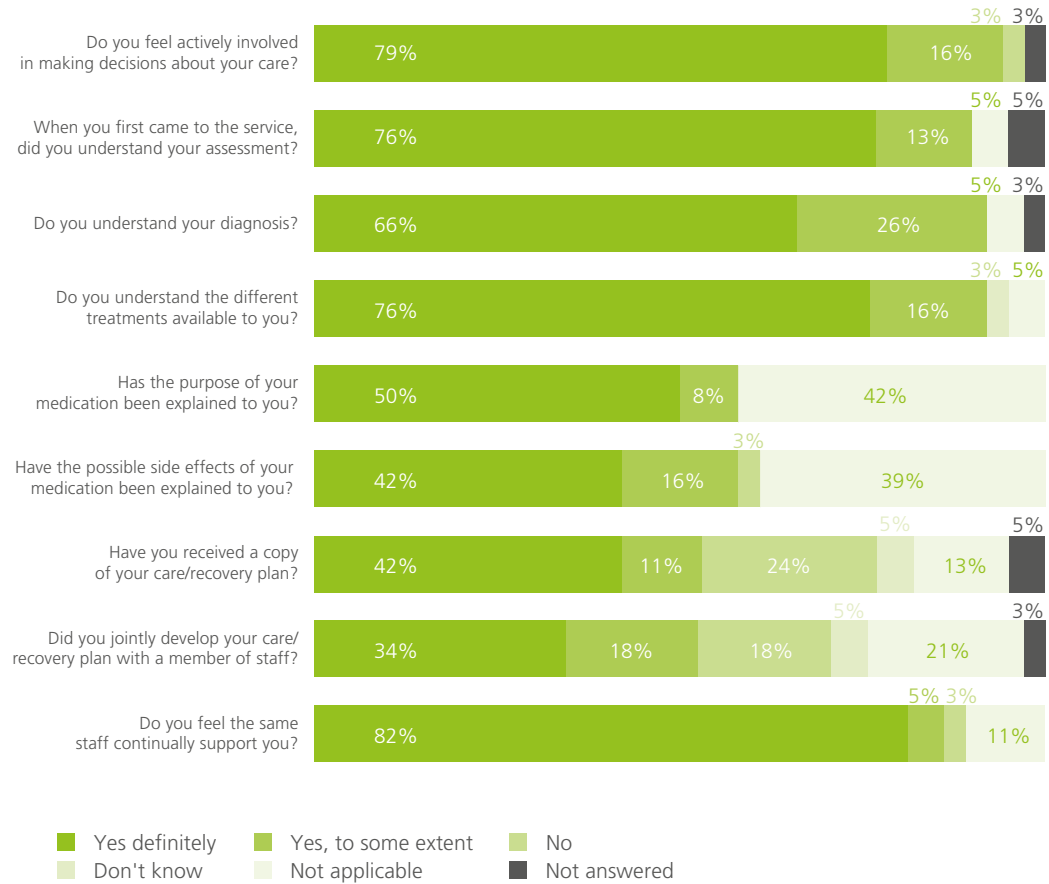
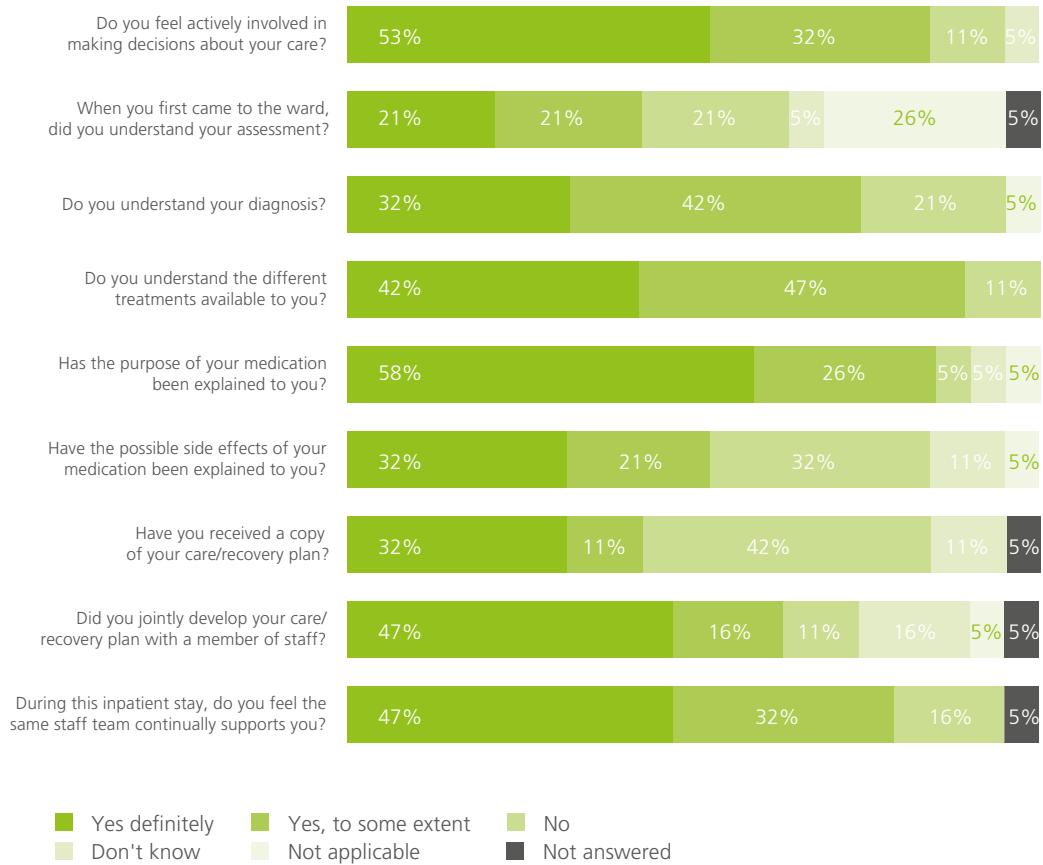


Figure 15 | Mother and baby inpatient



Clinical outcomes

Discharge HoNOS scores for both inpatient and community services (across the boroughs of Lambeth, Southwark, Lewisham and Croydon) are significantly lower than the initial admission scores, evidencing improvement in mental health following treatment in both the Inpatient Mother and Baby Unit and with Community Perinatal Mental Health Teams

HoNOS health and domain scales key as shown in the following graphs on the bottom axis

BEH	overactive, aggressive, disruptive or agitated behaviour
DSH	non-accidental self-injury
SUB	problem drinking or drug-taking
COG	cognitive problems
PHY	physical illness or disability problems
HAL	problems associated with hallucinations and delusions
DEP	problems with depressed mood
OTH	other mental and behavioural problems
RELS	problems with relationships
ADL	problems with activities of daily living
LIV	problems with living conditions
OCC	problems with occupation and activities

Figure 16 | Lambeth, Southwark and Lewisham (n=136)

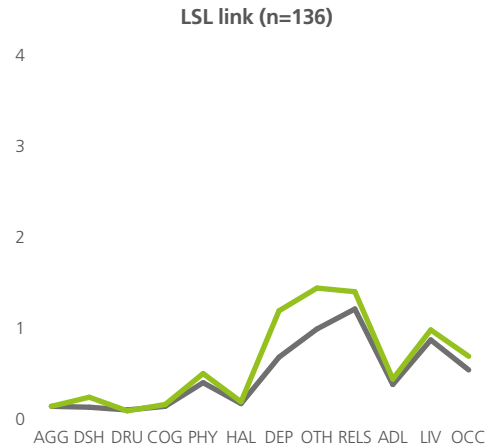


Figure 17 | National outpatients (n=119)

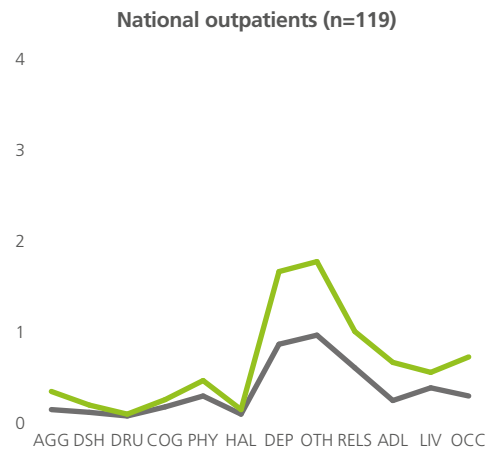


Figure 18 | MAPPIM (n=179)

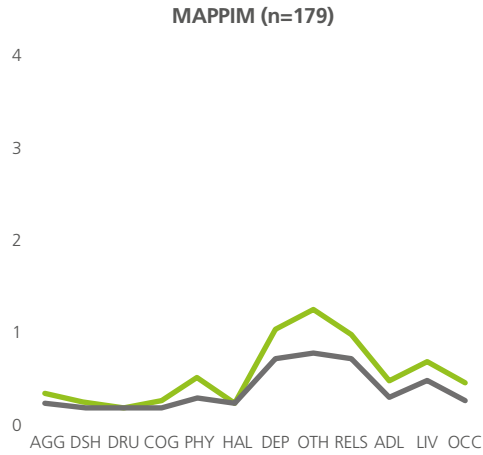


Figure 20 | Croydon CMHT (n=362)

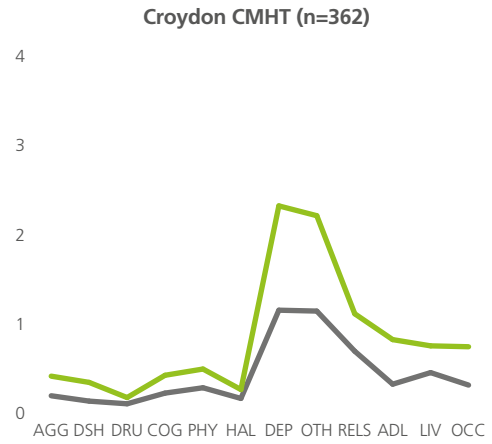


Figure 19 | Mother and Baby Unit (n=120)

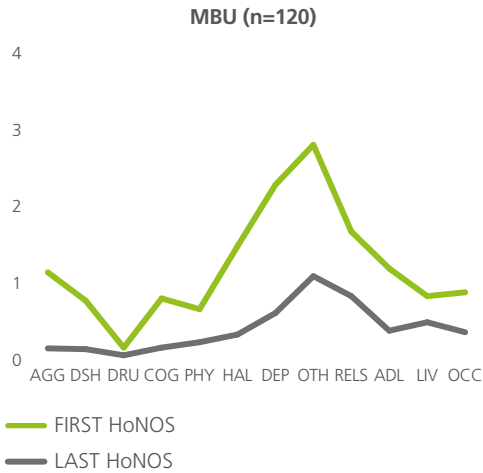
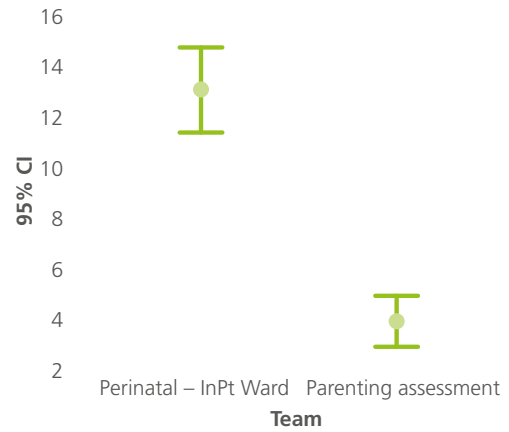


Figure 21 | Total HoNOS score adjusted for missing scales at first and last HoNOS 2010–2013

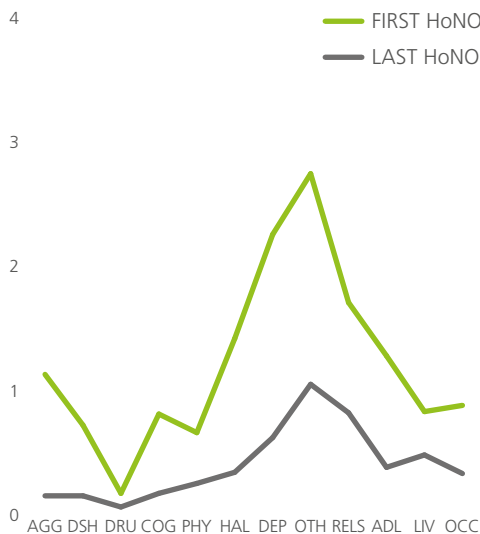


HoNOS Scores demonstrate improvement when comparing admission at discharge scores for women admitted to the Mother and Baby Unit for treatment of acute mental illness. Women admitted for parenting assessments are deemed to beat their optimal level of functioning and they are usually not mentally unwell. Thus, the HoNOS scores are lower compared with the ill group of mothers.

Error bars show the average (mean) total HoNOS score at first and last rating in 47 MBU episodes and the expected spread of scores in the MBU population based on this sample.

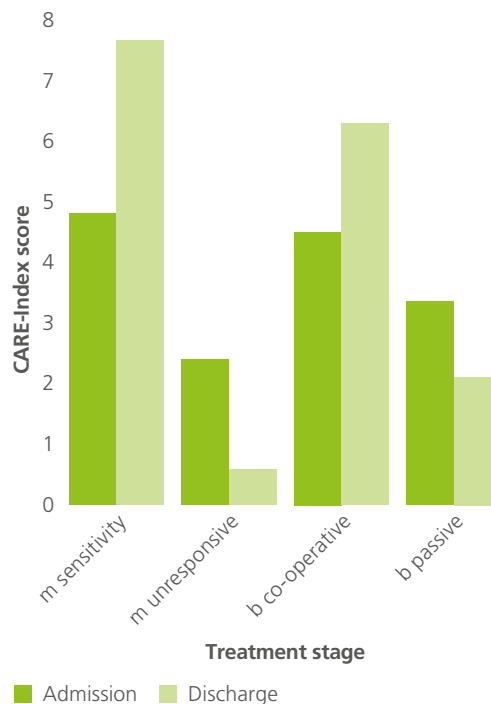
The absence of any overlap between the error bars suggests statistically significant change

Figure 22 | Change in mean score for each HoNOS scale 2012/13. Mother and Baby Unit (n=108)



For mothers admitted to the Mother and Baby Unit (MBU) when acutely mentally unwell, HoNOS scores at discharge for most items on the scale are significantly lower at discharge compared with admission. There is evidence of a high severity of mental illness of caseload for MBU admissions, as indicated by the items for hallucinations and depression. Psychosis and problems with relationships, which include a difficult relationship with the baby, are two indicators that increase length of stay.

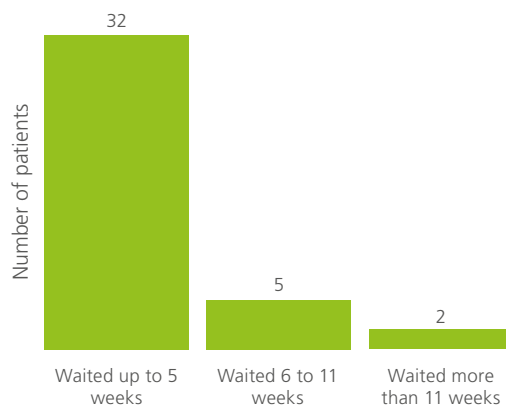
Figure 23 | Mother-infant interaction on admission and discharge from MBU 2012–13



There is significant improvement in the mother-infant relationship comparing admission and discharge scores using the Crittenden Care Index, with improved maternal sensitivity and reduced passivity in babies.

Performance measures

Figure 24 | Snapshot at the end of March 2014 on patient waiting time for the outpatient and outreach service



Research in focus

Effects of perinatal mental disorders on the fetus and child

The Lancet, 2014

Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M., Pariante, C.M.

Perinatal mental disorders are associated with increased risk of psychological and developmental disturbances in children. However, these disturbances are not inevitable. In this Series paper, we summarise evidence for associations between parental disorders and offspring outcomes from fetal development to adolescence in high-income, middle-income and low-income countries. We assess evidence for mechanisms underlying transmission of disturbance, the role of mediating variables (underlying links between parent psychopathology and offspring outcomes) and possible moderators (which change the strength of any association) and focus on factors that are potentially modifiable, including parenting quality, social (including partner) and material support, and duration of the parental disorder. We review research of interventions, which are mostly about maternal depression, and emphasise the need to both treat the parent's disorder and help with associated caregiving difficulties. We conclude with policy implications and underline the need for early identification of those parents at high risk and for more early interventions and prevention research, especially in socioeconomically-disadvantaged populations and low-income countries.

Bipolar disorder, affective psychosis and schizophrenia in pregnancy and the post-partum period

The Lancet, 2014

Jones, I., Chandra, P.S., Dazzan, P., Howard, L.M.

The perinatal period is associated with an increased risk of severe mental disorders.

We summarise the evidence regarding the epidemiology, risk factors and treatment of severe mental illness in relation to childbirth, focusing on bipolar disorder, affective psychosis and schizophrenia. We discuss women with ongoing chronic conditions and those with the onset of new episodes of post-partum psychosis. Despite the importance of perinatal episodes, with suicide a leading cause of maternal death, few studies are available to guide the management of women with severe mental disorders in pregnancy and the post-partum period. However, general principles of management are discussed, including the need for an individual risk-benefit analysis for each woman.

Developing a complex intervention for diet and activity behaviour change in obese pregnant women (the UPBEAT trial); Assessment of behavioural change and process evaluation in a pilot randomised controlled trial

BMC Pregnancy and Childbirth, 2013

Poston, L., Briley, A.L., Barr, S., Bell, R., Croker, H., Coxon, K., Essex, H.N., Hunt, C., Hayes, L., Howard, L.M., Khazaeezadeh, N., Kinnunen, T., Nelson, S.M., Oteng-Ntim, E., Robson, S.C., Sattar, N., Seed, P.T., Wardle, J., Sanders, T.A.B., Sandall, J.

Background: Complex interventions in obese pregnant women should be theoretically-based, feasible and shown to demonstrate anticipated behavioural change prior to inception of large randomised controlled trials (RCTs). The aim was to determine if a) a complex intervention in obese

pregnant women leads to anticipated changes in diet and physical activity behaviours and b) to refine the intervention protocol through process evaluation of intervention fidelity.

Methods: We undertook a pilot RCT of a complex intervention in obese pregnant women, comparing routine antenatal care with an intervention to reduce dietary glycaemic load and saturated fat intake, and increase physical activity. Subjects included 183 obese pregnant women (mean BMI 36.3 kg/m²). Diet was assessed by repeated triple pass 24-hour dietary recall and physical activity by accelerometry and questionnaire, at 16+0 to 18+6 and at 27+0 to 28+6 weeks' gestation in women in control and intervention arms. Attitudes to behaviour change and quality of life were assessed and a process evaluation undertaken. The full RCT protocol was undertaken to assess feasibility.

Results: Compared to women in the control arm, women in the intervention arm had a significant reduction in dietary glycaemic load (33 points, 95% CI -47 to -20), ($p < 0.001$) and saturated fat intake (-1.6% energy, 95% CI -2.8 to -0.3) at 28 weeks' gestation. Objectively measured physical activity did not change. Physical discomfort and sustained barriers to physical activity were common at 28 weeks' gestation. Process evaluation identified barriers to recruitment, group attendance and compliance, leading to modification of intervention delivery.

Conclusions: This pilot trial of a complex intervention in obese pregnant women suggests greater potential for change in dietary intake than for change in physical activity and, through

process evaluation, illustrates the considerable advantage of performing an exploratory trial of a complex intervention in obese pregnant women before undertaking a large RCT.

The stability and change of etiological influences on depression, anxiety symptoms and their co-occurrence across adolescence and young adulthood

Psychological Medicine, 2016

Waszczuk, M.A., Zavos, H.M.S., Gregory, A.M., Eley, T.C

Background: Depression and anxiety persist within and across diagnostic boundaries. The manner in which common versus disorder-specific genetic and environmental influences operate across development to maintain internalising disorders and their co-morbidity is unclear. This paper investigates the stability and change of etiological influences on depression, panic, generalised, separation and social anxiety symptoms, and their co-occurrence, across adolescence and young adulthood.

Method: A total of 2,619 twins/siblings prospectively reported symptoms of depression and anxiety at mean ages 15, 17 and 20 years.

