Using outcome measures in training
Recovery in the bin
A bumper bag of correspondence
Health locus of control in mental health
Clinical Psychology Forum

Clinical Psychology Forum is circulated monthly to all members of the Division. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial team welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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I S IT JUST ME or are Freudians getting Junger? No real reason for that other than it’s my favourite psychology joke of the month. As March is my birthday month, I hope you’ll allow me that little pleasure. Whilst we’re in a humourous mood, please have a look through the wonderful Experts by Experience column this month ‘A simple guide on how to avoid receiving a diagnosis of “personality disorder”’. I’m aware that it’s probably not everybody’s cup of tea, but I think it offers some interesting and serious points, presented in a light-hearted way. I love it, and it presents some important messages for us as professionals. It was produced by a group of people with lived experience who go under the banner ‘Recovery in the Bin’. Apparently, they are very active on Facebook. I don’t use that social media forum, but if you do, I suspect it is well worth having a look. I know they are quite an active group. Social media is really helping with the development of clinical psychology and making it a place where the evolution of our profession isn’t just a top down process; we are in a time where the service user movement is probably stronger than it has ever been, and rightly so in my book!

It’s interesting seeing a Pre-Qualification Group Column and a series of three articles from the clinical psychology training community sitting within the same issue. They make an interesting ‘compare and contrast’. Thank you to the Yorkshire clinical psychology programmes as well as Health Education Yorkshire and the Humber for this contribution. It is interesting that a this comes at a time when we are seeing the DCP nationally engage with a big clinical outcomes project, as mentioned in Richard Pemberton’s ‘Notes from the Chair’, in which he draws our attention to the interaction between outcome measurement and service contracts stating: ‘It is fraught with complications and if one isn’t careful, perverse incentives’. I guess the message for training providers is that we must always see our work within the bigger picture as well as at the level of individual trainee and client experience. We see this mirrored in the content of the Pre-Qual column looking at the quality of teaching, with conclusions including the comment: ‘In the current context of funding cuts to many courses, it is understandable that courses cannot feasibly attain the highest absolute standards in every key area and that courses already undergo stringent controls regarding the overall quality of the training they provide’. Interesting stuff, my friends. Check out the correspondence section too, there’s certainly plenty there to wake us up.

Happy reading.

Steph
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Clinical Psychology Forum 279 – March 2016
Correspondence

Clinical Psychology Forum free for all

IT NOW seems possible to argue that, since around 2008, clinical psychology in the NHS has become increasingly peripheral. This is perhaps most persuasive in secondary mental health services. One could also tentatively say it puts the brakes on a golden age of development for applied psychology in the UK. Whilst an obvious approximation, the year 2008 is a significant one. This is the year US investment bank Bear Stearns collapsed and heralded the start of the financial crisis. Fast forward to the present, and we are left examining the impact on society of this crisis. What emerges is interesting. Firstly, investment banks deemed ‘too big to fail’ meant misallocation of capital was not punished by loss. It appears this breach of the rules of capitalism has accelerated exponentially the gap between rich and poor. It would seem, therefore, that society’s need for clinical psychology has never been greater. Secondly, a renewed discourse of welfare austerity has resulted in a realignment of talking therapy in the NHS toward leaner and narrower approaches. This is despite the UK government committing £1.2 trillion to bail out the financial sector at the height of its crisis (National Audit Office, 2013), or the paradox of NHS under-spend (PULSE, 2013). One might then reflect on other UK industries of the past that did not benefit from a government bailout when the going got tough, and have now all but disappeared.

Mulling this over, it seems that profound change does in fact take place despite a human tendency to deny it. One also arrives at the idea that clinical psychology in the UK could ultimately be linked to the fate of the NHS, or that fate might actually one day lead the profession back to a purely technical role. What I keep coming back to is one of the reasons I wanted to train as a clinical psychologist in the first place. Genuinely, it came down to what was talked about and discussed in Clinical Psychology Forum. It was an intellectual and scientific aliveness brought to bear on the human condition that really got me going. Something that many online activists have argued comes to mind here: that keeping both computer software and hardware ‘open source’ is a key way of keeping the internet equitable (Assange, 2012). This seems to be another way of articulating the old truism that knowledge is power.

