Centre for Psychiatry

Barts and The London
School of Medicine and Dentistry

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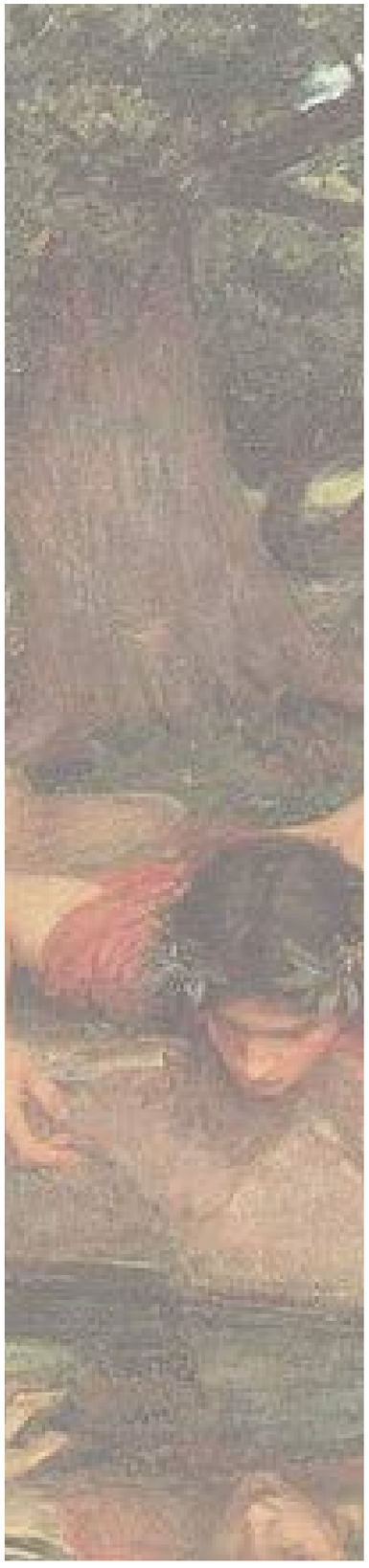

Editorial

Writing this editorial at the dawn of 2016 is quite exciting. 2015 has been a great year for the Centre for Psychiatry, with outstanding research, high impact publications and awards for senior and junior researchers. It has been a great year not only academically but also socially; with opportunities to get together, to feel proud of each other's achievements, relax over a glass of wine (or two) and plan for the future.

Although all the achievements of the Centre for Psychiatry are celebrated in this edition, the spotlight is on Forensic Psychiatry, a fascinating psychiatric subspecialty that brings together medicine, psychiatry and the law. Forensic psychiatry deals with individuals that not only have mental disorders, but also engage in offending behaviours. These individuals can be assessed and managed in a variety of environments such as inpatient facilities, outpatient clinical settings, police custody, prison establishments and courts.

And of course, as with other disciplines in mental health, forensic psychiatry adopts a variety of interventions to facilitate recovery from the mental disorder and relapse prevention, address offending behaviours and help the individual to learn how to address issues associated with their offending (such as personality traits, life style choices, substance use and abuse, mixing with the wrong crowds). Dr Cleo Van Velsen describes her experience as a forensic psychiatrist and psychotherapist in a Therapeutic Community (TC) for Offenders with severe personality disorders. Tony, a past resident of this TC very bravely gives us some insight about his experience of the forensic service and how he progressed to living independently.

In the Violence Prevention Research Unit, Professor Coid's team challenges the field of risk assessment to overcome rigid views and focus on identifying "true" risk factors for violent behaviour. The aim of their research is not only to untangle the complexity of the relationship between mental health and violence, but to enable clinicians to manage and prevent potential risk of harm to both the patient and the wider public.

The magic of forensic psychiatry is however not restricted to clinical and research prospects but also opportunities to get involved in education. Dr Catherine Marshall, an Advanced Forensic Psychiatry Trainee talks about her post in the Centre for Psychiatry as the teaching fellow in medical education (FME). She used her background and knowledge in medical ethics and law to develop lectures on psychiatric ethics. She is involved in undergraduate and postgraduate teaching, in educational research while also undertakes a formal teaching qualification at QMUL.