Results: Each symptom scale showed a similar pattern of moderate continuity across development, largely underpinned by genetic stability. New genetic influences contributing to change in the developmental course of the symptoms emerged at each time point. All

symptom scales correlated moderately with one another over time. Genetic influences, both stable and time-specific, overlapped considerably between the scales. Non-shared environmental influences were largely time- and symptom-specific, but some contributed moderately to the stability of depression and anxiety symptom scales. These stable, longitudinal environmental influences were highly correlated between the symptoms.

Conclusions: The results highlight both stable and dynamic etiology of depression and anxiety symptom scales. They provide preliminary evidence that stable as well as newly-emerging genes contribute to the co-morbidity between depression and anxiety across adolescence and young adulthood. Conversely, environmental influences are largely time-specific and contribute to change in symptoms over time. The results inform molecular genetics research and transdiagnostic treatment and prevention approaches

Domestic violence and perinatal mental disorders: A systematic review and meta-analysis

PLoS Medicine, 2013

Howard, L.M., Oram, S., Galley, H., Trevillion, K., Feder, G.

Background: Domestic violence in the perinatal period is associated with adverse obstetric outcomes but evidence is limited on its association with perinatal mental disorders. We aimed to estimate the prevalence and odds of

having experienced domestic violence among women with antenatal and postnatal mental disorders (depression and anxiety disorders including post-traumatic stress disorder [PTSD], eating disorders and psychoses).

Methods and findings: We conducted a systematic review and meta-analysis (PROSPERO reference CRD42012002048). Data sources included searches of electronic databases (to 15 February 2013), hand searches, citation tracking, update of a review on victimisation and mental disorder and expert recommendations. Included studies were peer-reviewed experimental or observational studies that reported on women aged 16 years or older, that assessed the prevalence and/or odds of having experienced domestic violence, and that assessed symptoms of perinatal mental disorder using a validated instrument. Two reviewers screened 1,125 full-text papers, extracted data and independently appraised study quality. Odds ratios were pooled using meta-analysis. Sixty-seven papers were included. Pooled estimates from longitudinal

studies suggest a 3-fold increase in the odds of high levels of depressive symptoms in the postnatal period after having experienced partner violence during pregnancy (odds ratio 3.1, 95% CI 2.7–3.6). Increased odds of having experienced domestic violence among women with high levels of depressive, anxiety and PTSD symptoms in the antenatal and postnatal periods were consistently reported in cross-sectional studies. No studies were identified on eating disorders or puerperal psychosis. Analyses were limited because of study heterogeneity and lack of data on baseline symptoms, preventing clear findings on causal directionality.

Conclusions: High levels of symptoms of perinatal depression, anxiety and PTSD are significantly associated with having experienced domestic violence. High-quality evidence is now needed on how maternity and mental health services should address domestic violence and improve health outcomes for women and their infants in the perinatal period.

Publications

Published books		
Author	Title	Publisher
C.Pariante (Editor), S.Conroy (Editor), P.Dazzan (Editor), L.Howard (Editor), S. Pawlby (Editor), T.Seneviratne (Editor)	Perinatal psychiatry: the legacy of Channi Kumar	Oxford University Press 2014

Mother and Baby/Perinatal	
List of publications	Journal
Kenny, M., Pariante, C., Conroy, S., Seneviratne, G. & Pawlby, S. (2013) Mother-infant interaction in mother and baby unit patients: Before and after treatment. An important paper evidencing outcomes on an MBU	Journal of Psychiatric Research
Pawlby, S., Fernyhough, C., Meins, E., Pariante, C. M., Seneviratne, G. & Brent, R. P. (2010) Mind-mindedness and maternal responsiveness in infant-mother interactions in mothers with severe mental illness.	Psychological Medicine
Plant DT, Barker ED, Waters CS, Pawlby S, Pariante CM. Intergenerational transmission of maltreatment and psychopathology: the role of antenatal depression.	Psychological Medicine
O'Keane V, Lightman S, Patrick K, Marsh M,, Papadopoulos AS, Pawlby S, Taylor A, Seneviratne, G, Moore R. (2011) Changes in the Maternal Hypothalamic-Pituitary-Adrenal Axis During the Early Puerperium may be Related to the Postpartum 'Blues'	Journal of Neuroendocrinology
Howard LM, Oram S, Galley H, Trevillion K, Feder G. Domestic violence and perinatal mental health: systematic review and meta-analysis.	Plos Med
Molyneux E, Poston L, Howard LM. Obesity and mental disorders during pregnancy and postpartum: a systematic review and meta-analysis.	Obstetrics & Gynecology Online first
Howard LM, Bekele D, Rowe M, Demilew J, Bewley S, Marteau TM(2013) Smoking cessation in pregnant women with mental disorders: a cohort and nested qualitative study	An International Journal of Obstetrics and Gynaecology
Flach C, Leese M, Heron J, Evans J, Feder G, Sharp D, Howard LM. (2011) Antenatal Domestic Violence, maternal mental health and Subsequent Child Behaviour: a cohort study	An International Journal of Obstetrics and Gynaecology
Pawlby, S., Hay, D.F., Sharp, D., Waters, C.S. & O'Keane, V. (2009) Antenatal depression predicts depression in adolescent offspring: prospective longitudinal community based study	Journal of Affective Disorders
Dolman C, Jones I, Howard LM. A systematic review and meta-synthesis of the experience of motherhood in women with severe mental illness	Archives of Women's Mental Health
Green L, Vais A, Harding K. (2013) Preconception care for women with mental health conditions	British Journal of Hospital Medicine

Chronic fatigue service

Introduction

Chronic fatigue service

Our service is an internationally recognised research and treatment unit, providing specialist diagnostic assessment and treatment for people with chronic fatigue syndrome (CFS). We have developed models for understanding and treating CFS and continue to be at the forefront of research and development in this field.

We pride ourselves in our ability to engage with people who have complex and sometimes long-standing difficulties. Our treatment is time-limited, focuses on recovery and aims to help patients develop skills and feel empowered to manage their problems independently.

Chronic fatigue syndrome is characterised by moderate to severe fatigue which lasts for more than six months and is not alleviated by rest. Fatigue may also be accompanied by other symptoms such as muscle pain, unrefreshing sleep and headaches (Sharpe et al, 1991; Fukuda et al, 1993).

Patient experience

"I have always felt very respected, understood and heard, which I am so grateful for as the general population has such limited insight on this"

Written comment from patient satisfaction questionnaire

To improve patient experience, the chronic fatigue service is currently making sure everyone has a written copy of their treatment plan.

Figure 25 | Patient experience for chronic fatigue service

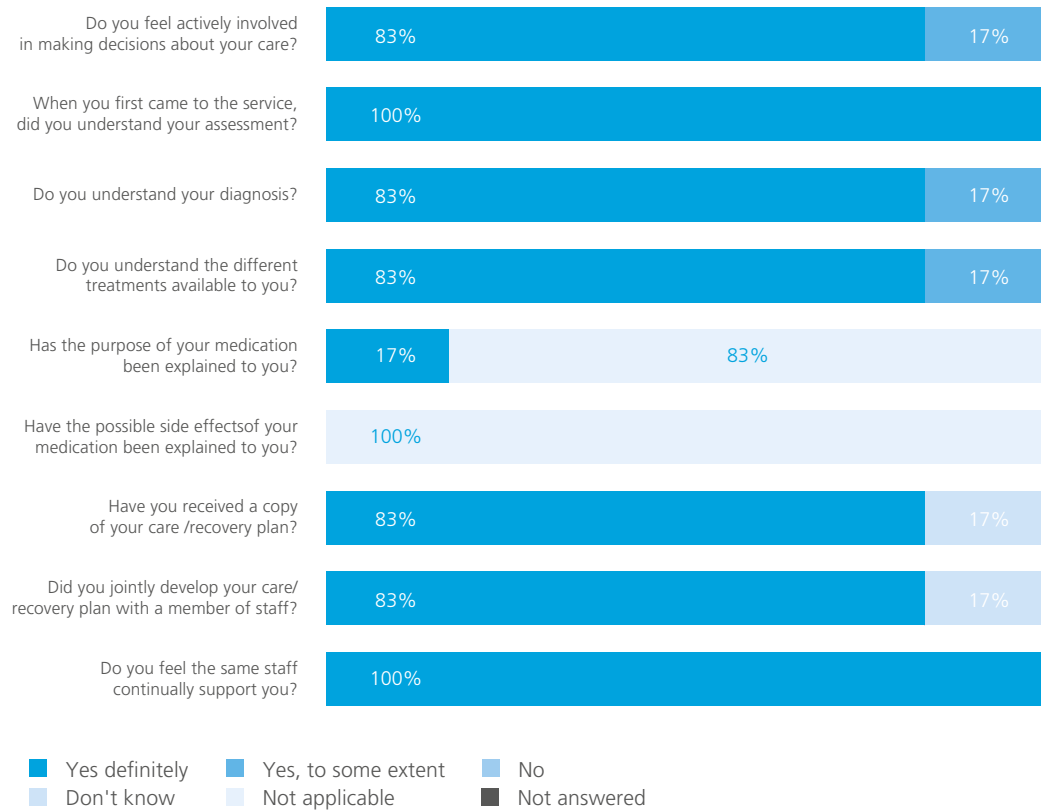
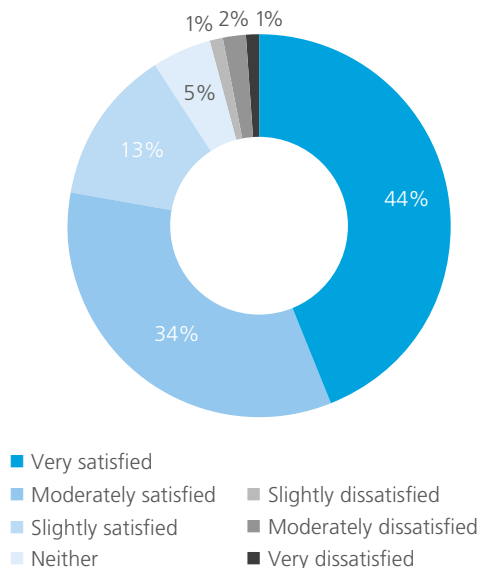


Figure 26 | Patient satisfaction rate by end of March 2014



At the end of treatment, patients were asked to rate how satisfied they were with the outcome of treatment. The chart above shows that 78% were 'very satisfied' or 'moderately satisfied' with their treatment.

Research and innovation

Comparison of clinic results with the results of a randomised controlled trial

The PACE trial (White et al, 2011) was a large-scale randomised controlled trial of cognitive behaviour therapy (CBT), graded exercise therapy

(GET), adaptive pacing therapy (APT) and standard medical care (SMC) for chronic fatigue syndrome.

At the end of the 52-week trial, participants who received CBT or GET with SMC showed reduced fatigue and better physical functioning than those who received APT or SMC alone.

The figures below show the mean Chalder Fatigue Scale scores and SF-36 physical functioning scores for the chronic fatigue unit routine clinic data and the PACE trial.

Both cohorts showed a reduction in fatigue and an increase in physical functioning after treatment. However, a caveat is that these studies differed in terms of methodology. For example, patients in the CFS unit received slightly more sessions over a longer duration than participants in the PACE trial.

Figure 27 | Fatigue scores for CFS clinic and PACE

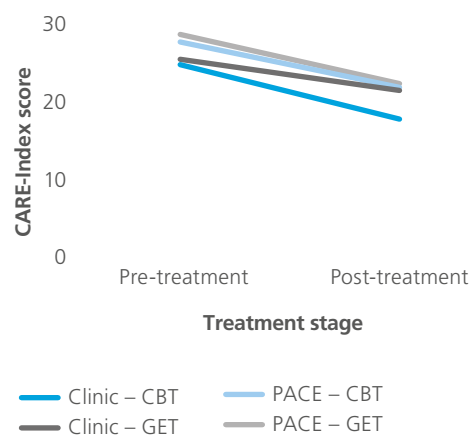
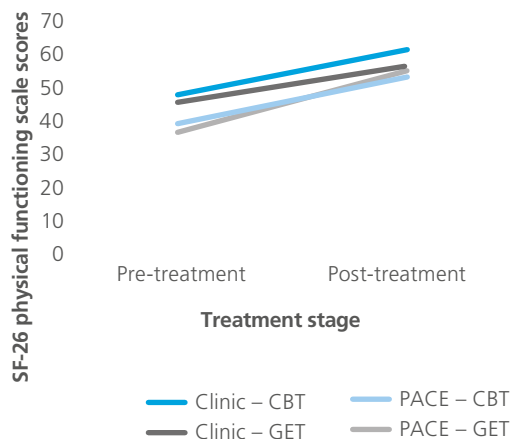


Figure 28 | Physical functioning scores for CFS clinic and PACE trial



Clinical outcomes

Our service has evolved in collaboration with patient organisations and our evidence-based treatments are routinely evaluated. Our goal is to increase the person's functioning, improve quality of life and wellbeing, reduce the severity of their fatigue and facilitate a return to work or education.

Clinical outcome for chronic fatigue service between 2007 and May 2014

Questionnaires are administered routinely throughout the course of treatment. Questionnaires include measures of fatigue,

social functioning, physical functioning, sleep, perfectionism, coping behaviours and mood.

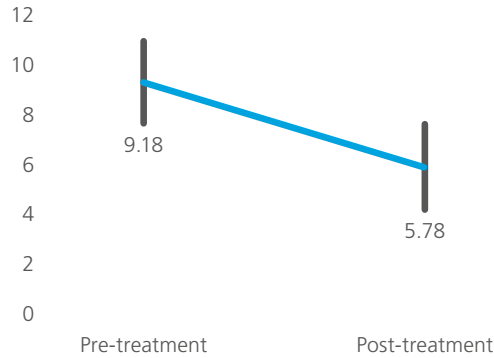
The analysis presented here is based on a sample of patients who began their treatment between November 2007 and April 2013. Some patients were excluded from the analysis, for example, if they had received both cognitive behavioural therapy (CBT) and graded exercise therapy (GET), if they had a psychiatric diagnosis such as bipolar disorder or if they had a specific medical cause for their fatigue (eg. cancer). Paired t-tests were used to compare differences between scores at pre-treatment, post-treatment and follow up.

We routinely collect outcome measures from patients throughout the course of their treatment at the Chronic Fatigue Research and Treatment Unit. We offer two treatments: CBT and GET. The main outcome measures we collect are measures of fatigue, social functioning and physical functioning.

Fatigue

Fatigue is measured using the Chalder Fatigue Questionnaire (Chalder et al, 1993). This scale is well- validated and has been used in community and primary care settings. There are eleven items which are summed to obtain a maximum score of 11. A higher score indicates greater fatigue. As seen in Figure 29, patients in the current sample showed a reduction in fatigue at the end of treatment.

Figure 29 | Change in fatigue score over time



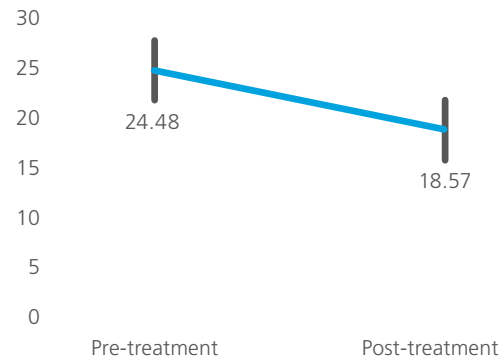
	N	Mean	SD
Pre-treatment	506	9.18	2.88
Post-treatment	316	5.78	4.43

Social functioning – work and social adjustment

The Work and Social Adjustment Scale (Mundt et al, 2002) measures how patients are functioning at work and in their social and personal relationships. The scale is scored from 0 to 40 and scores over 20 indicate impaired functioning. We see in Figure 30 that in the current sample, the mean was above 20 at baseline indicating a high level of impairment. However, the average score reduced to below 20 after treatment indicating better functioning. This reduction was statistically

significant, $t(277)=12.21$, $p<.001$. Improvements were maintained at three-month follow up.

Figure 30 | Mean work and social adjustment scores throughout treatment

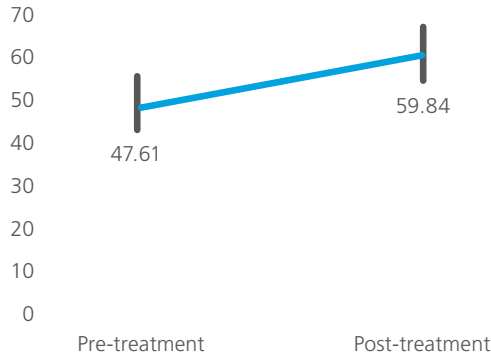


	N	Mean	SD
Pre-treatment	507	24.48	9.27
Post-treatment	307	18.57	11.07

Physical functioning – SF 36 Physical functioning scale

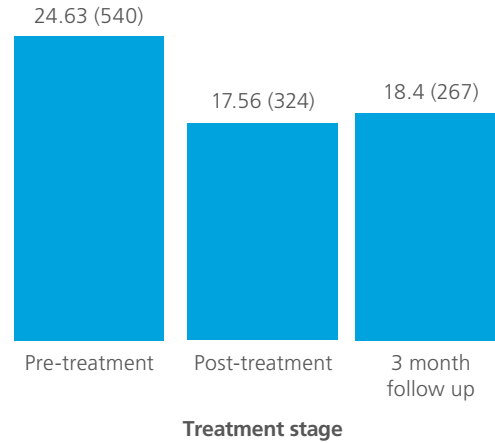
Physical functioning was measured using the SF-36 Physical Functioning Scale (Ware et al, 1988). Scores range from 0 to 100, with a higher score indicating better physical functioning. Figure 31 shows that scores increased after treatment, indicating a lower level of disability and a higher level of physical functioning.

Figure 31 | SF 36 Physical Functioning Scale



	N	Mean	SD
Pre-treatment	479	47.61	26.3
Post-treatment	308	59.84	28.76

Figure 32 | Chalder Fatigue Scale outcomes between November 2007 and April 2013. The number in brackets indicates the number of respondents to the questionnaire



Chalder Fatigue Scale (Chalder et al, 1993)

Fatigue was measured using the Chalder Fatigue Scale and is scored using the Likert scoring method where the scores of all the 11 items in the questionnaire are summed to give a total of 33. The table below shows a statistically significant decrease in fatigue from pre- to post-treatment. These improvements were maintained at three-month follow up.

Figure 33 | Work and Social Adjustment Scale outcomes between November 2007 and April 2013. The number in brackets indicates the number of respondents to the questionnaire

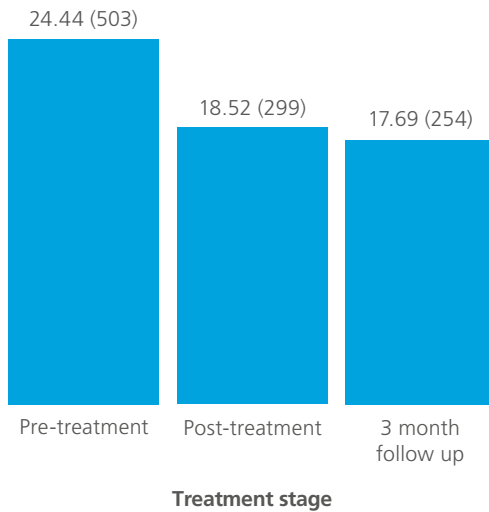
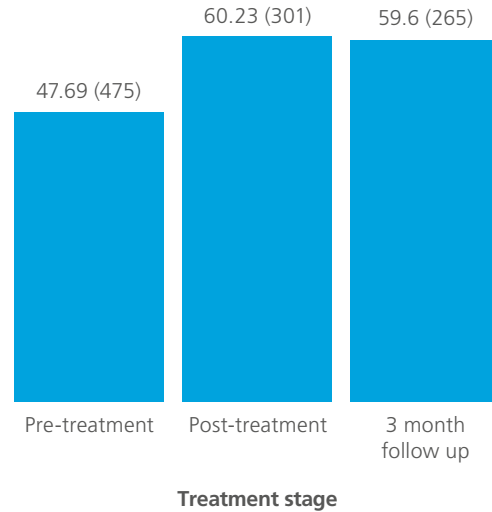


Figure 34 | Physical functioning scale outcomes between November 2007 and April 2013. The number in brackets indicates the number of respondents to the questionnaire

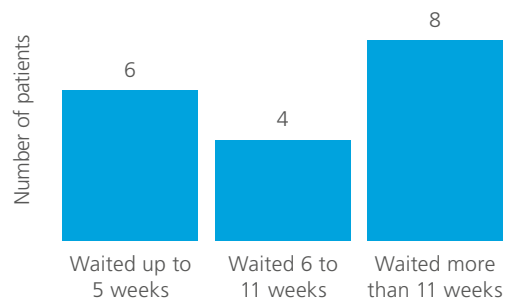


SF-36 Physical functioning scale

Physical functioning was measured using the SF-36 physical functioning scale (Ware et al, 1988). Scores range from 0 to 100, with a higher score indicating better physical functioning. Table 22 shows mean scores on this scale at pre-treatment, post-treatment and three-month follow up. There was a statistically significant increase in physical functioning after treatment, $t(263) = -8.45, p < .001$. Improvements were maintained at follow up.