What I want to suggest is that Clinical Psychology Forum embraces this notion and allows full online access to its content free of charge for everyone. Technology now makes it simple to provide a free, fast, usable and searchable database of papers online. The DCP could adopt a standard business model by restricting access to recent issues to subscribers only. The Division would also enjoy an additional revenue stream from internet site traffic. Importantly, the picture I have of policy makers, NHS managers, journalists, talented graduates and service users having their own intellectual epiphany is a beautiful one. In this fundamentally different NHS, where the Secretary of State now only ‘promotes’ rather than ‘provides’ healthcare for all, a move like this could prove vital for applied psychology. Over to you DCP.

Ben Donner
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References


We want to hear from you!

Do you have an opinion on anything in Forum or clinical psychology generally? Why not write to us?

Please send all letters for publication to:
Sue Maskrey, CPF Administrator
(s.j.maskrey@sheffield.ac.uk).
The Enigma of ‘leadership’

ANYONE in the NHS at the moment can’t fail to have been exposed to a new revitalised ‘leadership’ agenda which seems to have captured the imagination of senior NHS managers. It’s now seen as so crucial to our development that, at least in our trust and probably yours, it has been introduced across the board and is striving to embed itself in our consciousness along with fire safety, infection control and all the other mandatory awareness skills that we can’t function properly without.

I found myself sat in the leadership half day course struggling to understand the terminology and puzzling how I was meant to apply this to everyday working life. I thought I understood broadly what leadership was, but ended up confused and wondering was there a parallel ‘followership’ course further down the corridor that I should have been attending instead. Unfortunately, it turns out that as a psychologist I could well be professionally negligent, inhibit patient outcomes, not justify my pay grade and fail the organisation for my inability to understand never mind aspire to ‘leadership’. If that’s not bad enough, I am also in now in danger of losing ground to doctors, social workers, nurses, occupational therapists and health service managers who are also busy learning how to be leaders.

Ignorance isn’t a strong justification to dissent to a seemingly universally accepted wisdom, so I turned to some of the extant literature, including the NHS Leadership Academy website. Despite the large volume of information I must say that my anxieties to understand professional ‘leadership’ were not greatly mollified and even Sarah Dexter-Smith, Jenny Oddy and Tim Cate’s enthusiastic letter in December’s Forum didn’t help, despite providing me with my own ‘Applied Leadership Profile’ flashcard. Having given all this some thought I managed to draft out three intellectual concerns that may well be preventing my understanding this growing but seemingly muddled epistemology.

Firstly, no matter how you sweeten it, the notion of a ‘leader’ starts from a position of individualised hierarchical control and a power relationship with ‘followers’, which seems at odds with the values and skills that I recognise in working life. My experience of the best clinical practice is about collaboration and shared problem solving where leadership might emerge out of meaningful relationships with others, sometimes through a process of sapiential authority, at other times by simply who has the less pressing caseload. ‘Leadership’ in this sense is fluid and dynamic process that is focused upon a specific goal or project rather than a set of skills to be operationalised, put on competency checklists and then done by one person to another.

Secondly, and seemingly antithetically to the first point, whilst the NHS leadership discourse is rooted in elite individualism, it is also at the same time being promulgated as a necessity for everyone. The acquisition of leadership skills and mindset seems no longer aspirational for a chosen few; it’s actually now being spoken of as an essential part of good working practice for all. However, democratising it doesn’t make it by definition valid or attractive to me, and if we are all striving to become leaders then how do we share power, and whose job is it to be a follower and just how far are we stretching the definition of leadership and to what purpose.

The third concern relates to my suspiciousness of the fact that the ‘leadership’ agenda exemplifies pretty well how large institutions of state misappropriate language in the service of their own organisational and political ends. It perhaps comes as no surprise that the language of neo-liberal individualism finds its way revitalised into the new Conservative NHS.