It would have been a great omission not to congratulate the members of the Centre for Psychiatry that received prestigious Global, National and Local Awards. Professor Kamaldeep Bhui, Centre Lead for Psychiatry was renowned as a world leader in the field of Cultural Psychiatry and mental health policy and practice. Dr Micol Ascoli, Consultant Psychiatrist in Newham and Honorary Senior Lecturer, was presented with the "Sava Award" for her contributions to the field of Cultural Psychiatry. Congratulations also to Eleanor King who was shortlisted for the RCPsych Awards 2015, Paulina Szymczynska who won a poster prize at the 3rd International Clinical Trials and Methodology Conference, Miriam Mallett who won the Outstanding Contribution to the RSM Psychiatry Section & Trainee Prize, Eoin Golden for winning the poster prize at William Harvey Day and Ioanna Skaltsa for winning one of 5 college prizes within SMD awarded to postgrad taught students of Academic Excellence.

Artemis Igoumenou, Clinical Lecturer

Contents Winter 2016

Millfields Unit

After completing the first part of my training as a psychiatrist I specialised in psychotherapy and was a consultant in general psychotherapy for five years. I always had an interest in Forensic Psychiatry and thus moved into forensic psychotherapy. I worked in the general Medium Secure Unit (MSU) for some years before becoming a Responsible Clinician in the Millfields Unit which started as one of the projects for the treatment of forensic personality disorder within medium security in the NHS. It opened in 2006 and is located within a general MSU. It is part of the Offenders Personality Disorder Pathway, a joint health and criminal justice venture. Millfields is accredited with the Community of Communities CQC body.

The people and the therapeutic milieu

Millfields houses 16 patients. A multidisciplinary team attached to the unit includes two responsible clinicians; I am the Responsible Clinician for twelve of the patients and Dr Taylor is Responsible Clinician for four. The multidisciplinary team contains representatives from psychiatry nursing, social therapy, social work, occupational therapy and psychology. There is also a psychotherapist, sports instructor, facilitators of small groups and a lead nurse.

The treatment model of the Millfields unit is an adapted therapeutic community, similar to units such as HMP Grendon Underwood, although there are differences as a result of being located within the NHS, for example, more medical input and a more diverse group of patients. The underlying philosophy is the need for patients to take responsibility for themselves, and the damage done as a result of their offending and antisocial behaviour and also how their interpersonal dynamics reflect in the here and now of the unit.

Patients who suffer from severe personality disorder have significant deficits in their capacity to maintain healthy relationships and to take care of themselves or others. Therefore the involvement of each patient with the running of the unit and in challenging, confronting and supporting their fellow patients is vital. Much of the treatment is therefore group based.

There is an expectation that offending behaviour, including that for which there have been no convictions, is disclosed and explored in some depth. In addition, in the two weekly small groups, lasting one and half hours, patients are encouraged to explore their difficulties in a smaller group, which can then be taken to the community or other therapeutic situations.

There are specific treatments that occur on the unit in which a proportion of the patients take part. These include substance misuse, art therapy, orientation to therapy, self-change program and individual psychotherapy of a psychodynamic or cognitive behavioural type. Patients are actively encouraged to participate in community activities such as sports, gym, music, cooking etc. There are community jobs and roles of varying responsibility, which patients are expected to apply for – some are paid but others are not. There is an expectation on the unit that patients participate in treatment in an active way and all activities are considered therapeutic.

Working in a Therapeutic Community

From a dynamic point of view working in such units can be challenging. The features associated with antisocial, borderline (emotionally unstable) and narcissistic personality disorders are: increased aggression and violence; impulsivity; lack of empathy; intolerance; sense of entitlement; acute sense of injustice and justice; instability, sensitivity to relationships; insecure sense of self etc. All these dynamics can have an impact on the institution because the dynamic of patient groups will always be reflected in staff group to a lesser or greater extent.