Performance measures

Figure 35 | Snapshot at the end of March 2014 on patient waiting time for the outpatient service



Research in focus

Chronic fatigue syndrome: Understanding a complex illness

Nature Reviews Neuroscience, 2011

Holgate, S.T., Komaroff, A.L., Mangan, D., Wessely, S.

Chronic fatigue syndrome (CFS) is a debilitating illness that affects many people. It has been marred by controversy, from initial scepticism in the medical community about the existence of the condition itself to continuing disagreements – mainly between some patient advocacy groups on one side and researchers and physicians on the other – about the name for the illness, its aetiology, its pathophysiology and the effectiveness of the few currently available treatments. The role of the central nervous system in the disease is central in many of these discussions. *Nature Reviews Neuroscience* asked four scientists involved in CFS research about their views on the condition, its causes and the future of research aimed at improving our understanding of this chronic illness.

Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial

The Lancet, 2011

White PD, Goldsmith KA, Johnson AL, Potts L, Walwyn R, DeCesare JC, Baber HL, Burgess M, Clark LV, Cox DL, Bavinton J, Angus BJ, Murphy G, Murphy M, O'Dowd H, Wilks D, McCrone P, Chalder T*, M Sharpe*, on behalf of the PACE trial management group.

Trial findings show cognitive behaviour therapy (CBT) and graded exercise therapy (GET) can be effective treatments for chronic fatigue syndrome (CFS) but patients' organisations have reported that these treatments can be harmful and favour pacing and specialist health care. We aimed to assess effectiveness and safety of all four treatments. In our parallel-group randomised trial, patients meeting Oxford criteria for CFS were recruited from six secondary-care clinics in the UK and randomly allocated by computer-generated sequence to receive specialist medical care (SMC) alone or with adaptive pacing therapy (APT), CBT, or GET. Primary outcomes were fatigue (measured by Chalder Fatigue Questionnaire Score) and physical function (measured by SF-36 subscale score) up to 52 weeks after randomisation and safety was assessed primarily by recording all serious adverse events, including serious adverse reactions to trial treatments. Primary outcomes were rated by participants, who were necessarily unmasked to treatment assignment; the statistician was masked to treatment assignment for the analysis of primary outcomes. We used longitudinal regression models to compare SMC alone with other treatments, APT with CBT, and APT with GET. The final analysis included all participants for whom we had data for primary outcomes.

We recruited 641 eligible patients, of whom 160 were assigned to the APT group, 161 to the CBT group, 160 to the GET group, and 160 to the SMC-alone group. Compared with SMC alone, mean fatigue scores at 52 weeks were 3.4 (95 CI 1.8 to 5.0) points lower for CBT ($p=0.0001$) and 3.2 (1.7 to 4.8) points lower for GET ($p=0.0003$), but did not differ for APT (0.7 [-0.9 to 2.3] points lower; $p=0.38$). Compared with SMC alone, mean physical function scores were 7.1 (2.0 to 12.1) points higher for CBT ($p=0.0068$) and 9.4 (4.4 to 14.4) points higher for GET ($p=0.0005$), but did not differ for APT (3.4 [-1.6 to 8.4] points lower; $p=0.18$). Compared with APT, CBT and GET were associated with less fatigue (CBT $p=0.0027$; GET $p=0.0059$) and better physical function (CBT $p=0.0002$; GET $p<0.0001$).

Subgroup analysis of 427 participants meeting international criteria for CFS and 329 participants meeting London criteria for myalgic encephalomyelitis yielded equivalent results. Serious adverse reactions were recorded in two (1) of 159 participants in the APT group, three (2) of 161 in the CBT group, two (1) of 160 in the GET group, and two (1) of 160 in the SMC-alone group. CBT and GET can safely be added to SMC to moderately improve outcomes for CFS, but APT is not an effective addition.

Cognitive behavioural therapy and graded exercise for chronic fatigue syndrome: A meta-analysis

Clinical Psychology: Science and Practice, 2011

Castell, B.D., Kazantzis, N., Moss-Morris, R.E.

Several reviews have concluded that graded exercise therapy (GET) and cognitive behavioral therapy (CBT) may be the most efficacious treatments for chronic fatigue syndrome (CFS). The current review extends the evidence for overall and outcome-specific effects of CBT and GET by directly comparing the treatments and addressing the methodological limitations of previous reviews. GET ($n=5$) and CBT ($n=16$) randomized controlled trials were meta-analysed. Overall effect sizes suggested that GET ($g=0.28$) and CBT ($g=0.33$) were equally efficacious. However, CBT effect sizes were lower in primary care settings and for treatments offering fewer hours of contact. The results suggested that both CBT and GET are promising treatments for CFS, although CBT may be a more effective treatment when patients have comorbid anxiety and depressive symptoms.

Measuring disability in patients with chronic fatigue syndrome: Reliability and validity of the Work and Social Adjustment Scale

Journal of Psychosomatic Research, 2011

Cella M, Sharpe M, Chalder T.

Disability is a defining feature of chronic conditions and it is an increasingly-used measure of therapy effectiveness. The Work and Social Adjustment Scale (WSAS) is a simple and clear measure of disability. Although the scale is widely used, no study has yet investigated its psychometric properties in patients with chronic fatigue syndrome (CFS).

Methods: Data from two samples of patients were used, one from a multicenter randomized controlled clinical trial of treatments for CFS (n =639) and the other from a clinic that specializes in CFS (n=384). All patients completed the WSAS, as well as other measures.

Results: Internal consistency and the Spearman-Brown split-half coefficient values indicated that the scale is reliable. CFS patients who had comorbid diagnoses of depression, anxiety or fibromyalgia had higher WSAS scores. High levels of disability were associated with high number of physical symptoms: severe fatigue, depression, anxiety, poor sleep quality and poor

physical fitness, with correlation coefficients ranging between 0.41 and 0.11. Lower scores on the WSAS were modestly associated with better physical functioning, as well as higher levels of physical capacity as assessed by a walking test. Sensitivity to change was evaluated in a subgroup of patients who had undergone a course of cognitive behavioral therapy. Disability significantly decreased after therapy and remained stable at follow-ups.

Conclusion: The WSAS is a reliable and valid assessment tool for disability in patients with CFS.

Publications

List of publications	Journal
White PD, Goldsmith KA, Johnson AL, Potts L, Walwyn R, DeCesare JC, Baber HL, Burgess M, Clark LV, Cox DL, Bavinton J, Angus BJ, Murphy G, Murphy M, O'Dowd H, Wilks D, McCrone P, Chalder T*, M Sharpe*, on behalf of the PACE trial management group. (2011) Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial	The Lancet
White PD, Goldsmith K, Johnson AL, Chalder T & Sharpe M. (2013) Recovery from chronic fatigue syndrome after treatments given in the PACE trial	Psychological Medicine
Burgess M, Manoharan A, Chalder T. (2011) Cognitive behaviour therapy for chronic fatigue syndrome in adults: Face to face versus telephone treatment; a randomised controlled trial	Behavioural and Cognitive Psychotherapy
Cella M, Sharpe M, Chalder T. (2011) The reliability and validity of the work and social adjustment scale in chronic fatigue syndrome	Journal of Psychosomatic Research. On line
Cella M, White P, Chalder T. (2011) The heterogeneity of chronic fatigue syndrome as a moderator of the response to cognitive behaviour therapy	Psychotherapy and Psychosomatics
Knudsen AK, Henderson M, Harvey SB, and Chalder T. (2011) Long term sickness absence among patients with chronic fatigue syndrome	British Journal of Psychiatry

Burgess M & Chalder T. (2011) Treatment of a bedbound. CFS patient	British Medical Journal
Brooks S Rimes K & Chalder T. (2011) Does acceptance change after a course of cognitive behaviour therapy for chronic fatigue syndrome	Journal of Psychosomatic Research
Stahl D, Rimes K & Chalder T. (2013) Mechanisms of change underlying the efficacy of cognitive behaviour therapy for chronic fatigue syndrome in a specialist clinic: a mediation analysis	Psychological Medicine
Musiat P, Conrod P, Treasure J, Tylee A, Williams C, Schmidt U (2014), Targeted prevention of common mental health disorders in university students: randomised controlled trial of a trans diagnostic trait-focused web-based intervention	PLoS

Quality and safety measures across the Complex Care Pathway

Introduction

We aim to ensure that all patients get the most effective care in a timely and efficient manner. Quality of care is a guiding principle in assessing how well the health system is performing in its mission to improve the health of patients. The quality of care outcomes we collect assess the health system's performance and measure how safe, effective, patient-centred, timely, efficient and equitable the care we provide is.

Violent incidents and medication incidents are reported quarterly across the CAG to the CAG governance exec. The CAG is engaged in a trust wide initiative – the Four Steps to Safety quality improvement programme which aims to reduce violent incidents in inpatient services.

Figure 36 | Violent incidents

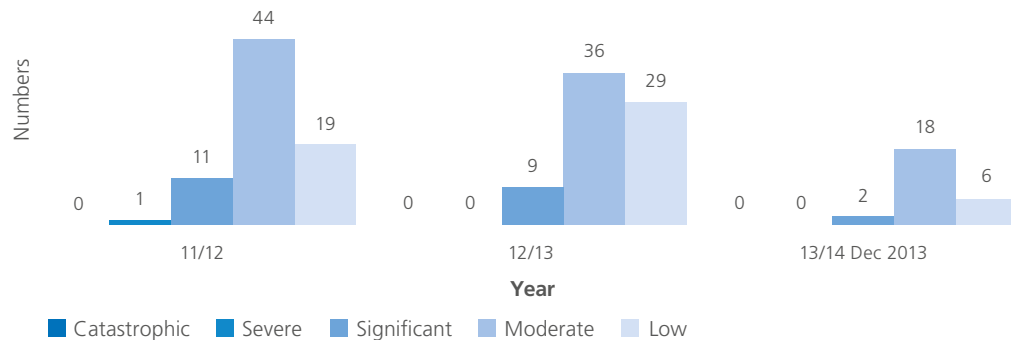
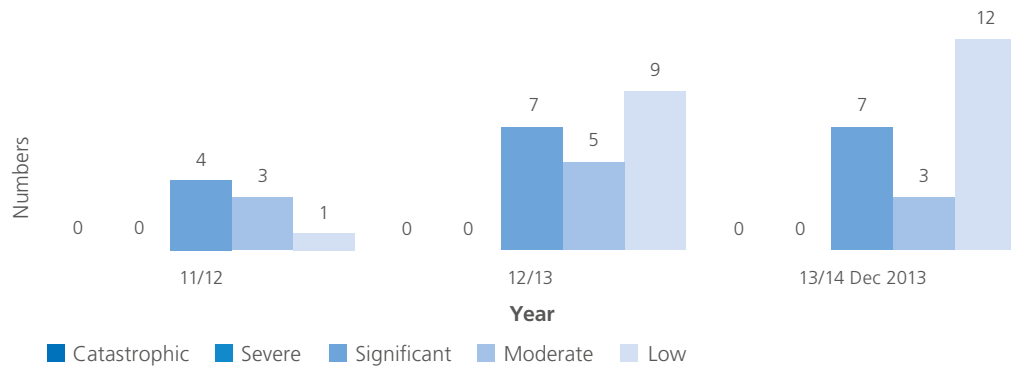


Figure 37 | Medication incidents



Modified Early Warning Scores (MEWS)

MEWS is a system for improving patient outcomes by detecting and acting upon early signs of deterioration in physical health in patients with mental health problems.

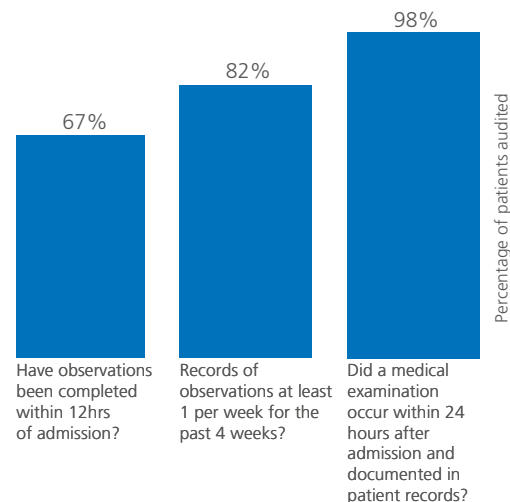
It is a form of track-and-trigger scoring system. The triggers are based on routine observations and are sensitive enough to detect subtle changes in a patient's physiology which will be reflected in a change of score should the patient be improving or deteriorating. All patients have their vital signs measured and these are converted into a score. The higher the score, the more abnormal the vital signs are. If the scores reach above a certain threshold, a doctor must be called to assess the patient. It is important when assessing service users in a mental health setting to identify those that may have an illness so that treatment can be initiated quickly, early identification of possible side effects of medication can be made and a timely response to those who are acutely physically deteriorating can be initiated.

MEWS audit

MEWS audits are completed monthly on all inpatient wards within the CAG and are reported quarterly to the CAG Governance Exec.

Below is a snapshot of three of the items audited:

Figure 38 | Complex care MEWS audit (Number of beds: n=46)



Crisis care pathway

Crisis care services are for those people who are experiencing a mental health crisis and need immediate help across the boroughs of Lambeth and Southwark such as the services provided by Crisis Resolution and Home Treatment Team (CREST) who treat people at home with the aim of providing an alternative to hospital admission. The point of access for these services are:

- Mental Health Liaison
- Triage Services (Lambeth and Southwark)
- Home Treatment Teams

Mental health liaison

Introduction

Our Mental Health Liaison services provides care to people aged over-18 with mental health problems, who are patients at University Hospital Lewisham, King's College Hospital, Guy's and St Thomas' Hospital and Croydon University Hospital. There is a high demand for A&E liaison, especially at our King's College Hospital site. Some of our strengths include:

- having excellent 'in reach' into general hospitals
- a well-developed model of specialist liaison clinics
- specialist expertise in deliberate self-harm
- meeting the tripartite mission and good working relationships with other CAGs.

Patient experience

A group of service users and carers have worked with clinicians to produce a brief satisfaction survey for people using psychiatric liaison services in Emergency Departments. The group developed

a set of statements and created an eye-catching design to fit on one side of paper. The survey was piloted and amended. It is now routinely being used.

The statements:

- I was kept informed whilst waiting to be seen
- I felt that the environment was safe
- Overall, I was treated well whilst waiting to be seen
- I understand why I was seen today
- I was treated with dignity, empathy & respect by the mental health team
- I felt actively involved in deciding the way forward
- Overall, I was treated well by the mental health team
- I got the help I wanted

Information is currently being collected on responses and will be available in the future.

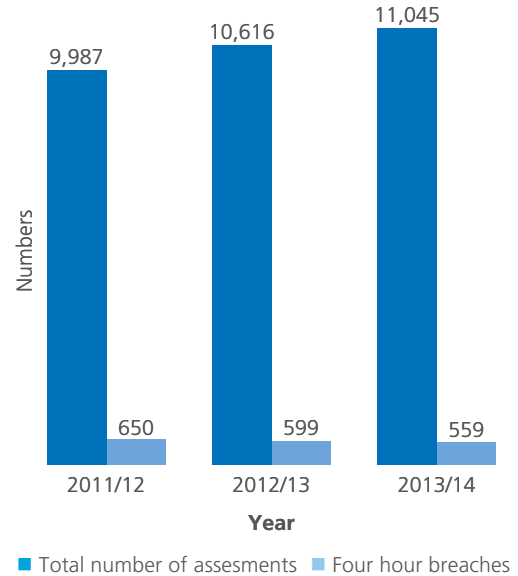
Clinical outcomes

Liaison psychiatry services will be using the Framework for Outcome Measurement (Liaison) produced by the Royal College of Psychiatry, published 2015. This is currently being implemented and there will be data in the future.

Performance measures

All attendances to A&E whether for physical or mental health reasons, are measured against the national four-hour quality target. Breaching these targets occur in a small proportion of the total number of assessments conducted as can be seen in the graph below. The reasons for breaches include the challenges of getting a Mental Health Act assessment to occur in an emergency setting with the number of professionals who need to come together or because the patient presents with complex mental and physical health problems which require excellent joint working. This reinforces the need for KHP's Mind & Body programme.

Figure 39 | Number of breaches against the number of assessments



Number of four-hour breaches has gone down from 6.5% in 2011/12 to 5.06% in 2013/14, even though the number of assessment has increased year-on-year

Triage services

Innovation within the service

Our triage wards are recognised as an innovative model of inpatient care provision in the UK and were developed by South London and Maudsley. It is the admission model for Lewisham, Lambeth and Croydon boroughs. There is no triage ward currently for Southwark. Triage wards cater to approximately nine hundred admissions per year, with 50% of patients discharged home directly from the ward. Our service provides comprehensive assessment and brief treatment combined with the shortest length of stay compared to any other acute psychiatric inpatient unit in the country. The service innovation has resulted in patients receiving a high quality of care while significantly reducing the length of stay and improving the patient journey in and out of hospital.

Patient experience

"To whom it may concern,

I would like to take the time to thank the team on Triage ward for fulfilling their duties of care to me since I was

admitted. It was a pleasant and peaceful stay. Staff members always have time for their team and patients. They are polite and go the extra mile to see that patient needs are taken care of. The nurses and doctors try their best to get us up and back on our feet so we can go back into the community, and feel safe and comfortable. The ward manager and her team are very compassionate about their jobs and my stay here has always been one of good experiences.

Thank you all."

Letter of thanks from service user who was admitted to Lewisham Triage

Clinical outcomes

All three Triage wards demonstrate that the HoNOS scores are improved at discharge compared with admission to the ward.

Figure 40 | Lewisham Triage

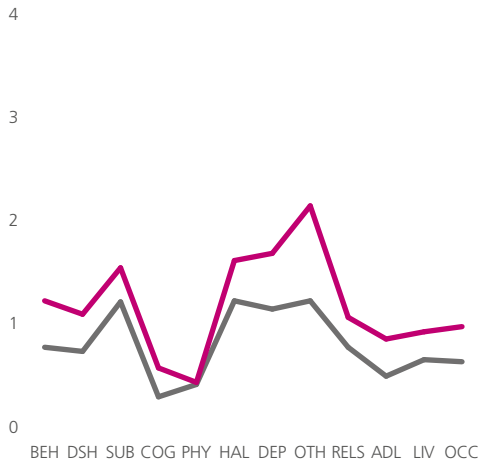


Figure 42 | Lambeth Triage

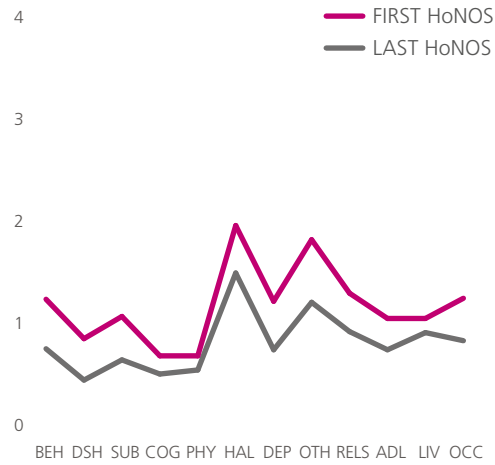
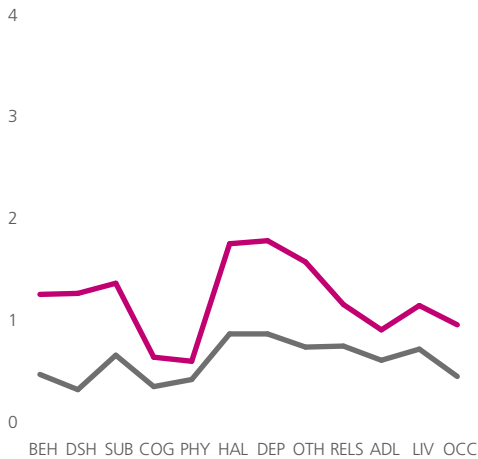


Figure 41 | Croydon Triage



Innovation

Destigmatising HIV testing in psychiatric patients (Bhatia, Telang, Pliszka, Pringle, Hutt, Welz, Rao)

In October 2013, Lewisham Triage successfully launched the voluntary HIV (BBV project – blood borne virus) testing among admitted patients. The project presented at the 2013 Royal College of Psychiatrists international congress in Edinburgh and was a winner in the service evaluation category, competing with around 200 submissions from all over the UK and many other countries.