My own struggles with leadership then, seem to be about both the value of concept itself and the way it is being used within the NHS. The moral philosopher Harry Frankfurt (2005) notes that the essence of bullshit is a lack of respect for the ‘truth’ of language and perhaps the chief skill of clinical psychologists in listening and communicating with patients is to develop a heightened sensitivity and respect for the precision of language and meaning. This may well not be equipping me well to be transformed through leadership as I’m getting far too distracted by the smell.

Andrew Ganley
Clinical Psychologist
The Surviving Work Survey

IF YOU’RE WORKING in mental health, it’s time to talk about money. Whether you’re a psychologist or counsellor the growing reality is that you’re probably concerned about earning enough to sustain yourself in the current mental health job market.

Why are we doing the Surviving Work Survey?
An important report by the British Psychoanalytic Council and the UK Council for Psychotherapy about the working lives of psychotherapists concludes that there has been a 77 per cent increase in complex cases and 63 per cent of clients reporting that NHS therapy was too short to do any good. Mental health workers report that the reality of working in mental health and containing increasing levels of distress is becoming unsustainable.

The lack of understanding about employment relations in the sector exposes a range of problems faced by mental health workers, including the growth of contract and agency labour, the use of unwaged labour, the insecurity of ‘permanent' employees in the NHS. For psychotherapists and counsellors this can lead to the retreat into private practice. Because of the growing insecurity of work in mental health and the fear of blacklisting of individuals who raise their concerns, people are often unwilling to speak up at work. As a result, not much is known about what is happening to wages, working conditions and clinical practice in our sector.

Why is the surviving work survey being conducted?
The aims of this survey are to help us build a map of the trends in working conditions for psychotherapists and mental health workers in the UK. Through the Surviving Work Survey and anonymous case studies we want to create a map which measures:
- unwaged and honorary work;
- growth of private contractors and private employment agencies providing clinical services;
- trends in wages and earnings in the sector;
- impact on clinical supervision and professional practice;
- impact on our relationships at work.

As we build a picture of our sector, we will produce infographics and an online map to raise awareness and encourage debate about the future of work in mental health. As a research team we will produce journal articles and carry out a series of debates and events.

Who is conducting the research?
The research will be jointly carried out by:
- Elizabeth Cotton, Surviving Work & Lead Researcher
- Leanne Stelmaszczyk, British Psychoanalytic Council
- Clare Gerada, Practitioner Health Programme
- John Grahl, Professor in Economics, Middlesex University

The lead researcher for the project is Elizabeth Cotton. If you would like to contact her anonymously to help build up a picture of what is happening in our sector, please feel free to e-mail her directly at the address e-mail below.

Anonymity
We guarantee that all information submitted will be anonymised and used only for the purposes of this mapping exercise. Any information you submit will be held anonymously by Surviving Work and will not be passed on to your employer or any professional body. We will not use your data to try to sell you anything, nor will we make any commercial gain from the information you give us. We ask participants to provide us with a personal e-mail address so that we can follow up with phone interviews to deepen our understanding of the issues faced.

Dr Elizabeth Cotton
info@survivingwork.org

Take the survey:
www.survivingwork.org/surviving-work-survey

Surviving Work Survey leaflet:

How to Survive Work article:
www.survivingwork.org/how-to-survive-work-as-a-psychotherapist
**To claim or not to claim...?**

During the past 12 months there has been increasing discussion among clinical psychologists about the Widening Access Training Scheme, which relates to NHS staff who were also in full-time education between 1999 and 2013. Under this scheme, it might be possible for such staff to claim back some of the income tax they paid on their earnings during education. Our understanding is that this tax exemption was designed for people who were mandated by their NHS employer to swap their normal working pattern for a taught course, and was intended primarily to encourage nursing staff to explore ongoing learning opportunities.

It is, of course, also possible to frame clinical psychology training in this way. However, as clinical psychologists we are encouraged to be critical and reflective, and we have been surprised by the absence of discussion in public forums about the ethics and politics of claiming back income tax. We hope, therefore, that this letter might be a way of stimulating discussion.