The emphasis on psychological and social intervention means that the stress on staff can be somewhat different to that associated with other settings.

The Therapeutic Community is based on what is called the four pillars. One is reality confrontation in which behaviour, thinking and feelings will be enquired about, examined and understood as part of everyday treatment. Events or thoughts in the here and now are described and examined in order to understand links with offending and personal history. Staff and peers are entitled to comment on each other's behaviour.

Communalism is another pillar and this reflects the central aspect of the model namely that an individual is embedded within a matrix of relationships. One of the early founders of the Therapeutic Community, Dr Tom Main, a psychiatrist and psycho-analyst used the phrase 'Community as Doctor'. This means that how the individual behaves has consequences for the community and cooperation is through shared tasks. There is sharing of information about offending, which is not found in many other units. Also patients have to agree to be admitted and participate.

Permissiveness is a third pillar which describes the freedom to be oneself, discouraging inauthenticity and empty conformity. Many of the patients who are in Milfields have a past in which they have been consistently "told off" and punished for their actions, which becomes routine and ineffective. Permissiveness is not to say that 'anything can go', but that, within the containment of rules and boundaries, people can express and explore characteristics of behaviour and thinking, both conscious and unconscious.

The fourth pillar is democratisation where as much responsibility as possible is delegated to the community (of which staff are a part), without losing sight of the authority of staff group (particularly so in a Forensic Therapeutic Community where people are detained under the Mental Health Act).

There is shared ownership of how well or not the community is running and, for this reason, there are three community meetings a week. This is a forum where there is discussion about actions and decisions, freedom of speech and healthy opposition. The staff group has authority and needs to manage boundaries and share responsibility but also be accountable, as are all the members of the community.

Resident perspective

I thought that I would finish with an extract of a self-report by a patient, Tony, who has now been discharged. He spent many years in a maximum secure hospital, before moving to us where he had quite an "up and down" journey. It appeared that 25 years in maximum security taught him conformity, but his underlying attitude was anti-authority and antagonistic, so much so that he would undermine his treatment and progress as a way of attacking us and the institution. He now works as an expert by experience on our PG Cert Course on Personality Disorder.

Tony has given me permission to quote a self-report from a year prior to discharge where his thinking and attitude is thoughtful and self-exploratory.

> "I can't change how people behave or what they say, only how I react to them"

"Years ago my commitment to therapy and treatment fluctuated in parallel with my mood. My sensitivities to what others say and do have direct links with my thinking patterns and behaviours. I fully understand that "I can't change how people behave or what they say, only how I react to them"…… understanding this is different to being able to do much about it.

It is the same when talking about my inside or the understanding of my core beliefs, cues and triggers, emotional regulation, thinking and behaviours. These have all contributed to my attitudes and behaviour within my offending spilling over in to general day to day livings.

I would at this point, like to list my opinion of current and continuing problems and difficulties. Not with any hierarchy:

- A degree of impulsivity (a good deal less than 20 years ago)
- Hypersensitivity (to what people say and do and my judgement of why)
- Attitude to authority (mainly negative and suspicious)
- Core beliefs, schemas, triggers (and how I use these)
- Unforgiving
- A select and strict number of staff I wish to engage with (which includes the writing off of people and being judgemental)
- Problems with my thinking skills and style
- What I think of others and as a result what I teach them
- The entire scope of relationships, attachment styles and interpersonal interactions.
- Deficits with the control and management of my frustrations, anger and other emotional states.
- Fear of the outside (and fear of failure)
- Sexual attitudes
- Criminal attitudes
- Violent attitudes and fantasies
- Negativities
- Low self-esteem and self-worth issues (at times)

There are a few other areas of concerns for me but they have less consequences and could be dealt with at a later time. The very real issue for me is that I am NOT in conflict with my team over whether all this work needs completing, but where it should be completed and what part of this work could be dealt with whilst at Milfields.

I could write a lengthy article on my thoughts, feelings and opinions of Milfields, but I won't.