Project aims: To enable early diagnosis with a view to improving treatment outcomes,

developing care pathways and establishing feasibility of testing for BBV in psychiatric patients.

Background: Evidence from America suggests the prevalence of HIV in those with serious mental illness may be eight times higher than the general population [1]. The prevalence in the London Borough of Lewisham is 8/1,000 as compared to the UK average of 2/1,000 [2]. Mentally ill patients have poor physical health, are less likely to access healthcare services and have higher rates of drug abuse and 'high risk behaviours'. NICE guidelines recommend routine HIV testing should be commissioned as a priority for all general medical admissions in high prevalence areas.

Exposure category of newly-diagnosed HIV service user in London clinics, 2002–2011:

The most common route of acquiring HIV in those diagnosed in London in 2011 was through sex between men (n=1,427, 54% of new diagnoses). Sex between men and women was the second most common route of infection accounting for 1,130 (43%) new diagnoses of HIV. During the decade prior to 2010, sex between men and women had been the most common route of infection. However, numbers in this group have declined since 2003 (n=1,936, 59% of new diagnoses). In 2011, 39 people who injected drugs (PWID) were newly-diagnosed with HIV, accounting for one per cent of all new diagnoses, a proportion which has remained relatively stable since 2000. (*London Council (2013), Review of HIV Epidemiology in London. [Online], Available at: www.londoncouncils.gov.uk [24 June 2014].*)

Method: A phased education and training programme was rolled out by public health with the HIV and mental health teams were involved in the project. The care pathway was to link BBV-positive patients with local clinical services. All patients admitted to triage between October 2012 and June 2013 with capacity to consent were offered BBV screening. Training and support for providing HIV screening was given to clinicians throughout the project. The project was divided into two stages.

Stage 1 (October 2012 – February 2013)

1. Junior doctors (SHOs) completed paper forms to record patient's capacity and consent for BBV screening
2. Posters informing patients about BBV screening were displayed on the ward.

Posters informing doctors that vacutainers for collecting blood samples for BBV test were put in medical examination rooms.

Following Stage 1, a survey of junior doctors revealed that the process of recording the offer of BBV Screening needed to be simplified and, as a result, paper forms used in Stage 1 were replaced with electronic entries.

Stage 2 (February 2013 – June 2013)

1. A ward staff member ensured all new admissions were offered BBV screening along with routine blood tests

2. Patients without capacity to consent were approached later in the process
3. Improved interface between the project team and junior doctors through intermittent visits to their weekly meetings to address concerns around testing and regular email reminders sent
4. A system for feedback of the results from the hospital's pathology laboratory was developed.

Stage 3 (June/July 2013 – December 2013)

All as in Stage 2, plus significantly improved phlebotomy service on the ward

Results

Stage 1 commenced in October 2012. In the first fourteen weeks, 281 admissions, 40% (114) of whom were tested for BBV.

Stage 2 commenced in February 2013. Over ten weeks there were 190 admissions, 52% (100) of whom were tested for BBV.

Stage 3 commenced in June/July 2013. 445 new admissions of whom 59% were tested.

In total, four patients tested HIV positive, five patients tested positive for Hepatitis C and one patient for Hepatitis B positive.

Figure 43

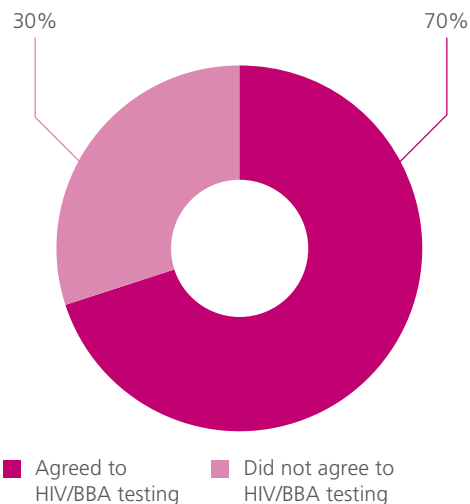


Figure 44

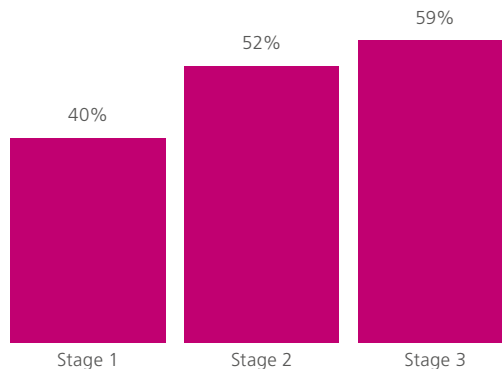
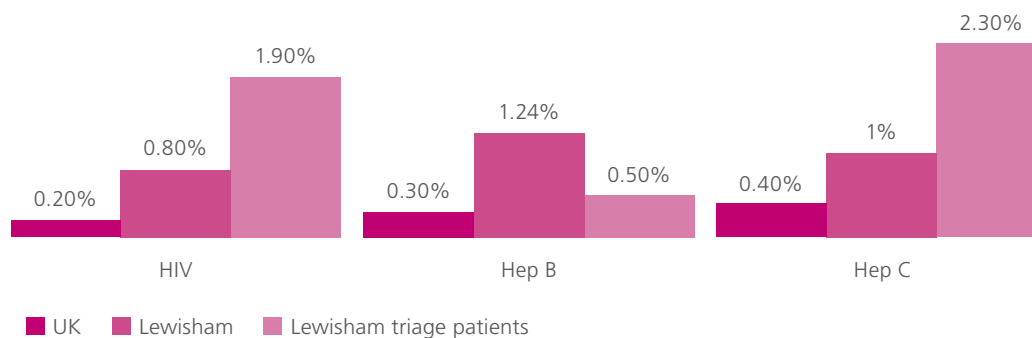


Figure 45



Conclusions

1. Routine BBV screening of patients newly-admitted to a mental health triage ward is feasible and acceptable to patients
2. Ward junior doctors felt comfortable offering the test
3. Prevalence of HIV appears to be higher in psychiatric inpatients compared to the general UK population
4. As far as we know, this is the largest study on BBV testing so far conducted in the UK on psychiatric inpatients
5. Percentage of patients receiving a test is growing with every stage.

Limitations

1. Patients' reasons for declining testing included: refusing all tests and interventions, not consenting to BBV screening, a recent HIV test

2. Reasons for doctors not offering a test included: locum/agency on call doctor unfamiliar with procedure, time constraints, patients lacking capacity to consent
3. Stage 4 prevalence data still to be analysed in detail.

References

1. Rosberg et al Prevalence of HIV, Hepatitis B and Hepatitis C in people with severe mental illness. *Am J Public Health* 2001; 91: 31–37
2. Health Protection Agency 2012
3. HIV prevalence amongst 15–59 year olds; Hepatitis C prevalence amongst 15–59 year olds Health Protection Agency 2012. Hepatitis B prevalence amongst women tested antenatally (London figure used for Lewisham), Health Protection Agency 2012
4. Physical health care monitoring (PHCM) on admission to Lewisham triage unit (Low, Pliszka, Okon-Rocha).

Background: Morbidity and mortality due to physical illness is more common in patients with mental illness [1]. In addition, when mentally ill patients are admitted to psychiatric inpatient units, physical illnesses are often not diagnosed, leading to further potential morbidity and mortality [2]. Although suicides represented a large proportion of excess deaths for patients with mental illness, physical conditions represent the majority of excess deaths. Cardiovascular disease was the main comorbidity, particularly for patients with schizophrenia (32% males, 46% females), other psychoses (33% males, 41% females) and neurotic disorders (38% males, 38% females).[3]

Aims: A comprehensive physical health assessment should be a core component of the initial psychiatric admission assessment in order to reduce potential morbidity and mortality from physical illness, to facilitate recovery from mental illness and to reduce length of hospital admission.

Method

A. Standards

1. Physical examination to be completed within first 24 hours for all patients.
2. ECG and blood tests to be completed within 72 hours for all patients.

B. Data collection

Clinical records for all patients admitted to Lewisham triage ward in November 2013 were examined to determine whether physical

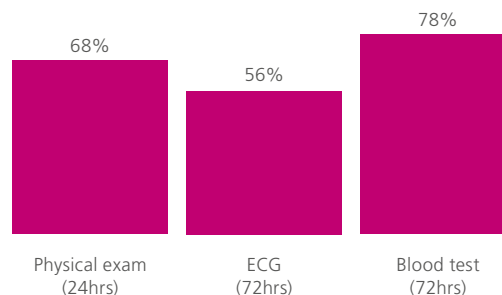
examination, ECG and various blood tests were carried out at South London and Maudsley NHS Foundation Trust prior to transfer to the Lewisham triage ward or after admission to the triage ward, within the time periods set as standards. Reasons for examinations and investigations not being carried out within these time periods was also recorded.

C. Data analysis

The percentage of patients who had or did not have a physical examination, an ECG, or various blood tests done, was calculated.

Results: Physical Examination: 68% of patients had a physical examination at South London and Maudsley NHS Foundation Trust prior to transfer to the Lewisham triage ward or within 24 hours following admission to the triage ward.

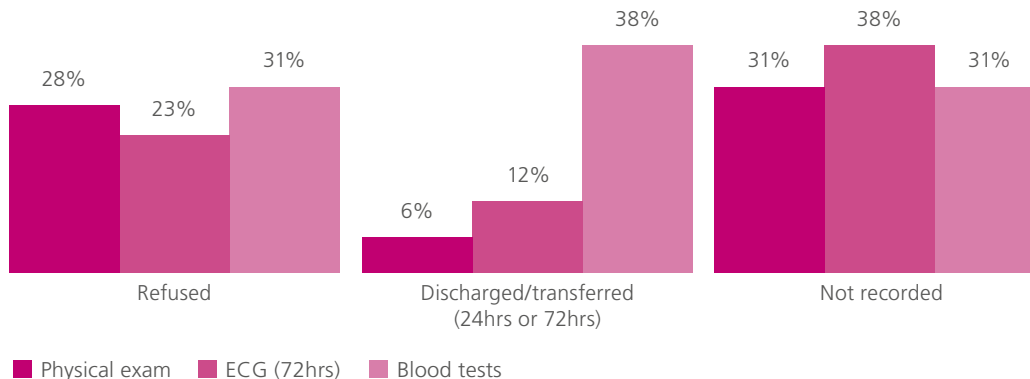
Figure 46 | Physical health assessment compliance for all patients on the ward (n=16)



1. Of the 32% who did not have a physical examination, 28% refused, 6% were

- discharged within 24 hours and 66% had no documented reason for physical examination not being done
- ECG: 56% of patients had an ECG at South London and Maudsley NHS Foundation Trust prior to transfer to the Lewisham triage ward or within 72 hours following admission to the triage ward
 - Of the 44% who did not have an ECG, 23% refused, 8% were discharged within 72 hours, 4% were discharged within 72 hours, in 8% of cases the ECG machine was documented as not functioning properly and in 56% there was no documented reason for an ECG not being done.

Figure 47 | Reason for not performing any of the main PHCM



- Blood test: 78% of patients had a blood test of some type done at South London and Maudsley NHS Foundation Trust prior to transfer to the Lewisham triage ward or within 72 hours following admission to the triage ward
- Of the 22% who did not have a blood test, 31% refused, 15% were discharged within 72 hours, 23% were transferred back to South London and the Maudsley NHS Foundation Trust within 24 hours and 31% had no documented reason for blood tests not being done.

Conclusions

- All doctors should be reminded the reason for physical examination or investigations not being done should be clearly documented in the clinical record
- All doctors should be reminded of the correct number and type of blood sample tubes required for the admission screening blood tests (in particular, an extra blood sample tube is required for HbA1c)
- Better communication between doctors and phlebotomists to ensure the most effective use of the phlebotomy service.

4. Nurses already trained in carrying out ECGs may do some ECGs during periods when there are many admissions, before asking doctors to interpret the ECG.
5. South London and Maudsley NHS Foundation Trust NHS Foundation Trust (2013) Psychosis CAG CQUIN Standard.
6. Royal College of Psychiatrists (2009). Physical Health in Mental Health.

Limitations

1. The sample size is relatively small (70 patients) and based on one month of admissions, as compared to the total number of Lewisham Triage annual admissions (~1,000) – South London and Maudsley Clinical Records Interactive Search (CRIS) database could be used to analyse larger sample.
2. Lack of documentation about the reasons for the PHCM not completed may have affected the second part of the results.

References

1. Garden, G.(2005) Physical examination in psychiatric practice, 11:142–149.
2. Felker, B., Yazell, J. J. & Short, D. (1996) Mortality and medical comorbidity among psychiatric patients: a review. *Psychiatric Services*, 47, 1356–1363.
3. Thornicroft G. (2013), Life expectancy gap widens between those with mental illness and general population. *British Medical Journal Online*, Available at: www.bmj.com/press-releases/2013/05/21/life-expectancy-gap-widens-between-those-mental-illness-and-general-popula [10 January 2014].
4. South London and Maudsley NHS Foundation Trust NHS Foundation Trust (2011), Physical Healthcare Policy.

Performance measures

Figure 48 | Number of admissions

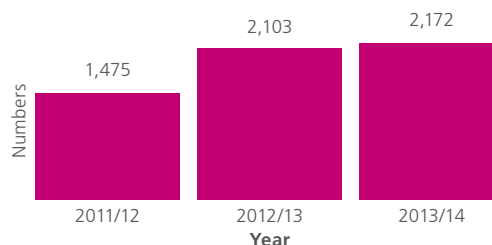
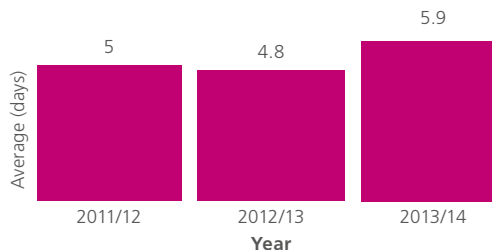


Figure 49 | Average length of stay



Average length of stay and showing the trend is much more meaningful in terms of getting patients moved out of the service than just showing the total number of discharges and transfers out.

Home treatment teams

Introduction

Home treatment is a way of helping people at home rather than in hospital. This can help to avoid the stress, anxiety and upheaval that can happen with a hospital admission. Our service provides short-term treatment for people who are having a mental health crisis across the four London boroughs of Lambeth, Southwark, Lewisham and Croydon. Wherever possible, we avoid the need for hospital admission.

The service brings together different health and social care professionals, including nurses, social workers, occupational therapists and psychiatrists. We work closely with the patient, their carers, GP, local day care centres and housing providers, as required. The Trust has four Home Treatment Teams (HTT); one in each borough. Teams comprise of between 25 and 32 staff and are multi-professional, consisting of a consultant psychiatrist, speciality doctors, a team leader, experienced community nurses, social workers, occupational therapists, health care assistants and a business manager/ administrator. We are recruiting clinical psychologists to the teams to further enhance the range of services and interventions we provide.

Teams operate between the hours of 8am and 10pm, 365 days-a-year. Their main aim is to provide a high-intensity service to people with acute mental health problems or crises as an alternative to hospital admission, enabling patients to receive care at home wherever possible. The team's staffing levels allow a high frequency of home visits, quite often twice daily, through to a minimum of two home visits per week.

Teams work in conjunction with promoting recovery teams from the Psychosis CAG or the treatment teams from the Mood, Anxiety and Personality CAG, providing an additional level of support. We provide a range of interventions from medication management and mental state monitoring through to practical and social support, carer support and specific therapeutic interventions, such as solution-focused therapy and recovery-focused care plans.

We also provide a service enabling patients who have had admission to hospital to be discharged as soon as practicable through high-intensity input, providing supervision and support through the often difficult phase from hospital back to community living. This is also done in conjunction with other community services. Some of our teams

specialise in offering specific care packages to those who are being started on clozapine medication in the community as opposed to the alternative practice of this being carried out during a hospital admission. Our teams can provide a high level of medical and nursing supervision to such patients, visiting up to four times daily when required.



Patient experience

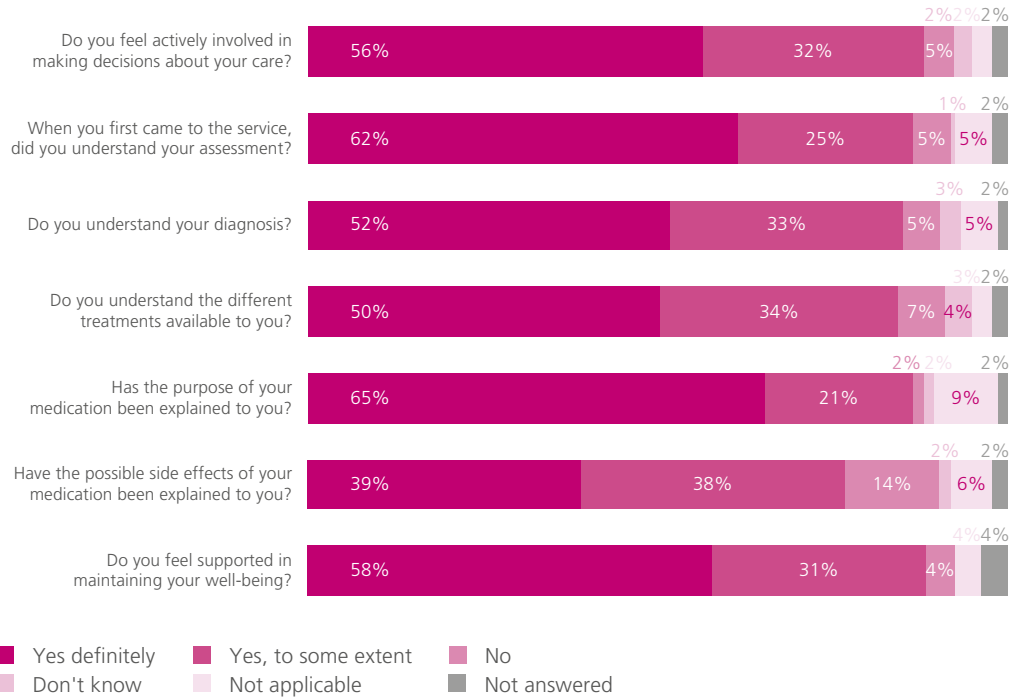
"Thank you so much for all your help and support when our daughter was going through such a difficult time. Without all your help and encouragement we would not have been able to have her at home."

Letter of thanks to Croydon HTT, 2013

"I would like the Chief Executive to acknowledge the extreme dedication of three different members of staff. One visited me and took me on outings when I needed a friend to support me through terrifying experiences. He showed great sensitivity and professionalism. I felt honoured to be nursed by another member of your team. They made me feel safe – I wish all nurses were like him. Yet another member of your staff proved to be kind and dedicated."

Expression of thanks conveyed to Southwark HTT, June 2012

Figure 50 | Patient experience for HTT 2013/2014



Clinical outcomes

Home Treatment Team

Change in mean score for each HoNOS scale

Depression and other problems (HoNOS scales 7 and 8) are the most common for HTT patients, although hallucinations and relationship problems

are also common. Depression and other problems tend to show the greatest improvements.

Each service area has a different profile and this reflects the needs of their targeted patient group, as well as their service delivery. In this way, we can see the profiles are quite similar for all four HTTs, even though they may have different patients and staff because the four HTTs have the same service model and theoretical patient groups.