Questions about which we are curious include:

- Do we want to run the risk of making it appear more expensive to train clinical psychologists, particularly when qualified posts are being cut?
- Where exactly will the money to pay us come from, particularly at a time of ‘austerity’ – and how much might the total cost to the taxpayer be?
- Is it ethical for relatively powerful and comfortable professionals to claim tax rebates?
- Does the spirit of the Widening Access scheme truly apply, given that we presumably accepted our coveted places on the understanding that we would be paid – and taxed – a clearly defined amount throughout training?

There may be no simple answers to these questions, nor to the one that preoccupies us the most: what would the users of our services think?

Dr Joe Judge (@JoeJudgePsy)
Dr Simon Stuart (@soothron)
Glasgow

**Re: Voluntary psychology internships**

I COULDN’T agree more with Vaughan Bell (CPF 275, November 2015) regarding voluntary psychology internships. My colleagues and I have found over many years that the following criteria works well for us and volunteers:

- Refer to it as ‘volunteer placement experience’, which implies that it’s about gaining relevant experience and contributing to a useful piece of work in a psychology service.
- Limit it to one day a week maximum.
- The volunteer works with a maximum of two psychologists, on a specific project (e.g. an audit, developing a questionnaire).
- The psychologists liaise and communicate clearly with the volunteer and each other.
- The volunteer attends psychology meetings, if feasible, to become informed about services and the NHS.
- A list of duties and responsibilities are agreed and signed up to.
- The placement is reviewed at three and six months and lasts no longer than a year.
- The placement is reviewed within appropriate Trust policies.

In my experience these placements have been highly valued by volunteers and psychologists, with an acceptable input by both parties.

Marie Stewart
Principal Clinical Psychologist in Medicine Psychology Service, Lancashire Teaching Hospitals Trust, Preston; marie.stewart@ltchr.nhs.uk
Pre-Qualification Group Column

A survey of UK clinical psychology doctoral training on specialty issues

Stephanie Minchin, Sophie Neech, Jacqui Scott, Katherine Nutt & Ian Asquith

THE DCP Pre-Qualification Group (PQG) conducted a survey of trainee’s experience of teaching in four speciality areas of clinical psychology: addictions, clinical health, perinatal psychology and older adults.

The survey was designed in collaboration with the Faculty of Addictions, Faculty of Clinical Health Psychology, Faculty of Perinatal Psychology, and Faculty for the Psychology of Older People; all a source of expertise on the specialist issues relating to their respective areas. Members of the respective faculties are supported with a forum for the exchange of expert knowledge and skills. Each faculty aims to liaise with professional bodies, consult on policies and national guidance documents, promote research and educational training and share examples of best practice.

As trainees, we are aware of the broad and dynamic nature of clinical training. The aim of the survey was to give a general understanding of trainee experiences in four key areas of training, in order to inform the PQG, the DCP faculties and course providers of future training needs in these specialities of clinical psychology.

Method

A consultation process with each faculty committee encouraged the team to explore the competence of each of the specialist areas and formulate the research questions. An ethical opinion was sought from the British Psychological Society Policy Team Lead Advisor, as well as guidance and feedback from the Group of Trainers in Clinical Psychology.

To account for learning being progressive across the three years of training, the survey was distributed to third year trainees only, as they had completed their academic teaching. The key research questions were:

- What is the extent of teaching on topic areas relating to key competencies for the specialist areas of clinical psychology being investigated?
- What experience in the specialist areas of clinical psychology are trainees gaining from placements?
- What experience in the specialist areas of clinical psychology are trainees gaining from research conducted as part of their course?
- How confident do trainees feel about working in these specialist areas of clinical psychology?
- Would trainees consider working in one of these specialist areas upon qualification?

The survey was created on a QuestBack online survey tools and abided by research ethics such as maintaining anonymity and confidentiality. The survey was e-mailed to final year qualifying trainees via course directors on all 32 DClinPsy training courses in the UK.

Results

There was a total of 76 respondents (13 per cent of national sample) from 21 of 32 courses (66 per cent of courses surveyed).

Faculty of Addictions

The Faculty of Addictions aims to foster effective psychological services and practice, providing a forum for presentation and dis-
cussion of issues, experiences and findings in addiction work.