The clear and undeniable fact is that I have to conform to Milfields, not the other way round. If I should fail it is my failure not the unit's failure. I am confident failure will not occur or present risk factors. For a long time I have been quite isolative when not involved with community meetings or small groups. There are defences about what harm I might cause to myself or others through negative thoughts about those, poor body language that might be interpreted as hostile, aggressive or threatening and the rude or dismissive avoidant conduct I sometimes display.

In addition, I have unhelpful and difficult personal interactions with a number of staff and residents. I am not naïve to suggest that all my risk factors relate to my current environmental situations. This has its part to play. Indeed, my presentation reflects, largely, my preference of self-reliance, quiet thought and engagement in activities that require of me little consideration of others.

With regard to my risk, make off this what you will. I would ask for the teams continued support and understanding of the internal conflict I still have that sometimes does not allow me to remain positive and appropriate."

Dr Cleo Van Velsen MBBS MRCPsych, Member British Institute of Psychoanalysis, Consultant Psychiatrist in Forensic Psychotherapy, Millfields Unit

Violence Prevention Identifying the Causes of Violent Behaviour

Clinicians are under increasing pressure to accurately assess and manage the risk posed by individuals in their care. This is especially pertinent when a service user is approaching discharge to the community from an inpatient setting, as they may be more vulnerable and there is a clinical responsibility to manage potential risk of harm to both the patient and the wider public.

There are currently more than three hundred risk assessment instruments available and administered by professionals such as psychiatrists, psychologists, and probation officers to assess the risks of violence and sexual offending among psychiatric patients, prisoners, and the general population. In several forensic mental health services the hospital does not get paid unless staff have completed a risk assessment on their patients. Producing risk assessment instruments has become an 'industry' and new instruments are being constructed annually. Unfortunately, none of these instruments have any advantage over those created before. Furthermore, even when using the best instruments they will misclassify approximately 30% of the cases. This is probably one of the most important reasons why patients are staying longer and longer in secure mental health services. Administration of such instruments achieves little more than making healthcare professionals increasingly risk averse.

In the Violence Prevention Research Unit, we try to overcome these obstacles. The standard approach to creating and validating risk assessment instruments is the statistical prediction of future behaviour. Risk and protective factors for violence measured at some time point are modelled as exposure for violence in a subsequent time window. Our research, though, has shown that this is the wrong approach to identify associations. If the aim of risk assessment is to prevent future violence the focus should be on risk factors which are amenable to intervention and treatment. Such dynamic factors, however, change over time. We have demonstrated that delusions (occurring in the past 10 weeks) do not predict violence in a subsequent 10-week time window. However, when considering their co-occurrence in a defined 10-week time window they demonstrated a significant and strong association with violence. The notion of temporal proximity extends to all risk factors for violence which are dynamic in nature.

We have recently compared predictive and temporal proximity models to investigate accuracy and strength of association of the items of a Structured Professional Judgement risk assessment instrument, the HCR-20. Using the traditional approach, the predictive model produced statistical coefficients of low size, suggesting that the risk factors were poor in identifying who would be violent and who would not. Because many associations between the factors and violence were weak, few appeared useful in identifying those which should be targeted to manage future violence. When we applied a temporal proximity approach aiming to confirm which risk factors resulted in violence, the findings were very different. Symptoms of major mental disorder, the patients' living condition, and whether they were taking medication were highly important factors, a finding overseen by the traditional model.

We are fully aware that causality is difficult to prove. To interpret associations identified with temporal proximity models as causal they need to be plausible and all available knowledge of cause and effect needs to be considered. However, by provocatively introducing the term "causal" we aim to challenge the field of risk assessment to overcome rigid views and focus on identifying "true" risk factors for violent behaviour to enable clinicians to prevent violent acts.

Simone Ullrich, Senior Lecturer in Forensic Mental Health

World Health Organization

GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE
VIOLENCE PREVENTION ALLIANCE / ALLIANCE POUR LA PREVENTION DE LA VIOLENCE

Catherine M Marshall Fellow in Medical Education

In August I began a year-long post in the Centre for Psychiatry as the teaching fellow in medical education (FME) for East London NHS Foundation Trust.