Figures: HoNOS scores for the HTTs 2012/13

Figure 51 | Southwark

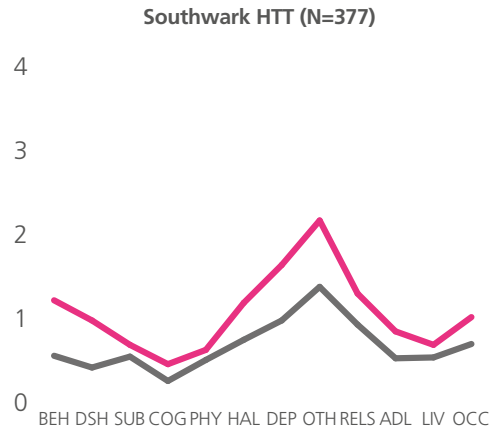


Figure 53 | Croydon

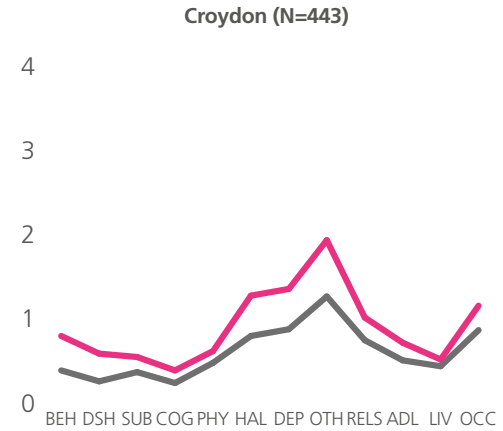


Figure 52 | Lambeth

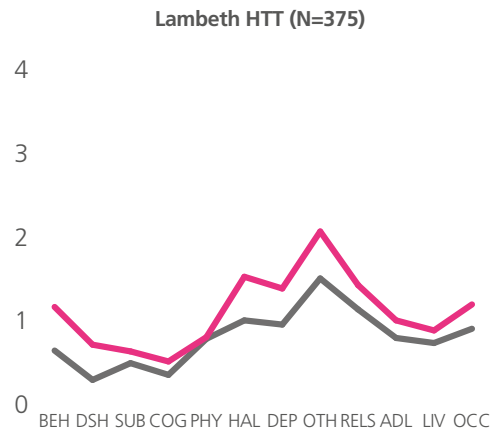
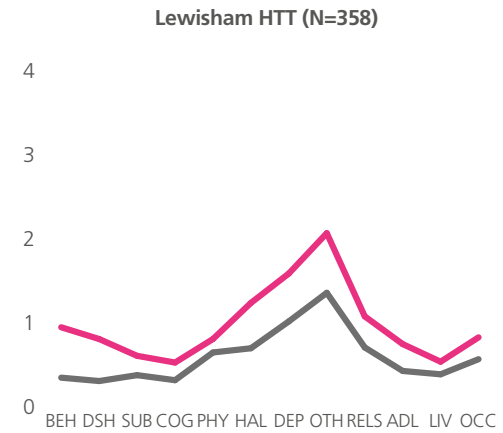


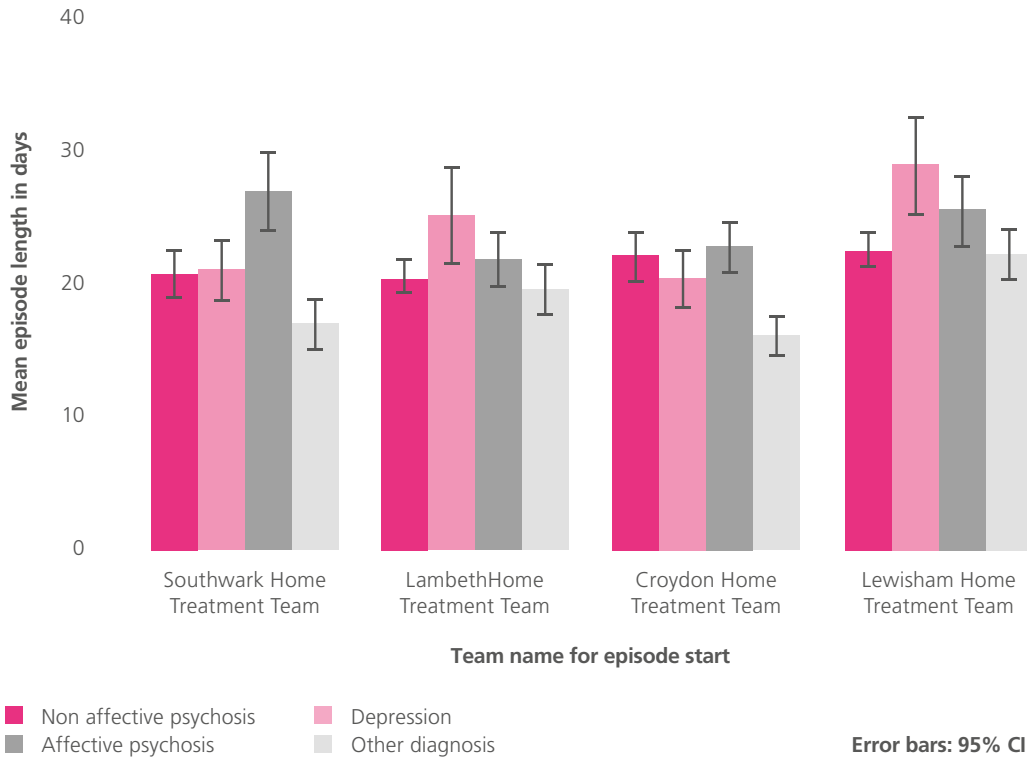
Figure 54 | Lewisham



Each clinical service tends to have a different HoNOS 'profile', which reflects the needs of their patients and their service delivery.

HTTs are a complement to triage and acute services rather than a substitute.

Figure 55 | Length of contact (LOC) by diagnosis

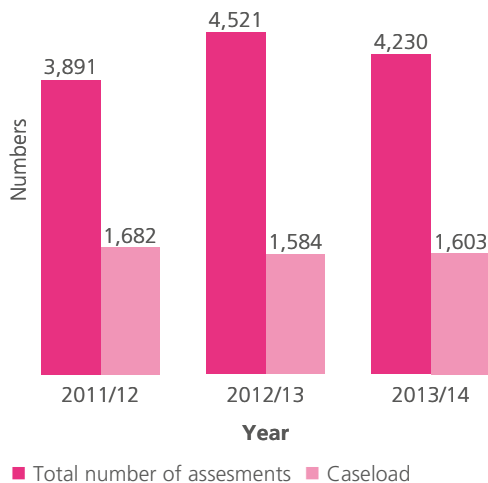


Lewisham has higher than average LOC.

Average LOC for HTTs is roughly comparable to length of stays for patients in acute wards. For comparison, average length of stay for triage patients is around five days.

Performance measures

Figure 56



for carers may improve well-being in both carers and patients.

Aims: To examine an interpersonal maintenance model of eating disorders, using a self-help intervention for carers.

Method: A pre-test / post-test design was used with carers randomised into self-help or guided self-help, which included the Expert Carers Helping Others (ECHO) intervention. Carers' distress, well-being, proposed maintenance factors and carer reports on the status of the patient were measured.

Results: Carers' distress reduced and secondary outcomes improved. Improvement in carers' status and perceived improvements in patients were associated with reductions in expressed emotion and in accommodating and enabling behaviours. Self-help and guided self-help versions were comparable.

Conclusions: Changes in maintenance factors from the theoretical model were associated with a reduction in carers' distress and improvement in perceived patient functioning. Interventions which specifically target maintaining factors may be of benefit.

Research in focus

Cognitive interpersonal maintenance model of eating disorders: Intervention for carers

British Journal of Psychiatry, 2011

Goddard, E., Macdonald, P., Sepulveda, A.R., Naumann, U., Landau, S., Schmidt, U., Treasure, J

Background: Carers of people with eating disorders report high levels of distress. In addition, carers' responses to the illness may perpetuate eating disorder symptoms. A cognitive interpersonal maintenance model of eating disorders is proposed and interventions

Are media warnings about the adverse health effects of modern life self-fulfilling? An experimental study on idiopathic environmental intolerance attributed to electromagnetic fields (IEI-EMF)

Journal of Psychosomatic Research, 2013

Du Toi, G, Roberts, G, Sayre, P.H, Bahnson, H.T, Radulovic, S, Santos, A.F, Brough, H.A, Phippard, D, Basting, M, Feeney, M, Turcanu, V, Sever, M.L, Lorenzo, M.G, Plaut, M, Lack, G

Objective: Medically unsubstantiated 'intolerances' to foods, chemicals and environmental toxins are common and are frequently discussed in the media. Idiopathic environmental intolerance attributed to electromagnetic fields (IEI-EMF) is one such condition and is characterized by symptoms that are attributed to exposure to electromagnetic fields (EMF). In this experiment, we tested whether media reports promote the development of this condition.

Methods: Participants (N= 147) were randomly assigned to watch a television report about the adverse health effects of WiFi (n= 76) or a control film (n= 71). After watching their film, participants received a sham exposure to a WiFi signal (15 min). The principal outcome measure was symptom reports following the sham exposure. Secondary outcomes included worries about the health effects of EMF, attributing symptoms to the sham exposure and increases in perceived sensitivity to EMF.

Results: 82 (54%) of the 147 participants reported symptoms which they attributed to the sham exposure. The experimental film increased: EMF related worries ($\beta= 0.19$; $P=.019$); post sham exposure symptoms among participants with high pre-existing anxiety ($\beta= 0.22$; $P=.008$); the likelihood of symptoms being attributed to the sham exposure among people with high anxiety

($\beta=.31$; $P=.001$); and the likelihood of people who attributed their symptoms to the sham exposure believing themselves to be sensitive to EMF ($\beta=0.16$; $P=.049$).

Conclusion: Media reports about the adverse effects of supposedly hazardous substances can increase the likelihood of experiencing symptoms following sham exposure and developing an apparent sensitivity to it. Greater engagement between journalists and scientists is required to counter these negative effects.

Work and common psychiatric disorders

Journal of the Royal Society of Medicine, 2011

Henderson, M., Harvey, S.B., Øverland, S., Mykletun, A., Hotopf, M.

Psychiatric disorders are now the most common reason for long-term sickness absence. The associated loss in productivity and the payment of disability benefits places a substantial burden on the economies of many developed countries. The occupational dysfunction associated with psychiatric disorders can also lead to poverty and social isolation. As a result, the area of work and psychiatric disorders is a high priority for policymakers. There are two main agendas and for many researchers and clinicians, the focus is on the need to overcome stigma and ensure people with severe psychiatric disorders have meaningful work. However, the public health agenda predominantly relates to the more common disorders such as depression and anxiety, which contribute a greater burden

of disability benefits and pensions. In this review, we attempt to address this second agenda. The relatively sparse evidence available reveals a complex field with significant interplay between medical, psychological social and cultural factors. Sick leave can be a 'process' as well as an 'event'. In this review, we propose a staged model where different risk and protective factors contribute to the onset of psychiatric disorders in the working population, the onset of short-term sickness absence and the transition from short- to long-term absence. We also examine strategies to manage psychiatric disorder in the workforce, with a view towards returning the employee to work. Our aim in this review is to highlight the complexity of the area, to stimulate debate and to identify important gaps in knowledge where further research might benefit both patients and wider society.

Effectiveness of group and self-help cognitive behaviour therapy in reducing problematic menopausal hot flushes and night sweats (MENOS 2): A randomized controlled trial

Menopause, 2012

Ayers, B., Smith, M., Hellier, J., Mann, E., Hunter, M.S.

Objective: The aim of this study was to examine the effectiveness of group cognitive behavioural therapy (CBT) and guided self-help CBT in reducing hot flush and night sweat (HF/NS) problem rating at six and 26 weeks after randomisation.

Methods: This was a randomised control trial of 140 women having ten or more problematic HF/NS a week for at least a month. The primary outcome was HF/NS problem rating (1–10) at six weeks after randomisation. Secondary outcomes were physiologically measured HF/NS at 6 weeks; HF/NS problem rating at six weeks; and frequency, mood (Women's Health Questionnaire) and health-related quality of life (General Health Survey Short Form-36) at six and 26 weeks. Intention-to-treat analysis was used, and between-group differences were estimated using linear mixed models.

Results: Baseline mean (SD) HF/NS weekly frequency was 63.15 (49.24), and problem rating was 5.87 (2.28). Group and self-help CBT both significantly reduced HF/NS problem rating at 6 weeks-group CBT versus no treatment control (NTC; adjusted mean difference, 2.12; 95% CI, 1.36–2.88; $P < 0.001$) and self-help CBT versus NTC (adjusted mean difference, 2.08; 95% CI, 1.29–2.86; $P < 0.001$)-and at 26 weeks-group CBT versus NTC (adjusted mean difference, 1.33; 95% CI, 0.54–2.13; $P = 0.001$) and self-help CBT versus NTC (adjusted mean difference, 1.19; 95% CI, 0.36–2.02; $P = 0.005$). Group and self-help CBT significantly reduced night sweat frequency at 6 and 26 weeks. There were improvements in mood and quality of life at 6 weeks and improved emotional and physical functioning for group CBT at 26 weeks.

Conclusions: These results suggest that CBT delivered in group or self-help format is an effective treatment option for women during the menopause transition and postmenopause with problematic HF/NS.

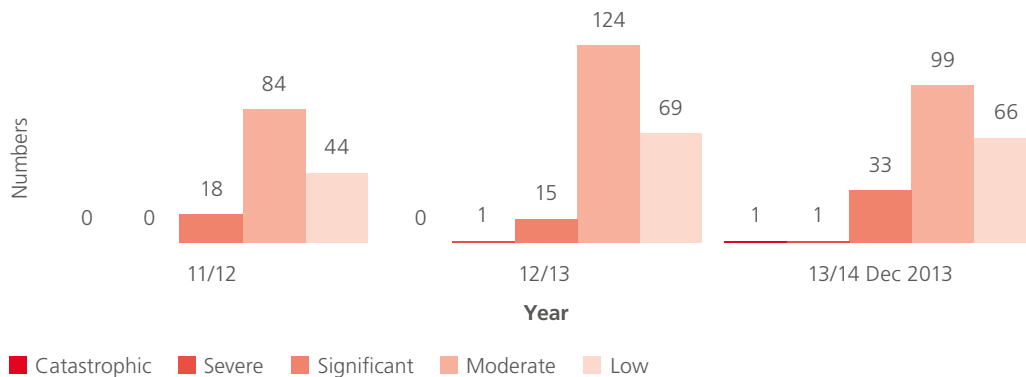
Quality and safety measure for crisis care pathway

We aim to ensure all patients get the most effective care in a timely and efficient manner. Quality of care is a guiding principle in assessing how well the health system is performing in its mission to improve the health of patients. The quality of care outcomes we collect assess the health system's performance and

measure how safe, effective, patient-centred, timely, efficient and equitable the care we provide is.

Violent incidents and medication incidents are reported quarterly across the CAG to the CAG Governance Executive.

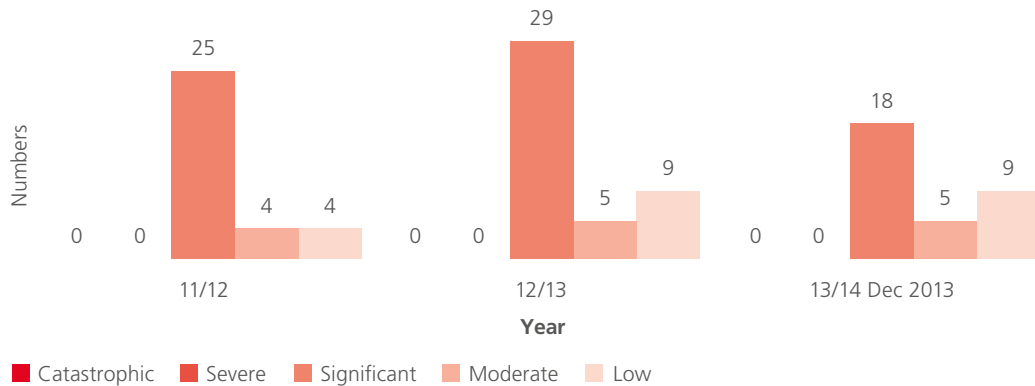
Figure 57



The CAG is engaged in a trust-wide initiative – the Four Steps to Safety quality improvement

programme which aims to reduce violent incidents on inpatient wards.

Figure 58



Modified Early Warning Score (MEWS)

The Modified Early Warning Score (MEWS) is a system for improving patients' outcomes by detecting and acting upon early signs of deterioration in physical health for patients with mental health problems. The system is applied when patient observation takes place and is applied to adults over-18 only.

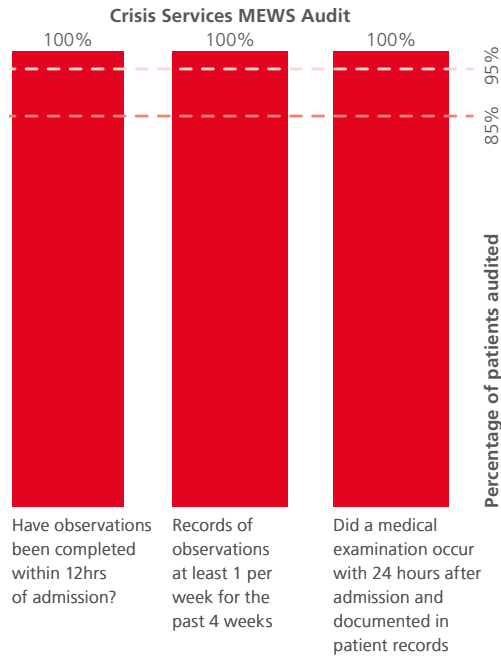
MEWS is a form of 'track and trigger' scoring system. The triggers are based on routine observations and are sensitive enough to detect subtle changes in a patient's physiology which will be reflected in a change of score should the patient be improving or deteriorating.

All patients have their vital signs measured and these are converted into a score. The higher the score, the more abnormal the vital signs are. If the scores reach above a certain threshold, a doctor must be called to assess the patient. It is important when assessing service users in a mental health setting to identify those that may have a minor illness, so treatment can be initiated quickly, early identification of possible side effects of medication can be made and a timely response to those who are acutely physically deteriorating can be initiated.

It is important when people are in crisis they are monitored safely and that overshadowing of an underlying physical condition is excluded, as well as their safety being ensured when introducing new medication to treat patients who are psychiatrically unwell.

MEWS Audit

Figure 59: Crisis care MEWS Audit – Three Wards Audited (n=50 patients approximately)



Benchmark

The standard is that all patients are required to have MEWS undertaken (100%). A score of over 95% means that the audit does not have to be carried out the following month as observations have been carried out in compliance with physical health check procedures. The red marker is the percentage compliance.

Neuropsychiatry

Our neuropsychiatry service at King's College Hospital and South London and Maudsley Hospital manages the psychological complications of neurological disorders. This includes: psychiatric complications of epilepsy, Tourette's syndrome, movement disorders and other neurological disorders, including; early onset dementias and other memory disorders, depersonalisation and conversion and dissociative disorders, including non-epileptic seizures and other somatoform disorders.

The **Neuropsychiatry and Memory Disorders Clinic at St Thomas' Hospital** provides a general Neuropsychiatry service and Specialist Memory Disorders service. It provides assessment and treatment of the psychiatric and behavioural manifestations of medical disorders (for example, systematic lupus erythematosus, HIV, Korsakoff's syndrome, Tourette's syndrome, neuropsychiatric inherited metabolic disorders, cerebral hypoxia, cardiac and neurological disease).

Within the Specialist Memory Disorders service, we treat memory complaints and other cognitive impairments like language, reasoning, visuo-spatial skills, mental calculation and frontal-lobe functions. These may arise from hypoxia, head injury, alcohol, encephalitis, stroke, ageing or dementia.

This service has strong links with the Clinical Neurosciences CAG. South London and Maudsley provides the following services:

- brain injury inpatient and outpatients and neuropsychiatry inpatients and outpatients at Maudsley and King's College hospitals
- neuropsychiatry and memory disorders outpatients and at St Thomas's Hospital, MRI/Neuro-radiology.

Our mode of treatment is inpatient, outpatient and outreach and averages up to 12 weeks.



- Neuropsychiatry
- Neuro-radiology
- MRI

Neuropsychiatry

Introduction

The UK specialist Rehabilitation Outcomes Collaborative (UKROC) was set up by a Department of Health, National Institute of Health Research (NIHR) Programme Grant to develop a national database for collating case episodes for inpatient rehabilitation. In the first five years, it focused on neurorehabilitation and ultimately will include data from all specialist Level 1 and 2 neurorehabilitation services across the UK.