The majority of survey respondents (66 per cent) felt their teaching on addiction was ‘inadequate’, one out of five respondents indicated that alcohol and illegal drug misuse was not covered on their course. Some 46–66 per cent had no teaching on misuse of prescription drugs, gambling difficulties or working with affected others. Trainees wanted further teaching in these areas, along with other addictions (i.e. sex and the internet).

Despite a lack of teaching, 92 per cent of trainees surveyed thought addiction psychology was relevant to their work, and 37 per cent would consider working in addictions. Over 80 per cent had some exposure to clients with drug or alcohol difficulties, and 46 per cent had worked independently with at least one client where this was a key issue. This fits the national picture within mental health services, where it is estimated that 30–50 per cent of service users have difficulties with substance misuse (Rethink, 2004; Petersen & McBride, 2005; MHF, 2015). The majority of this trainee work was outside addiction services; only 5 per cent of respondents had a specialist placement.

Almost half of trainees surveyed indicated they did not feel confident working with illicit drug use issues or with family members affected by addiction; however, half reported feeling confident working with alcohol difficulties (Figure 1). An understanding that substance use increases risk of suicide (MHF, 2015) is important within clinical psychology, and addictions need to be considered in mental health settings. Anecdotal evidence suggests community mental health team colleagues do not feel confident working with addiction-related issues and less than 40 per cent of community mental health teams routinely screen for substance misuse (Strathdee et al., 2002).

Additional training on addictions may help trainees explore links between mental health and addiction difficulties, or dual diagnosis. For example, recognising that individuals with a diagnosis of bipolar, personality disorder or psychosis are more likely to consume alcohol to problematic levels (Moran, 2006), and cocaine users may have symptoms suggesting a diagnosis of affective or personality disorder (Crome & Chambers, 2009).

The Faculty of Addictions recognises that lack of teaching and placement opportunities remain perennial problems, and will use audit data to inform future CPD events. The Contribution of Clinical Psychologists to Recovery-Orientated Drug and Alcohol Treatment Systems (BPS, 2012) highlights how clinical psychology can make meaningful contributions and support individuals and teams when working with co-occurrence of addiction and mental health difficulties.

Figure 1: Self-reported levels of confidence in final year trainees relating to areas of addiction work

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<thead>
<tr>
<th>Area</th>
<th>% Confident</th>
<th>% Neither</th>
<th>% Not confident</th>
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<tr>
<td>Affected others</td>
<td>34</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Gambling</td>
<td>14</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Alcohol misuse</td>
<td>50</td>
<td>29</td>
<td></td>
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<tr>
<td>Prescription drug misuse</td>
<td>30</td>
<td>53</td>
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<td>Illicit drug use</td>
<td>39.5</td>
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The Faculty of Clinical Health Psychology aims to support psychologists working clinically in services for people with physical health conditions, their families and carers. Clinical health psychology is a growing area due to recent government policies that point towards integration of physical and mental healthcare (DH, 2011; NHS England, 2014), and due to research which suggests that 12–18 per cent of NHS expenditure on long-term health conditions is linked to poor mental health and well-being (Naylor et al., 2012).

For this survey, competencies for clinical health psychology were drawn from the DCP (2009) good practice guidelines for training providers. The majority of respondents reported that their teaching covered many of the competencies ‘moderately’, ‘a lot’ or ‘extensively’. However, 14.4 per cent of respondents reported overall that teaching was ‘inadequate’. Some competency areas stood out as having less teaching; for example, 69.7 per cent reported that ‘health economics in service evaluation/audit’ was covered ‘a little’ or ‘not at all’. This is of concern as it becomes increasingly important for psychologists to have a role in developing services and advocating for the benefits psychology brings to healthcare settings economically as well as clinically.

Regarding clinical experience, 65.8 per cent of respondents had completed at least one specialist placement in clinical health psychology, and many had gained clinical experience through other placements, resulting in 91 per cent reporting direct independent experience of ‘complex formulation including health conditions’. Despite this, reports of indirect experience, such as ‘engaging service users, families or carers in service delivery’ and ‘teaching or consultancy in healthcare contexts’, were much lower at 38.2 per cent and 36.9 per cent respectively.