Medicine is permeated with a culture of continuous education right from the start of medical school. It also follows an apprenticeship style where junior doctors learn from their seniors throughout all of the specialities and many clinicians consequently find themselves involved in teaching medical students, bringing their job enthusiasm and experiences to life in the lecture theatre, as well as on the ward. I was the same, thoroughly enjoying the opportunities I had teaching psychiatry, until I realised that I really wanted to augment my teaching skills further, ultimately in order to pursue a career formally combining clinical work as a forensic psychiatrist with being a medical educator.

Fortunately the FME post is excellently designed to support embarking on this kind of career pathway with many possibilities to teach in different formats, as well as involvement in educational research and the opportunity to work towards a qualification in education.

Currently I am primarily working on teaching projects for the undergraduates. Drawing on my background in medical ethics and law I have developed a lecture on psychiatric ethics for the fourth year medics as part of their Brain and Behaviour module which aims to introduce some of the historical and philosophical notions associated with psychiatry and its interface with mental health law.

Having recruited other teaching-minded psychiatric specialist registrars, I have also designed a new teaching session for the third year medical students focusing on the mental state examination as part of their Clinical and Communication Skills module. By December we will have filmed two new clinical scenarios that will enable a practical and interactive small group session for the students.

Although not part of my FME role, I have also been able to continue teaching the postgraduate core psychiatry trainees and I have assisted in creating a course supporting their preparation for their final exams in order to attain membership of the Royal College of Psychiatrists. We now run a weekly group led by a senior clinician leading on revision of the topic and then observing clinical role-plays before providing structured feedback for the future exam candidates.

Overall I've found that challenging the stigma associated with psychiatry as a profession still remains a key underlying feature of the curriculum, however I am inspired to see more and more medical students appreciate the impact of mental illness and demonstrate motivation in making the most out of their psychiatric placements and promote psychiatry through PsychSoc and the Open Minds initiative. In my opinion the purpose of teaching psychiatry is not only to improve the standards of clinical knowledge and practice, but also to encourage future professionals into the field and dispel some of the myths associated with psychiatry for those who will treat patients with a comorbid mental illness. Indeed a central in medical education currently is the concept of how clinicians themselves build resilience and are aware of their own wellbeing. With this in mind, early next year I will be investigating how professionalism and future career resilience develops in medical students, particularly the role of mentoring.

Undertaking a formal teaching qualification is also a requirement of the FME role and I have enrolled in the Certificate in Learning and Teaching (CILT) course at QMUL, which I have found invaluable for establishing an understanding in educational theory and practise. The core module is complemented by an optional module specific to teaching in medicine and features fortnightly group seminars, teaching observations and written assessments.

"The purpose of teaching psychiatry is not only to improve the standards of clinical knowledge and practice, but also to encourage future professionals into the field and dispel some of the myths associated with psychiatry for those who will treat patients with a comorbid mental illness.
Catherine Marshall

Alongside my teaching and academic commitments I still work two clinical sessions a week. I have taken the opportunity this year to start delivering Cognitive Analytic Therapy under supervision in Homerton and to co-facilitate a forensic inpatient learning disability anger management group. When this post ends I shall return to complete my last year of higher training in forensic psychiatry.

All that remains is to encourage all members of the Centre for Psychiatry to get involved in teaching; whether it be lecturing, facilitating small groups or using your acting skills in some role-play sessions- please get in touch!

SAVA Award Staff Win Two Global Awards

Two members of our Centre have received two prestigious global awards at the World Association of Cultural Psychiatry (WACP) 4th World Congress in Mexico. **Dr Micol Ascoli** and **Professor Kamaldeep Bhui** were recognised for their services to Cultural Psychiatry.

Professor Kamaldeep Bhui, Centre Lead for Psychiatry was recognised as a world leader in the field of Cultural Psychiatry and mental health policy and practice.

Dr Micol Ascoli, Consultant Psychiatrist in Newham and Honorary Senior Lecturer, received the "Sava Award" for services to the association and contributions to the field of Cultural Psychiatry.