The database development is undertaken in collaboration with the British Society

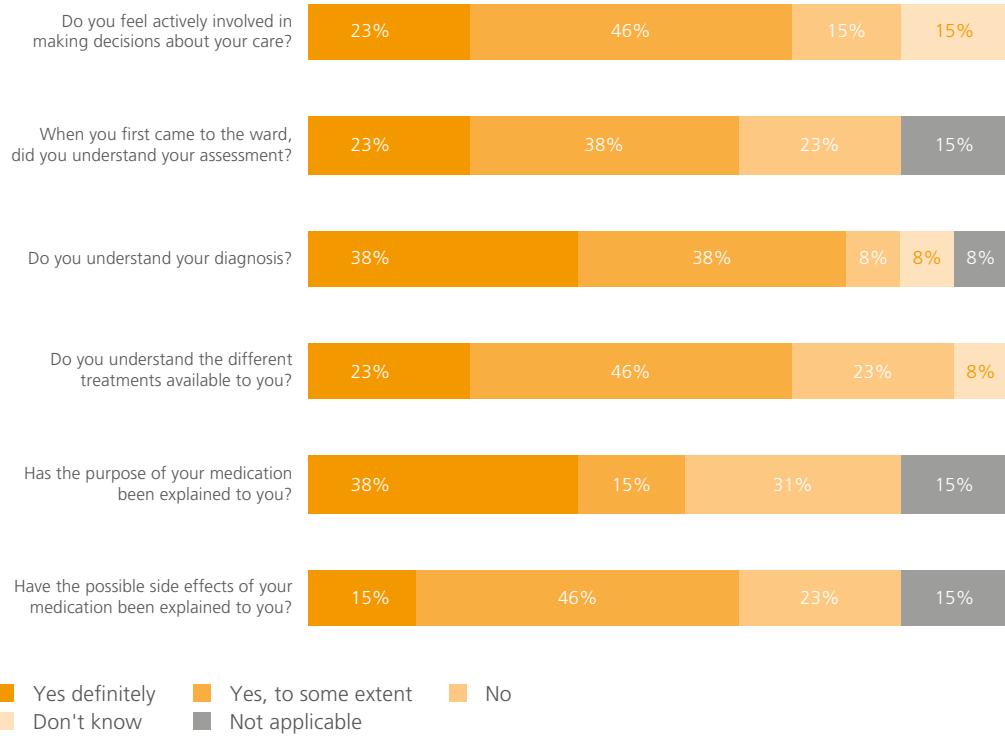
of Rehabilitation Medicine (BSRM) and the Australasian Rehabilitation Outcome Centre (AROC), which is now ten years into a similar programme.

The UK project started in September 2008. It is led by Professor Lynne Turner-Stokes, in collaboration with King's College Hospital.

Patient experience

To improve patient experience, the Neuropsychiatry service is increasing the range and number of activities available to patients on the ward during their inpatient stay.

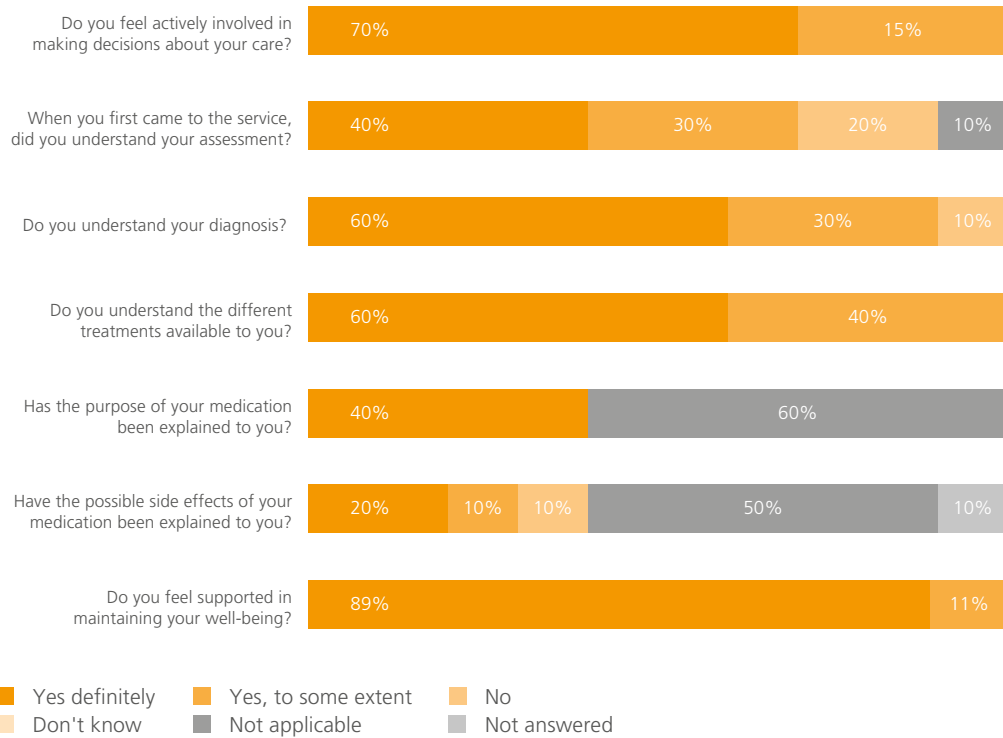
Figure 60 | Patient experience for Neuropsychiatry inpatients 2012/13



Following feedback from patients, a number of service improvements have been implemented on the ward. The service has employed a further

full-time occupational therapist and increased the funding for daily ward activities.

Figure 61 | Patient experience for neuropsychiatry outpatients



"The service has been fantastic in helping me with my non-epileptic seizures and helping me realise that depression can be helped as well. I have been supported by my therapists all the way through my treatment and they have helped me come to terms with my illness and how I can support myself through the tough times I have had."

"My therapist has been outstanding in dealing with me. My experience has been very therapeutic and I have learnt how to deal with difficult situations. As a result, my seizures have lessened and I hope the techniques I have learnt will continue to help."

Patient feedback from 2014

Clinical outcomes

Targets

The data collection started in 2008/9 with a target to record 12,000 cases by 2013 across all the neurorehabilitation services across England, which is around 65–70 eligible units involved in the data collection.

What are the outcome measures:

1. Barthel Index – measure performance in activities of daily living
2. Functional Independence Measure (FIM) or UK FIM & FAM (Functional Assessment Measure) N+ Neurological Impairments set
3. Goal attainment scaling.

What the database will provide:

1. Case mix
2. Clinical outcomes – to show gains made during rehabilitation
3. Cost benefits of rehabilitation.

Going forward

Data quality is continuously being improved in terms of recording and analysis in a consistent manner.



Performance measures

Figure 62 | Admissions against the number of discharges over the last three years

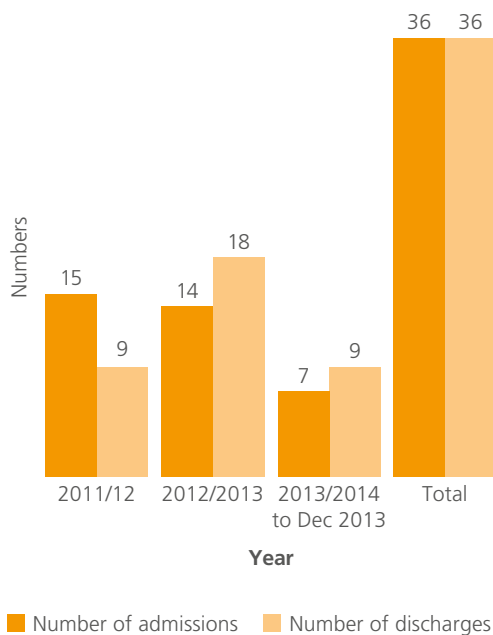
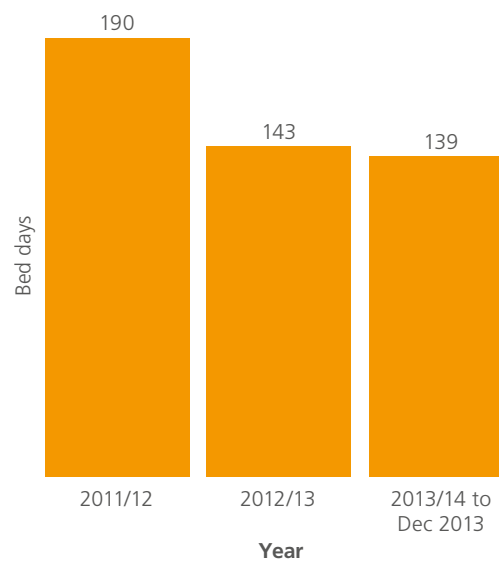


Figure 63 | Mean length of stay over the last three years



Research in focus

Inpatient treatment of severe motor conversion disorder: A case control study

R McCormack, 1 AS David. 2 1ST3 Academic Clinical Fellow, NIHR Biomedical Research Centre, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry, King's College London; 2Section of Cognitive Neuropsychiatry, Institute of Psychiatry, King's College London and NIHR Biomedical Research Centre, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry Psychology and Neuroscience, King's College London.

Objectives and aims

To evaluate the characteristics and outcomes of patients with motor conversion disorder admitted to a specialist neuropsychiatry unit. Motor Conversion disorder is a psychological disorder defined by suggestive neurological symptoms relating to motor functions.

Method: The study included all (n=33) patients discharged from the Lishman Neuropsychiatry Unit (Maudsley Hospital) between 2007 and 2011 with an ICD-10 diagnosis of dissociative motor disorder following multidisciplinary treatment. Brain injury inpatients (n=33, age-and sex-matched) acted as controls.

Data extracted included demographic details, duration of illness prior to admission, length of stay, medical/psychiatric co-morbidity and history, history of abuse, history as a carer or health/social-care professional and status with regards to employment, mobility, and activities of daily living (ADLs) on admission and discharge.

Results: The mean age of cases was 40.8yrs (s.d. 12.1, range 20–59; not significantly different from controls $p=0.299$). Both groups were 78.8%(n=26) female. Cases had marked levels of functional impairment on admission with 60.6%(n=20) wheelchair or bedbound, 42.4%(n=14) dependent for ADLs and an 87.9%(n=29) unemployment rate. The mean Modified Rankin Scale (MRS) score for cases was 3.64 (s.d. 0.86, range disability 2 [slight]-5 [severe]), with a median length of illness preadmission of 48 months (IQR 19–72), and median length of stay 101 days (IQR 84–130). All three values were higher than controls ($p=0.003$,

$p < 0.001$, $p = 0.03$ respectively). More cases were significantly more likely than controls to have a history of all forms of abuse, particularly childhood sexual abuse ($p < 0.001$; $n = 12/36.4\%$ of cases), a pre-morbid non-dissociative psychiatric history ($p > < 0.001$; $n = 27/81.8\%$ of cases), and a history of prior employment as a health/social-care worker ($p = 0.002$; $n = 15/45.5\%$ of cases). Regarding outcomes, cases showed a significant improvement in MRS scores ($p < 0.001$), mobility ($p > < 0.001$, and ADLs ($p = 0.049$). Degree of dependence for ADLs reduced by 50%, while the number wheelchair/ bed-bound reduced by 70%. Regression analysis could not identify statistically significant predictors of response to inpatient treatment in conversion patients. Having co-morbid non-epileptic dissociative features predicted an increased length of stay in hospital ($p = 0.04$).

Conclusion: Even patients with severe, long-standing motor conversion disorder can benefit from an inpatient admission to a specialist neuropsychiatry unit. Our study suggests links between motor conversion disorder, physical/sexual abuse and prior employment as a health/social-care professional. Previous studies have had similar problems identifying predictors of outcomes in conversion disorder. This study was limited by its retrospective design and observational nature. It is therefore not possible to state what elements of the treatment package brought about improvement. Generalisability is also limited by the inclusion of a particularly morbid subset of motor conversion cases.

Neuro-radiology

Introduction

The Centre for Neuroimaging Sciences (CNS) is a joint venture of the King's College London Institute of Psychiatry, Psychology and Neurosciences (IoPPN) and the South London and Maudsley NHS Foundation Trust (SLAM). Completed in early 2004, the centre provides, under one roof, an interdisciplinary research environment that combines the development of contemporary, high-resolution structural, functional and metabolic mapping techniques, with expertise in the definition, diagnosis and treatment of neurological and psychiatric disorders.

Philosophy of the CNS

The CNS aims (a) to provide a comprehensive and world-class neuroradiological service to users within SLAM, (b) to perform world-class research into psychiatric and neurological disorders, with a particular remit to study normal and abnormal development and (c) to translate the use of such contemporary neuroimaging techniques from the research to the clinical domain. It is co-directed by Dr Ginny Ng from SLAM and Prof Steve Williams from the IoPPN.



MRI

Introduction

Research facilities

For research studies, the CNS houses a dedicated GE 3T Excite II MRI scanner (which is also made available for clinical and advanced clinical scanning, where appropriate). Additionally, there is a GE SIGNA 1.5T neuro-optimised MR system housed in the adjacent Mapother House MR Unit. Both machines (along with the clinical 1.5T scanner) are capable of performing functional, spectroscopic, anatomical and pathological mapping techniques.

Post-processing support is provided by the Brain Image Analysis Unit of the CNS. Over the past ten years, the BIAU has focussed mainly on the application of nonparametric (permutation-based) inferential procedures to MR analysis. A growing

interest is the application of multidimensional wavelet analysis to MR data and the development of real-time functional magnetic resonance imaging (fMRI) analysis methodology running on Windows-based environments and portable PC systems. The unit has developed a number of software suites for automated MR analysis at single subject and group level which have been used in a large number of psychiatric and neurological investigations.

Current research projects span neurodegeneration, epilepsy, stroke, psychosis, affective disorders, developmental disorders, and normal brain function, using a battery of neuroimaging techniques which include perfusion, diffusion, functional and structural imaging. Our overall long-term objective is to translate our ongoing pre-clinical developments in neuroimaging to the clinic, improving diagnosis and treatment of all these diseases.

Research in focus for neuropsychiatry

Structural neuroimaging studies in major depressive disorder: Meta-analysis and comparison with bipolar disorder

Archives of General Psychiatry, 2011

Kempton, M.J., Salvador, Z., Munafò, M.R., Geddes, J.R., Simmons, A., Frangou, S., Williams, S.C.R.

Background: Although differences in clinical characteristics exist between major depressive disorder (MDD) and bipolar disorder (BD), consistent structural brain abnormalities that distinguish the disorders have not been identified.

Objectives: To investigate structural brain changes in MDD using meta-analysis of primary studies; assess the effects of medication, demographic and clinical variables; and compare the findings with those of a meta-analysis of studies on BD.

Data sources: The MEDLINE, EMBASE, and PsycINFO databases were searched for studies from 1st January 1980 to 2nd February 2010.

Study selection: Two hundred twenty-five studies that used magnetic resonance imaging or x-ray computed tomography to compare brain structure in patients with MDD with that of controls were included in an online database and 143 that measured common brain structures were selected for meta-analysis.

Data extraction: Twenty-five variables, including demographic and clinical data, were extracted from each study when available. For the meta-analysis, mean structure size and standard deviation were extracted for continuous variables and the proportion of patients and controls with an abnormality in brain structure was extracted for categorical variables.

Data synthesis: Compared with the structure of a healthy brain, MDD was associated with lateral ventricle enlargement, larger cerebrospinal fluid volume and smaller volumes of the basal ganglia, thalamus, hippocampus, frontal lobe, orbitofrontal cortex and gyrus rectus. Patients during depressive episodes had significantly smaller hippocampal volume than patients during remission. Compared

with BD patients, those with MDD had reduced rates of deep white matter hyperintensities, increased corpus callosum cross-sectional area and smaller hippocampus and basal ganglia. Both disorders were associated with increased lateral ventricle volume and increased rates of subcortical gray matter hyperintensities compared with healthy controls.

Conclusions: The meta-analyses revealed structural brain abnormalities in MDD that are distinct from those observed in BD. These findings may aid investigators attempting to discriminate mood disorders using structural MRI data.

Effects of aripiprazole and haloperidol on neural activation during the n-back in healthy individuals: A functional MRI study

Schizophrenia Research, 2016

Goozee, R., Reinders, A.A.T.S., Handley, R., Marques, T., Taylor, H., O'Daly, O., McQueen, G., Hubbard, K., Mondelli, V., Pariante, C., Dazzan, P.

Objective: Antipsychotic drugs target neurotransmitter systems that play key roles in working memory. Therefore, they may be expected to modulate this cognitive function via their actions at receptors for these neurotransmitters. However, the precise effects of antipsychotic drugs on working memory function remain unclear. Most studies have been carried out in clinical populations, making it difficult to disentangle pharmacological effects from pathology-related brain activation. In this study, we aim to investigate the effects of two

antipsychotic compounds on brain activation during working memory in healthy individuals. This would allow elucidation of the effects of current antipsychotic treatments on brain function, independently of either previous antipsychotic use or disease-related pathology.

Methods: We carried out a fully counterbalanced, randomised within-subject, double-blinded and placebo-controlled cross-over study of the effects of two antipsychotic drugs on working memory function in 17 healthy individuals, using the n-back task. Participants completed the functional MRI task on three separate occasions (in randomised order): following placebo, haloperidol and aripiprazole. For each condition, working memory ability was investigated and maps of neural activation were entered into a random effects general linear regression model to investigate main working memory function and linear load. Voxel-wise and region of interest analyses were conducted to attain regions of altered brain activation for each intervention.

Results: Aripiprazole did not lead to any changes in neural activation compared with placebo. However, reaction time to a correct response was significantly increased following aripiprazole compared to both placebo ($p = 0.046$) and haloperidol ($p = 0.02$). In contrast, compared to placebo, haloperidol dampened activation in parietal (BA 7/40; left: FWE-corr. $p = 0.005$; FWE-corr. right: $p = 0.007$) and frontal (including prefrontal; BA 9/44/46; left: FWE-corr. $p = 0.009$; right: FWE-corr. $p = 0.014$) cortices and the left putamen (FWE-corr. $p = 0.004$). Compared with

aripiprazole, haloperidol dampened activation in parietal cortex (BA7/40; left: FWE-corr. $p = 0.034$; right: FWE-corr. $p = 0.045$) and the left putamen (FWE-corr. $p = 0.015$). Haloperidol had no effect on working memory performance compared with placebo.

Conclusion: Cognitive functions are known to be impaired in schizophrenia and as such are an important target of treatments. Elucidating the mechanisms by which antipsychotic medications alter brain activation underlying cognition is essential to advance pharmacological treatment of this disorder. Studies in healthy individuals can help elucidate some of these mechanisms, whilst limiting the confounding effect of the underlying disease-related pathology. Our study provides evidence for immediate and differential effects of single-dose haloperidol and aripiprazole on brain activation during working memory in healthy individuals. We propose that these differences likely reflect their different receptor affinity profiles, although the precise mechanisms underlying these differences remain unclear.

The analgesic effect of oxytocin in humans: a double-blind, placebo-controlled cross-over study using laser-evoked potentials

Journal of Neuroendocrinology, 2016

Paloyelis, Y., Krahé, C., Maltezos, S., Williams, S.C., Howard, M.A., Fotopoulou, A.

Oxytocin is a neuropeptide regulating social-affiliative and reproductive behaviour in

mammals. Despite robust preclinical evidence for the antinociceptive effects and mechanisms of action of exogenous oxytocin, human studies have produced mixed results regarding the analgesic role of oxytocin and are yet to show a specific modulation of neural processes involved in pain perception. In the present study, we investigated the analgesic effects of 40 IU of intranasal oxytocin in 13 healthy male volunteers using a double-blind, placebo-controlled, cross-over design and brief radiant heat pulses generated by an infrared laser that selectively activate A δ - and C-fibre nerve endings in the epidermis, at the same time as recording the ensuing laser-evoked potentials (LEPs). We predicted that oxytocin would reduce subjective pain ratings and attenuate the amplitude of the N1, N2 and P2 components. We observed that oxytocin attenuated perceived pain intensity and the local peak amplitude of the N1 and N2 (but not of P2) LEPs, and increased the latency of the N2 component. Importantly, for the first time, the present study reports an association between the analgesic effect of oxytocin (reduction in subjective pain ratings) and the oxytocin-induced modulation of cortical activity after noxious stimulation (attenuation of the N2 LEP). These effects indicate that oxytocin modulates neural processes contributing to pain perception. The present study reports preliminary evidence that is consistent with electrophysiological studies in rodents showing that oxytocin specifically modulates A δ /C-fibre nociceptive afferent signalling at the spinal level and provides further specificity to evidence obtained in humans indicating that oxytocin may be modulating pain

experience by modulating activity in the cortical areas involved in pain processing.

Stress and inflammation reduce brain-derived neurotrophic factor expression in first-episode psychosis: A pathway to smaller hippocampal volume

Journal of Clinical Psychiatry, 2011

Mondelli, V., Cattaneo, A., Murri, M.B., Forti, M.D., Handley, R., Heggul, N., Miorelli, A., Navari, S., Papadopoulos, A.S., Aitchison, K.J., Morgan, C., Murray, R.M., Dazzan, P., Pariante, C.M.

Background: Reduced brain-derived neurotrophic factor (BDNF) levels have been reported in the serum and plasma of patients with psychosis. The aim of this cross-sectional case-control study was to investigate potential causes and consequences of reduced BDNF expression in these patients by examining the association between BDNF levels and measures of stress, inflammation and hippocampal volume in first-episode psychosis.

Method: Brain-derived neurotrophic factor, interleukin (IL)-6, and tumour necrosis factor (TNF)- α messenger RNA levels were measured in the leukocytes of 49 first-episode psychosis patients (DSM-IV criteria) and 30 healthy controls, all aged 18 to 65 years and recruited between January 2006 and December 2008. Patients were recruited from inpatient and outpatient units of the South London and Maudsley NHS Foundation Trust in London and the healthy controls were recruited from the same catchment area via

advertisement and volunteer databases. In these same subjects, we measured salivary cortisol levels and collected information about psychosocial stressors (number of childhood traumas, number of recent stressors and perceived stress). Finally, hippocampal volume was measured using brain magnetic resonance imaging in a subsample of 19 patients.

Results: Patients had reduced BDNF (effect size, $d = 1.3$; $P < .001$) and increased IL-6 (effect size, $d = 1.1$; $P < .001$) and TNF- α (effect size, $d = 1.7$; $P < .001$) gene expression levels when compared with controls, as well as higher levels of psychosocial stressors. A linear regression analysis in patients showed that a history of childhood trauma and high levels of recent stressors predicted lower BDNF expression through an inflammation-mediated pathway (adjusted $R^2 = 0.23$, $P = .009$). In turn, lower BDNF expression, increased IL-6 expression and increased cortisol levels all significantly and independently predicted a smaller left hippocampal volume (adjusted $R^2 = 0.71$, $P < .001$).

Conclusions: Biological changes activated by stress represent a significant factor influencing brain structure and function in first-episode psychosis through an effect on BDNF

Sleep apnoea and the brain: A complex relationship

The Lancet Respiratory Medicine, 2015

Rosenzweig, I., Glasser, M., Polsek, D., Leschziner, G.D., Williams, S.C.R., Morrell, M.J.

Intermittent hypoxia, reoxygenation, and hypercapnia or hypocapnia occur in both adults and children during untreated apnoea and hypopnoea, along with changes in cerebral blood flow and sleep fragmentation. These effects can result in cognitive deficits with functional effects on work and school efficiency. The assessment of how obstructive sleep apnoea affects cognition depends on the specificity and sensitivity of the tests, which are rarely developed specifically for obstructive sleep apnoea. In this Review, we discuss both the neural adaptive and maladaptive processes in response to hypoxaemia. The net result on cognitive and emotional performance depends on the stage of this dynamic process, effects on other body systems, cognitive reserve and idiosyncratic susceptibility. We also explore the contribution of fragmented sleep and the disruption of sleep structure, with focus on the effect at different times in the development of disease. This Review will address the gap in the underlying pathophysiology of new clinical and translational findings and argue their contribution to the inherent complexity of the association between obstructive sleep apnoea and the brain.

Staff satisfaction

Effects on patient care

Studies have shown satisfaction levels among hospital staff are closely linked to the quality of healthcare they provide. Previous research has tended to focus on single aspects of staff experience or one staff group. Few studies have directly examined the relationship between staff experiences of work and patient experiences of care at the team or individual level.

A study led by the National Nursing Research Unit at King's College London in 2012 identified variation in patient experience within Trusts and suggests this is significantly influenced by staff wellbeing at work and work experiences. The report concluded environments where staff reported issues influencing staff satisfaction – high demands on their time, little control over how best to meet those demands, a culture of harassment and bullying, little investment in the local team and where unsupported leaders tried to implement change but then left after a short time, leaving staff with a constant stream of new managers or none at all – meant staff were not enabled to provide high quality care for a range of patient groups.

Associations between various aspects of staff wellbeing and patient experience have been reported, mostly at hospital or systems level. For example, the National Staff Survey has been compared with various patient outcomes.

Research suggests situating staff experience (as well as patient experience) centre stage may be one of the best actions senior leaders can take.

Analysis of the staff and patient experience surveys indicate seven staff variables that are linked to good staff-reported experience. These are:

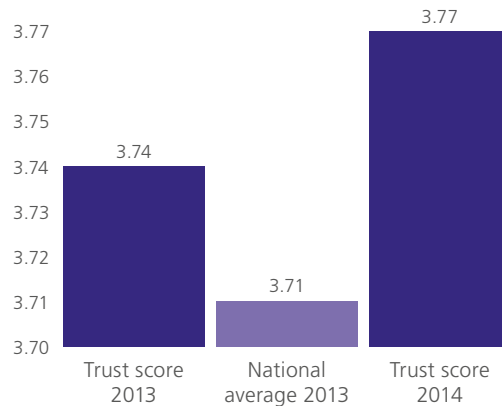
- a good local team/work group climate
- high levels of co-worker support
- good job satisfaction
- a good organisational climate
- perceived organisational support
- low emotional exhaustion
- supervisor support.

Below are some of the key findings, in relation to the above seven variables, from the National Staff Survey from 2013. The graphs compare the results of our CAG with the national average for other mental health/learning disability trusts.

Trust score

The overall indicator of staff engagement has been calculated using the questions that make up key findings that relate to staff members' perceived ability to contribute to improvement at work, their willingness to recommend the Trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

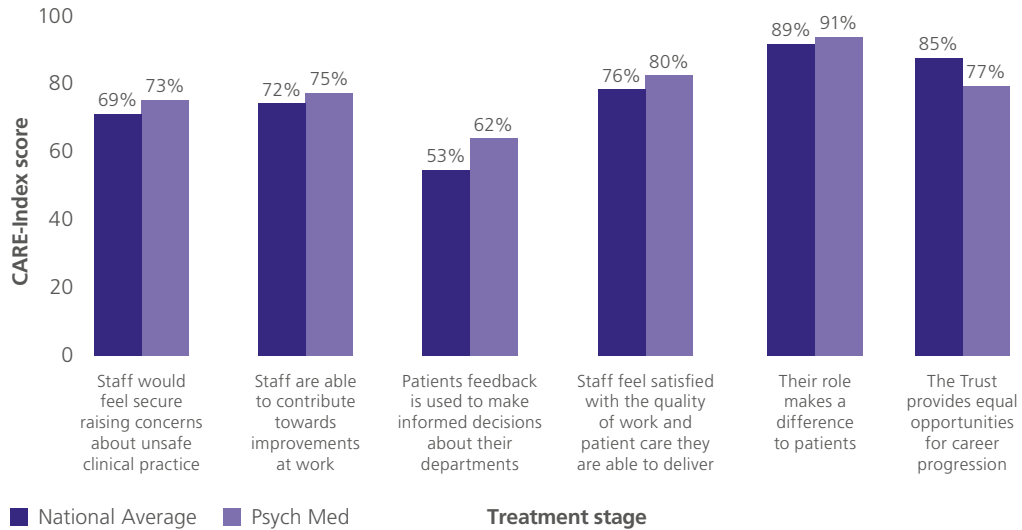
Figure 64 | Overall trust score compared with the national average for 2013 and 2014



Picker Institute survey

The results presented here are from the Staff Survey 2014, carried out by Picker Institute Europe on behalf of South London & Maudsley NHS Foundation Trust. This survey is an annual study, first run in 2003, and is required by NHS England for all NHS trusts in England. The Picker Institute was commissioned by 12 mental health trusts and the report presents the Trust's results in comparison to the average for these mental health trusts.

Figure 65 | Psychological Medicine CAG scores



The graph above shows how the responses for the CAG and reportable service lines compare with the the national average.

A higher proportion of staff within Psychological Medicine (compared to the national average) agreed that their role makes a difference to patients; this was also the question that scored highest across the CAG.

More respondents within the CAG felt secure about raising concerns than the national average.

Across the Trust, the 2014 result for staff believing the Trust provides equal opportunities for career progression or promotion has reduced since the 2013 survey, with the CAG reporting below the national average.

Education and training

Our CAG plays a central role in teaching and education within King's Health Partners. Our Academic Director is the Vice-Dean for Medical Education across undergraduate and postgraduate training in psychiatry. We host a Senior Lecturer in Medical Education post, with a specific remit to expand and enrich a wide range of educational activities both within South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) but also across King's Health Partners, to establish a hub of medical education research. A key product of our endeavour to date has been the production of a blueprint for the future of medical education within the Trust/IoPPN (www.maudsleytraining.com/Downloads/eLOPstrategy2_201103171816.pdf).

Undergraduate

General hospital psychiatry is a crucial exposure for the undergraduate experience and we have made a commitment to increase the exposure of King's College London medical students to liaison psychiatry over the next five years. We currently host six Phase Three King's College London Neurology, Ophthalmology & Psychiatry firms with feedback in terms of quantitative and qualitative

satisfaction metrics being amongst the best in the year. Examples of feedback taken from feedback forms from 2013/14 academic year include:

"...was by far the best consultant teacher I have had the pleasure of coming across ... helped me in my first few weeks of the rotation in the Psychiatric Liaison placement. [They] inspired and motivated me throughout the placement ..."

"...has a keen eye to teach and delivers useful and effective feedback. By far the best teaching I've had so far at King's."

"My firm head was excellent. It was well organised and taught and we had excellent learning opportunities in a supportive environment!"

"...the psychiatry half was great. It was very well organised, a variety of experiences within psychiatry were arranged ... We were always very well supported, with proper teaching."

"It is the best teaching I have had so far at medical school."

"...has been an incredible teacher, and has organised our rotation in psychiatry seamlessly."

We also offer training to a much larger number of students due to the fact that our CAG is responsible for front-end crisis assessment services in four emergency departments from where students gain invaluable on-call experience. We intend to increase the number of undergraduate firms and student placements going forward and plan to work closely with the new South London and Maudsley Director of Undergraduate Psychiatry.

We also host the double Student Selected Component (SSC) in psychiatry research, which is specifically intended not just to increase undergraduate exposure and familiarity with psychiatry and academic medicine but also to play a part in trying to reverse the national crisis in recruitment to the speciality. During the 2013/14 academic year, the SSC Psychiatry Research had sixty-two students and registered over seven hundred hours in the teaching database.

In 2013, we held three student mini-conferences where students had the opportunity to present their work as talks or posters. For the second year running, a former SSC student won a Pathfinder Fellowship and another started an academic foundation year. Two former students presented posters internationally and one other presented in the UK. There were at least four new student papers, which were accepted for publication,

including one, which was Pharmacogenomics' paper of the month. Another four papers are close to submission.

Postgraduate

In addition to having a large number of staff contributing to the general psychiatric postgraduate teaching programme, we hosted a Deanery awarded Fellowship in Medical Education (FME). This enabled higher trainees to work in medical education research for a period of six months, twice a year. This programme has evolved and as of 2013/14, existing CAG consultant staff supervise one core trust and one charitable trustee-funded FMEs in simulation with clinical placements provided for these post holders in CAG services.

Furthermore, we completed hosting the SHIELD project which is a multi-strand project aimed at improving the care of patients who self-harm, for which a series of educational initiatives have been embedded within non-medical CAG faculty spanning undergraduate, postgraduate and multi-professional learning.

We are also the first of the South London and Maudsley NHS Foundation Trust CAGs to make mandatory attendance at the new and extraordinarily well-received and multidisciplinary 'Emergency Team' simulation training course for all nursing staff holding an Emergency Team Leader role.

King's Health Partners Mentor Awards 2013

In May 2013, the Florence Nightingale School of Nursing and Midwifery hosted the second annual King's Health Partners Mentor Awards. The awards aim to recognise and celebrate nurses who go above and beyond their role to create a positive learning environment for King's students. Students and staff were asked to nominate mentors they felt had excelled in the role.

The winners included Christine Hinchcliff from the St.Thomas' Mental Health Liaison team for her role as a mental health mentor. She was also the overall winner of the Mentor of the Year award.



Engagement of the education and training agenda across the entire CAG

We hosted a unique workforce engagement day, inviting all members to attend in February 2014. The event brought together various disciplines throughout the CAG to help develop the next year's education and training plan in a collaborative way. There were the presentations on topics such as 'Training in a King's Health Partner Context' by Professor Anne Greenough, 'Safe Wards' by Professor Len Bowers and 'Simulation Training in Mental Health' by Sean Cross. During the event, teams within the CAG were given the opportunity to display posters in the venue to share knowledge and outcomes of their services with their counterparts. The half day event ended with a 'Dragon's Den'-style funding pitch when four services presented bids in order to win funding, all of which were supported going forward into 2014/15.

Evaluation forms were distributed to the 60 attendees and the event was rated at an average of eight out of ten. Qualitative feedback from this event included 'interesting', 'excellent' and 'well organised'. A summary was the event was fun, enjoyable and educational for everyone who attended.

Staff members enjoyed the multidisciplinary element where different professionals were brought together to work in partnership in a fun and relaxed environment. As well as the different disciplines, people enjoyed meeting colleagues from other teams and services, which raised awareness of the diversity of the CAG. The interactive exercises enabled integrative working and the sharing of ideas and good practice. There were requests for similar events to be held in the future.

Identifying future education and training needs across the CAG

Our CAG has an ambitious number of education and training aspirations. These are:

- to continue to offer high quality training for the whole workforce
- to continue to support the development of simulation based training
- to develop clinical leadership and succession planning through education and training
- to develop a master's programme.

Specific initiatives in 2015 include:

- new simulation training courses looking at perinatal psychiatry and more generic team handover skills

- targeting physical health care – including nutrition, wound care and tissue viability
- epilepsy awareness and management of seizures
- research awareness for nursing staff
- clinical skills tutor post for health care assistants.

Figure 66 | The number of postgraduates taught over the last three years

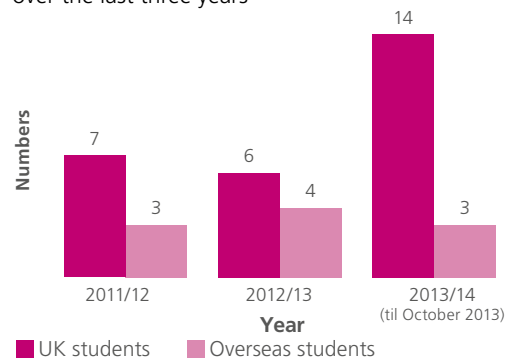
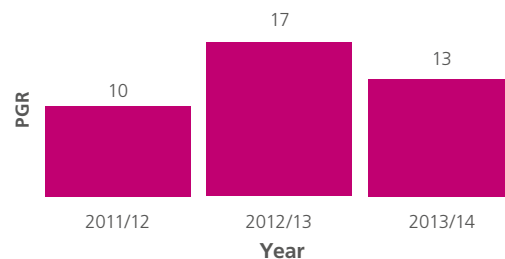


Figure 67 | The number of post graduate research students



Medical staff in CAGs

The undergraduate training programme cuts across all CAGs and is coordinated centrally. Last year, we achieved our strategic objective of increasing the number of liaison firms by three as a way of enhancing the recruitment into psychiatry. There is designated lead for undergraduate training who is a member of the Education and Training Committee.

Postgraduate training is also centrally coordinated by the Maudsley Training Programme. There was a detailed review of training posts across the Trust, interviewing the trainer and trainees and looking at satisfaction and training posts in our CAG and we had the highest ranking.

Nursing

Nursing forums

The Nursing Council

We have a Nursing Council which has been established in partnership with the Mood, Anxiety and Personality Disorder CAG. The Nursing Council provides an opportunity for nurses across all grades – both qualified and unqualified for reflection, consultation, development and sharing of good practice on clinical, professional, educational and research-based issues, to support excellence in mental health nursing practice. The overall purpose is for the direct benefit of our patients and nursing staff within the CAG.

Physical health care forum

We run a six-weekly physical health care forum and have physical health care 'champions' for each area. The forum provides an opportunity for learning and updating staff and planning the implementation of the Trust physical health care strategy.

Nursing achievements

There have been a number of achievements by nurses within the CAG – below are examples:

- the King's Health Partners Mentor of the Year Award 2013 was won by Christine Hinchcliff, psychiatric liaison nurse at St Thomas' mental health liaison team
- our nurses along with Maudsley International, hosted a three-week programme for visiting senior nurses from Hong Kong to share our nursing expertise and good practice
- our Modern Matron represented the Trust for a second time in teaching mental health nursing skills to Saudi nurses – this initiative was the first such venture
- senior nurses have represented South London and Maudsley NHS Foundation Trust in a training initiative with NHS London for practice nurses working with people with mental health issues. The feedback has been very positive and the evaluation has been published

- seven nurses have completed top up degrees including three master's degrees as part of the Nursing Strategy.

enhancing the recruitment into psychiatry. There is designated lead for undergraduate training who is a member of the E&T committee.

Medical staff in CAGs

The undergraduate training programme cuts across CAGs and is coordinated centrally. Last year the CAG achieved its strategic objective of increasing the number of Liaison firms by three as a way of

Post graduate training is also centrally co-ordinated by the Maudsley training programme. There was a detailed review of training posts across the trust interviewing the trainer and trainees looking at satisfaction and posts in psychological Medicine CAG have the highest ranking (Figures 69).

Figure 68 | Ranking by speciality

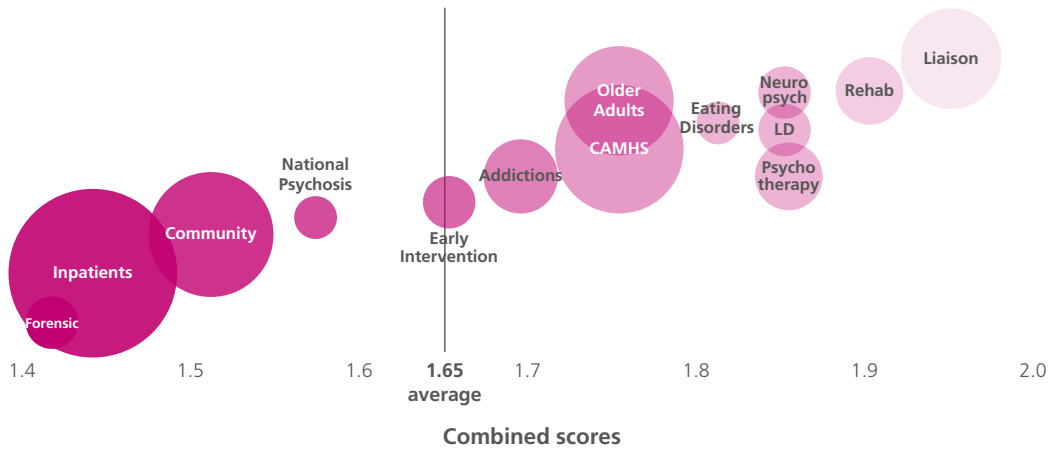
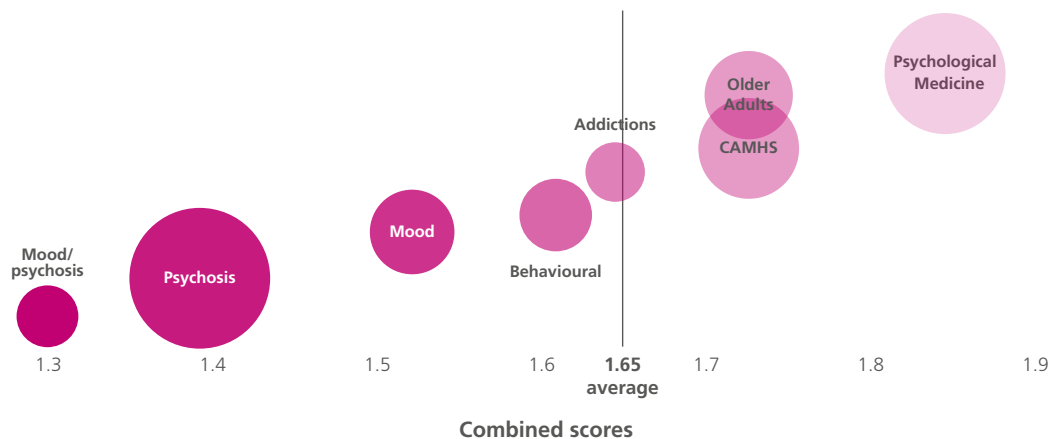


Figure 69 | Ranking by CAGs



We are keen to develop research capacity within the CAG and there is a need for staff, particularly in nursing, to develop research skills. Our commitment to support senior staff to complete MSc studies in part of the strategy to develop this capacity.