The WACP is the world's leading Scientific Society in Cultural Psychiatry, with 20 affiliated national associations and members from over 50 different countries worldwide. The congress connects 400 healthcare professionals from over 50 countries with an interest in the research, practice and theoretical perspectives on culture and mental health.

The awards celebrate best practice and individuals who are improving the quality of mental health care whilst working with diverse cultures, legal systems and commissioning processes.

Dr Micol Ascoli, a Consultant Psychiatrist and psychotherapist in the field of Adult Mental Health has been working with the WACP for a number of years. She was previously WACP Secretary 2013-2015 and is Chair of The Refugee Therapy Centre, a charity providing individual and group intercultural psychotherapy to refugees and asylum seekers.

For more information about Cultural Psychiatry or the WACO congress, follow these links http://www.waculturalpsy.org http://4wacpcongress.org/

"I am thrilled to have received this award; I am deeply passionate about cultural psychiatry and the role that it can play in recovery. My interest in cultural psychiatry stems from my own Jewish culture and working in the ethnically diverse area of Newham. I hope that cultural psychiatry continues to be recognised as critical to successful patient care and assessment.

Dr Micol Ascoli

Poster Prize 3rd International Clinical Trial and Methodolgy Conference

Well done Paulina Szymczynska!

We are very pleased to announce that Paulina Szymczynska won the poster prize at the 3rd International Clinical Trials and Methodology Conference for my poster titled "*The Trialists' Perspectives on the Participant Retention in Mental Health Randomised Controlled Trials*".

Competition was very strong with 235 posters displayed at the conference.

Poster Prize at William Harvey Day

Congratulations go to Eoin Golden

Eoin Golden based at the Unit for Social and Community Psychiatry has won a Poster Prize at the annual William Harvey Day.

William Harvey Day is the annual research day for Barts and the London School of Medicine and Dentistry, part of Queen Mary University of London. First started in 1990, it is an opportunity to celebrate innovation and expertise in research. This comes from both within our community, the students and staff working here, and it is also a chance to hear from eminent guest speakers.

"I was really pleased to learn that our poster won an Outstanding Poster Prize at William Harvey Day. In our Unit, we put a lot of effort into making our research accessible to the public, so it was rewarding to know that we're doing something right! The quality of posters was very high across the board. I would encourage other researchers to attend next year, as it is a fantastic way to get a broad sense of all the innovative research going on in Queen Mary at the moment."

Eoin Golden

Winner of one of five college prizes within SMD

Ioanna Skaltsa, winner of one of the five college prizes awarded to postgrad students of Academic Excellence within SMD, talks about the MSc she studied on.

Undertaking the MSc in Mental Health: Psychological Therapies at QMUL, has been a privilege and a highly rewarding experience. Being biracial (Greek-Japanese), whilst living in Greece; a country which lacks multicultural services, I was enthusiastic by the fact that this MSc programme, highlighted culture as an area that merits exploration within individuals' assessment and treatment delivery, by providing rich insights and knowledge necessary to develop cultural competence.

Lectures and tutorials provided opportunities to engage with thought-provoking issues and reflect on cutting-edge topics using a systematic approach towards developing critical thinking and research skills.

As a CBT therapist, learning about different psychological therapies from expert clinicians has fostered open-mindedness and incorporating research into practice, while working with psychiatric inpatients during my placement. Importantly, I had the opportunity to conduct research on my topic of interest under the excellent guidance, support, and encouragement to independent thinking of my research supervisor Dr. Heidrun Bien.

My thesis was a systematic review on "The impact of immigration detention on the mental health of adult asylum-seekers". An independent adverse impact of detention on asylum-seekers' mental health was indicated, with even brief detention being associated with severe disturbance, while prolonged length of stay was identified as a risk factor for mental health and a predictor of long-term psychological harm. Length of detention, legal status, and pre-migration trauma appeared to be important factors in influencing symptom levels. It was shown that detention constitutes a serious stressor characterized by deprivation, powerlessness, injustice, inhumanity, and uncertainty; underlying the requisiteness of policy re-evaluation, mental health services within these settings, and awareness by mental health professionals.