Academic research and innovations

First large scale study on Gulf War Syndrome

Professor Sir Simon Wessely is Professor of Psychological Medicine, King's College London and the President of the Royal College of Psychiatrists. He is a Consultant Liaison Psychiatrist at King's College and the Maudsley Hospitals. His research interests are in the grey areas between medicine and psychiatry, clinical epidemiology, psychiatric injury and military health. He has published over 800 papers on many subjects, including epidemiology, post-traumatic stress, psychological debriefing, chronic fatigue syndrome, history, chronic pain, somatisation, Gulf War illness, shell shock, military health and terrorism.

In the mid-1990s, the media started to report on what was known as Gulf War Syndrome, which had some similarities with CFS. It was then that Professor Wessely and Professor Tony David set up the first large scale studies of UK Gulf War veterans, comparing them with

service personnel who had served elsewhere. These studies confirmed that there was indeed a problem, and over the next few years they carried out a series of studies with colleagues in immunology, neurology and public health to take the research further.

Professor Wessely is the Co-Director of King's Centre for Military Health Research (KCMHR), a collaboration between psychiatry, medicine, history and war studies and of the Academic Centre for Defence Mental Health (ACDMH), a partnership between the Ministry of Defence and King's College London, in which serving military medics are seconded to the unit to carry out research and teaching in military mental health. KCMHR's main current research is around various aspects of military health, including psychological stressors of military life, post traumatic stress disorder (PTSD), risk communication, risk and benefits of military service, screening and health surveillance within the Armed Forces, social and psychological outcomes of ex-service personnel, offending and historical aspects of war and psychiatry.

In 2006, the Centre published the first results of a study of the physical and psychological health of 12,000 UK military personnel, half of whom served in the Iraq conflict. The principal results were that there has been no repeat of the Gulf War Syndrome saga, that there is no overall increase in psychiatric disorders in Regular forces who served in Iraq but there was an increase in those in combat roles and those in the Reserves. Other work showed the absence of long-term health problems related to either the anthrax vaccination or exposure to depleted uranium. The unit confirmed the importance of shorter tour lengths in reducing the risk of mental health problems and the ineffectiveness of pre-deployment mental health screening. In 2010, a unique follow-up of all those involved in the original study was published, which gave a first look at the longer term impact of Iraq/Afghanistan, including those who have now left the Services.

Some of the Centre's current research looks at mental health on operations, 'decompression', risk-taking behaviours, outcomes of primary and secondary health care, mild traumatic brain injury (mTBI) and the health and well-being of service leavers, including issues such as violence, convictions and social exclusion.

KCMHR have completed a randomised trial of a new system of peer-led support (TRIM) intended to reduce stigma and encourage help-seeking, now being rolled out across the Services, and a randomised controlled trial of the new US system of 'Battlemind'. A study of the impact of deployment on the mental health and adjustment

of military children started in 2010 and the first ever controlled trial of post-deployment mental health screening in 2011.

Biomedical Research Centre

Psychological Medicine is an active player in the South London and Maudsley NHS Foundation Trust NIHR Biomedical Research Centre through the Disorders of Affect and Addiction and their Interface with Medicine (DAAIM) theme.

Our research spans biological psychiatry, epidemiology, psychotherapy research and clinical trials. We use observational and experimental studies which are translated into new therapies to address problems at the interface between medicine and psychiatry.

Our current research funding includes: the Applied Research into Anorexia Nervosa and Not Otherwise Specified Eating Disorders programme, a multi-centre randomised controlled trial comparing the effectiveness of enhanced motivational interviewing with usual care in reducing cardiovascular risk and persistent fatigue induced by interferon alpha, a New Immunological Model for Chronic Fatigue Syndrome, Integrating Mental and Physical Healthcare Research Training and Services and Health and Wellbeing of UK Armed Forces Personnel cohort study.

Recent research findings include:

- the PACE trial showed cognitive behaviour therapy (CBT) and graded exercise therapy (GET) increase likelihood of recovery from chronic fatigue syndrome three-fold compared to other treatments
- embarrassment and not wanting to waste doctors' time are more frequently reported by British people than in other countries. This may hold British people back from presenting early with symptoms of cancer
- pregnant women with mental health disorders face too many barriers to help them quit smoking during pregnancy, despite their willingness to accept support
- men who have served in the UK Armed Forces are more likely to commit a violent offence during their lifetime than their civilian counterparts.

Medically unexplained symptoms (MUS) care pathway

We are developing a care pathway to address the needs of this group of service users, which is in line with the King's Health Partners strategy to work across the acute/mental health CAGs.

The development of the Medically unexplained symptom (MUS) care pathway establishes a whole-system approach which requires key

clinical changes across the system: moving away from medical investigations and towards a clear pathway for this group of patients who fall in between services and ensuring mental and physical health services work collaboratively, as outlined in the King's Health Partners strategy.

Currently leading nationally and internationally in this field with the work done in chronic fatigue syndrome (CFS), irritable bowel syndrome (IBS) and other research, we have the expertise to develop this model of care. In line with the King's Health Partners agenda, we are creating a system-wide change, investing to save by diverting patients away from expensive multiple secondary care contacts by providing an effective pathway back to primary care.

A joint assessment between physicians and senior mental health clinicians will be the key to determining which patients should enter the MUS care pathway. Neurology, gastroenterology, gynaecology, rheumatology and cardiology are being considered the five main areas to develop the service with presently.

There will be a small team of senior clinicians experienced in this field required to carry out the joint assessments as well as the planned interventions, which would be for approximately ten to 12 sessions. We will also offer training to primary care, consultation and the development of some guided self-help materials for Improving Access to Psychological Therapies (IAPT) for workers to use with people with mild to moderate symptoms.

Developing a training package is being considered which could be offered to GPs via the London Deanery and this would be to continue the pilot started by Healthcare for London. However, it is acknowledged this work could be commissioned locally.

Improved understandings of poor prognosis in medical conditions

Mental disorders are strongly associated with poor outcomes in most long-term conditions. We have explored these using population cohorts. We seek to develop this expertise in several directions:

- we will collaborate with the BRC Nucleus to use locally relevant clinical databases with suitable linkages to primary care, cancer registries and hospital episode statistics to allow for a more sophisticated understanding of patterns of morbidity and causes of mortality in our local populations with mental disorders, and to then identify targets for rapid public health translation
- our BRC disorder theme includes a strand on obesity, which will seek to develop interventions for high risk groups
- we will link expertise in biological technologies with epidemiology to develop

epidemiologically-robust study designs exploring biological underpinnings related to psychiatric disorders relevant to their excess mortality. (Example databases: SELCoH study; 1946 birth cohort)

- we will continue the ongoing research to understand which biological factors are associated with the pathogenesis of the depression-diabetes link and to develop effective psychological treatments to improve glycaemic control in diabetes.

The Consent for Contact (C4C) project at South London and Maudsley NHS Foundation Trust

Aims

C4C is aiming for the most effective way of recruiting service users into mental health research conducted by the Biomedical Research Centre (South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, Psychology and Neuroscience at King's College London).

C4C is a direct link between service users and researchers, with an aim to become a primary research recruitment gateway in Europe's largest mental health research centre.

Background

There are many services users wishing to take part in research and who are very keen to have research developed in their field but they are not aware of how to go about getting involved. Many patients also report that they would like to take part in research, if only their clinician would recommend them to do so.

Methods

Since May 2012, a phased education and training programme (supported by multimedia and intranet resources) has been rolled out by the C4C team to South London and Maudsley clinical teams. Clinicians ask their service users about participation in C4C and document the outcome in the clinical record. A C4C digital form was added on the South London and Maudsley electronic patient journey system (ePJS) for clinicians to document that C4C has been discussed, capacity ascertained and the service user decision noted.

C4C at Psychological Medicine CAG

In October 2012, Lewisham Triage adopted the C4C project and was the first and largest inpatient service to do so, joined by Lambeth Triage in May 2013. Lambeth is now one of the most successful services in implementing this programme.

A dedicated project worker has been approaching all admitted patients to discuss whether they would like to be a part of the South London and Maudsley research register (Consent 4 Contact). Due to the nature of distressing inpatient admission, it was agreed that only positive responses will be recorded to give some patients a chance to be approached again in the community when less distressed, in case they declined whilst inpatients.

Additionally, an initial feedback survey for service-users in our CAG was created for evaluation purposes (n=90).

Results

By the end of 2013, our CAG alone accounted for 23% (518) of all positive responses to South London and Maudsley research participation register (C4C). Additionally, the feedback survey revealed (n=90) that service users' main reasons for consenting to C4C was they wanted to use their own experience to help others with similar problems.

Efficiency of Consent for Contact (C4C) at Lewisham triage unit

There was also a high efficiency in approaching Lewisham triage ward (2012–2013): 70%

(704/997, excluding readmissions*) of all patients have been approached, 74% (515) had capacity to consent to the project at some stage of their admission and 69% (357) of patients agreed to join the South London and Maudsley NHS Foundation Trust research register (C4C).

Conclusions

Lewisham Triage has proven to be one of the most effective services for the C4C implementation at South London and Maudsley NHS Foundation Trust. Approaching mental health service users for C4C is feasible and acceptable for most patients admitted to Lewisham triage.

Figure 70 | Consent for Contact (positive response) in Psychological Medicine by end of 2013

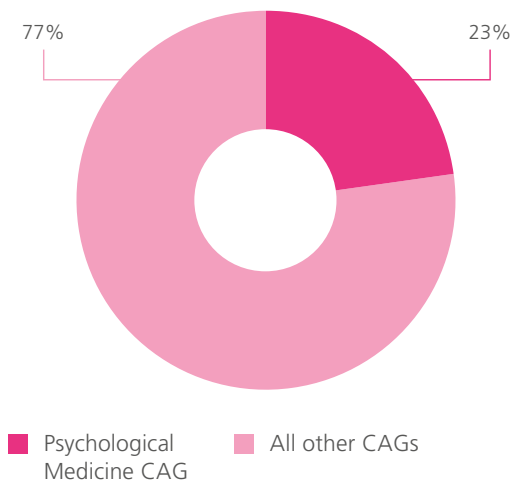


Figure 71 | Consent for Contact at Lewisham Triage: implementation efficiency

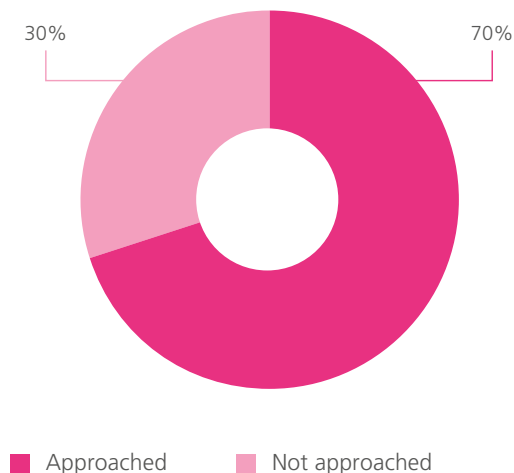


Figure 72 | Consent for Contact (positive response) at Psychological Medicine compared with the rest of South London and Maudsley Trust by the end of 2013. The high figures represent the numbers of patients passing through the Lewisham Triage Ward over the course of a year.

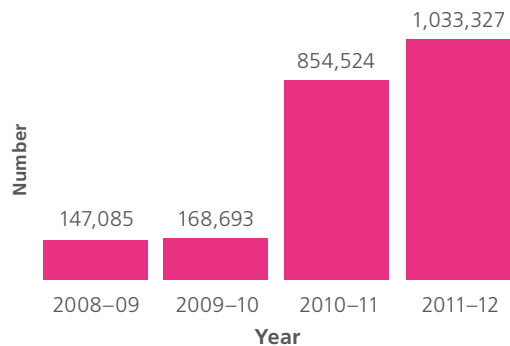
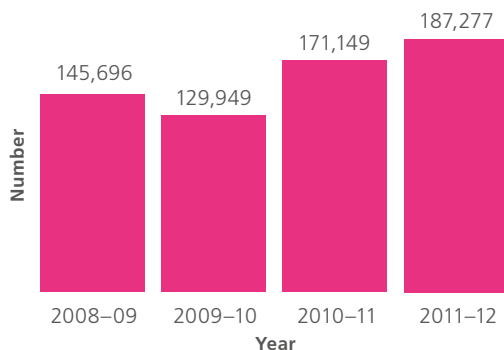


Figure 73 | Consent for Contact at Lewisham Triage: implementation efficiency



Research outcomes

Operational Criteria Checklist for Psychotic Illness (OPCRIT+) project at South London and Maudsley NHS Foundation Trust

The OPCRIT+ implementation at South London and Maudsley NHS Foundation Trust has been operating since October 2009 with the overall aims being:

a) spreading use of the form as widely as possible throughout South London and Maudsley NHS Foundation Trust

b) producing the most clinically usable and research beneficial tool.

OPCRIT+ in its current format is a single-page ePJS form located under the Assessments tab. It consists of eighteen psychiatric history and mental state examination headings, under each of which is a free text box and series of drop down questions.

Of the 311 drop down questions, 63 are core or 'root' questions and the remaining 248 sub or 'nested' questions, providing additional detail to the root questions. The original intention for all participating services was for one full OPCRIT+ form to be completed per new admission.

Clinical benefits

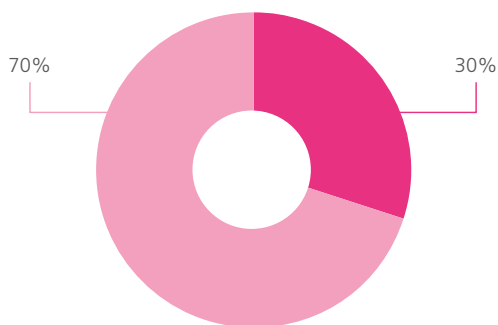
The following potential clinical benefits were listed, according to the three feedback surveys conducted among clinicians. The percentage of respondents who marked an item as a benefit is given and number of respondents in brackets:

- A. Collate summary button for creating other documents eg. Discharge summaries 66.7% (14/21)
- B. Improved structuring of assessments 52.4% (11/21)
- C. 'Help' function linking to definitions, prompts and useful websites 47.6% (10/21)
- D. Unified location for history and mental state assessments on ePJS 47.6% (10/21)
- E. Contribution to research that will lead to improved clinical practice 47.6% (10/21)
- F. Pull-through text feature 38.1% (8/21)
- G. Generation of diagnoses according to ICD and DSM 28.6% (6/21)
- H. Create summary links 23.8% (5/21)
- I. None of the above 9.5% (2/21)

Lewisham triage implementation

Due to the very high volume of admissions, a dedicated completer/OPCRIT+ project worker was appointed on Lewisham triage. This had advantages, such as increased numbers of OPCRIT+ assessments completed when compared with other services (767 (30%)) and when compared with the total South London and Maudsley NHS Foundation Trust's 2599 OPCRIT+ assessments to the end of February 2013/end of the project. The completion rate was also high, with 86% of patients (767/931 (excluding 92 readmissions)) having the assessment completed.

Figure 74 | Lewisham Triage share in total OPCRIT+ completed in SLaM by the end of the project



■ Lewisham triage ■ All other SLaM services

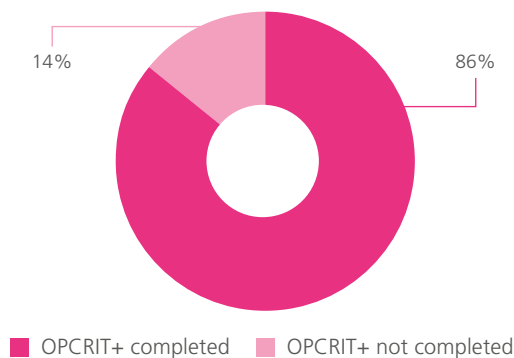
After the South London and Maudsley NHS Foundation Trust OPCRIT+ program had stopped, the completion of OPCRIT+ assessments continued

at the Lewisham triage by the end of 2013, there were 1060 completed in total.

References

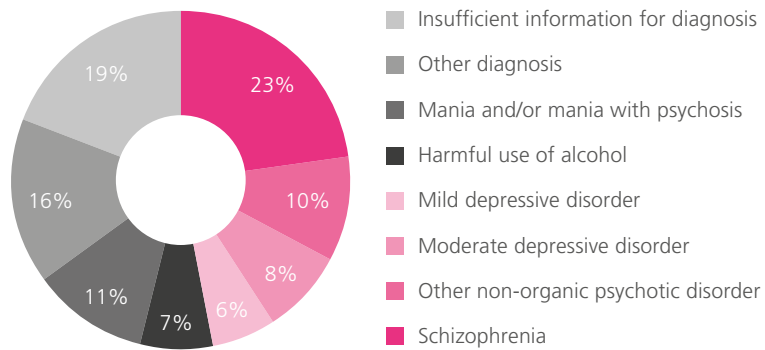
[1] Brittain, P., Lobo, S. (2013) OPCRIT+ Review. Institute of Psychiatry, Kings College London (internal report).

Figure 75 | Lewisham Triage OPCRIT + completion rate



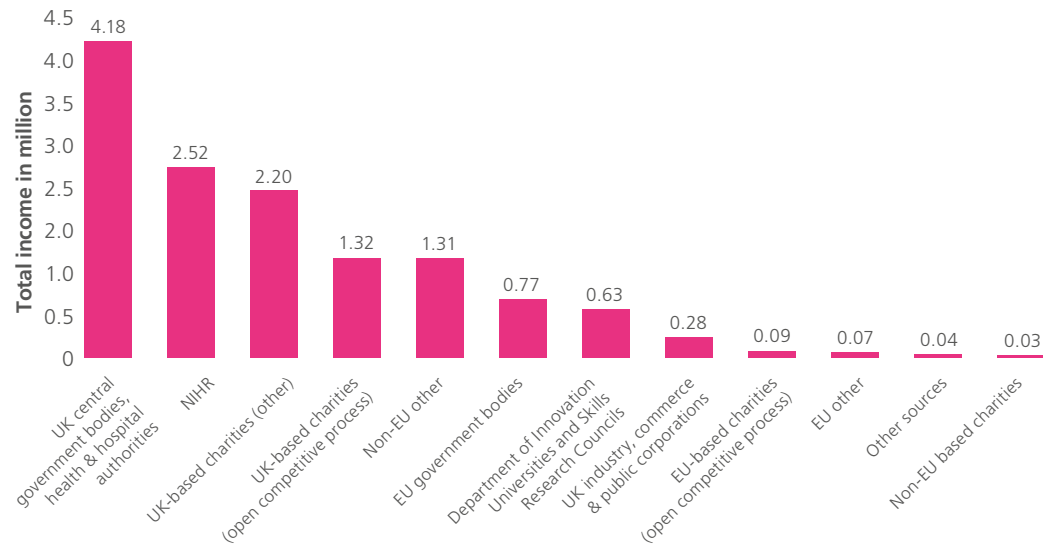
■ OPCRIT+ completed ■ OPCRIT+ not completed

Figure 76 | Main cluster of OPCRIT+ generated primary diagnosis



CAG research income

Figure 77 | Total income from 2008–2012



We have seen the level of research funding mainly increase over the last four years from some organisations, as shown above particularly

from UK based charities and the Department of Innovations, Universities and Skills Research Councils (DIUS).

King's Health Partners
Ground Floor
Counting House
Guy's Hospital
London SE1 9RT

Tel: 44 (0)20 7188 4058

Email: kingshealthpartners@kcl.ac.uk

Website: www.kingshealthpartners.org

Twitter: @kingshealth



Guy's and St Thomas' 
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King's College Hospital 
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South London and Maudsley 
NHS Foundation Trust