Currently I am taking seminars on human rights law and psychological first aid, whilst preparing for my role as a volunteer psychologist involving work with asylum-seekers and refugees.

Award for Outstanding Contribution to The RSM Psychiatry

Miriam Mallett was awarded a prize for outstanding contribution to the RSM Psychiatry section student and trainee prize. She was sadly unwell and could not attend the presentation.

The paper she submitted was a summarised version of her dissertation that she completed with her tutor Professor White, and colleague Eleanor King, in her 4th year of medical school. The paper is a survey of recommended treatment options for chronic fatigue syndrome comparing patient organisations with medical authorities.

New Starter Thomas Booker

Thomas joined the Unit for Social and Community Psychiatry in October 2015. He is working as a Research assistant for COFI (Comparing policy, effectiveness and cost-effectiveness of Function and integrated systems of mental health, PI: Professor Stefan Priebe).

The project is being carried out in the UK, Belgium, Poland, Germany and Italy. The study will look at differences between specialised teams versus personal continuity across inpatient and outpatient mental healthcare services.

Thomas completed his BA at Warwick University and his MSc at UCL.

Before joining the Unit, Thomas was working as a research assistant for trial run by the Tavistock and Portman NHS Foundation trust. The Tavistock Adult Depression Study (TADS) looked at the effectiveness of psychodynamic psychotherapy for patients with long term and treatment refractory depression. His work there centred on psychotherapy process research and personality assessment.

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Events

Date	Time	Title	By	Venue
1st Feb 2016	2pm	CLAHRC, ImprovE & Carer Involvement - forward planning	Domenico Giacco	Lecture Theatre, Academic Unit, Newham Centre for Mental Healt
8th Feb 2016	2pm	DIALOG + in depression	Victoria Bird	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
15th Feb 2016	2pm	Medication Adherence By Peter Haddad	Peter Haddad	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
22nd Feb 2016	2pm	Exploring community approaches to music therapy: preliminary thoughts	Stuart Wood	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
29th Feb 2016	2pm	VOLUME - Volunteer recruitment, training and coordination	Eoin Golden	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
7th Mar 2016	2pm	RADAR - Research into antipsychotic discontinuation and reduction	Ruth Cooper	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
14th Mar 2016	2pm	QuEST - Update on the feasibility study & cohort follow-ups	TBC	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
21st Mar 2016	2pm	Developing, refining and testing intensive group music therapy for acute adult psychiatric inpatients	Catherine Carr	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
4th Apr 2016	2pm	Findings from research on group processes in therapeutic groups	Stavros Orfanos	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
11th Apr 2016	2pm	ImprovE - Improving the practice & outcomes of involuntary hospital treatment in England	Liza Mavromara & Domenico Giacco	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
18th April 2016	2pm	Development of a mobile health intervention using positive psychology for common mental health disorders	Sophie Walsh	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
25th April 2016	2pm	COFI - Comparing functional and integrated systems of mental health care	Thomas Booker	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
9th May 2016	2pm	Retention of participants with mental health problems in non-pharmacological clinical trials	Paulina Szymczynska	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
16th May 2016	2pm	Social network assessments for schizophrenia	Claudia Gulea	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
23rd May 2016	2pm	The involvement of family & friends in mental health treatment	Aysegul Dirik	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
6th June 2016	2pm	Discussions around sex satisfaction in psychosis	Neelam Laxhman	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
13th June 2016	2pm	Hospital Environment Study	Nikolina Jovanovic	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
20th June 2016	2pm	VOLUME - Progress on the trail By Aida Farreny	Aida Farreny	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
27th June 2016	2pm	Long-term outcomes of psychiatric treatment	Gonca Bastug	Lecture Theatre, Academic Unit, Newham Centre for Mental Health
4th July 2016	2pm	The nature of the befriending relationship: findings from qualitative interviews	Megan Cassidy	Lecture Theatre, Academic Unit, Newham Centre for Mental Health

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