Reported levels of confidence in applying competencies in clinical health psychology largely appear to reflect the reported level of teaching, and are shown in Figure 2. In terms of research, 17 per cent of respondents had conducted their doctoral research in clinical health psychology, suggesting that clinical health psychology is of significant research interest to trainees. However, the Faculty of Clinical Health Psychology would hope that
more of this research would be disseminated, and will consider ways they might support this.

The vast majority of respondents (90.8 per cent) reported finding clinical health psychology relevant or very relevant to their work, with 50 per cent saying they would quite likely or definitely consider working in the area. With the increase in numbers of clinical psychology posts in health settings (Busuttil & Southall, 2015), qualifying psychologists are needed with the skills and enthusiasm to take on these positions.

The Faculty are keen to support the development of trainee skills in clinical health competencies, and will consider the results of this survey in future CPD events, guidance documents and other support for pre-qualified members.

Faculty of Perinatal Psychology
The Faculty of Perinatal Psychology aims to provide a forum for clinical psychologists working with women who are pregnant or in the postnatal period, and their families. This is important as psychiatric causes have been identified as the greatest reason for maternal death in the perinatal period (Lewis, 2007) and the cost of perinatal mental health problems in the UK is £8.1 billion per year (Bauer et al., 2014).

The outcome of the survey (see Figure 3) indicated only 2.6 per cent felt they were receiving adequate teaching on perinatal issues. The majority of trainees (64.4 per cent) reported that attachment was covered well, and some trainees felt infant development (35.5 per cent) and parental mental health (21 per cent) were also taught extensively. The areas with limited teaching included: foetal medicine and diagnosis; fathers in the perinatal period; fertility issues; fear of childbirth and perinatal loss. Over 90 per cent of respondents stated that these were not covered or only covered a little.

There is recognition that this is a highly specialist area of clinical psychology, but also that trainees and qualified psychologists may encounter this work within multiple settings. BPS (2014) standards for clinical psychology doctoral programmes indicate that teaching

![Figure 3: Perinatal teaching coverage](image)

- Perinatal loss
- Fear of child birth
- Fertility issues
- Fathers in perinatal period
- Foetal medicine and diagnosis
- Parental mental health (general)
- Infant development
- Attachment difficulties

- Not covered at all
- Covered little
- Covered moderately
- Covered a lot
- Covered extensively
should be received on specialist presentations, but emphasise the reality of working with multiple complexities and the skills needed for transtheoretical applications. Challenges also remain about identifying specific perinatal teaching, as aspects may be covered within other areas including: adult and infant mental health; attachment; developmental psychology; and loss.

The majority of respondents had direct clinical experience of: attachment difficulties (75 per cent); parenting interventions in the context of parental mental health (54 per cent); and of general parental mental health (50 per cent). It appeared this clinical experience in a context of limited teaching may have impacted on the confidence trainees reported in working with these difficulties. Trainees reported being quite or very confident in attachment difficulties (73.7 per cent), parenting interventions in the context of parental mental health (63.2 per cent), and general parental mental health (60.5 per cent). There were, unsurprisingly, low reports of confidence in the areas where trainees had both limited teaching and clinical experience. Although there were limited clinical experiences in many areas 81.6 per cent of respondents felt perinatal mental health was relevant to their work and 56.5 per cent stated they would consider working in this area.

NICE (2014) guidelines recommend that there should be specialist perinatal multidisciplinary services in every locality to include access to mental health support, so clinical psychologists may experience situations where they need to offer specialist advice or input. The Faculty of Perinatal Psychology have included aims within their strategic plan to support the expansion of a knowledge base in this area both through liaising with relevant academic and professional bodies, and via training. The results of this survey could support this by identifying areas of need.

Faculty of Psychology of Older People
The Faculty for the Psychology of Older People (formerly PSIGE) aims to highlight the importance of psychological issues in how we age; challenge stereotypes and age discrimination; and provide and encourage education about late life issues.

Whilst the British Psychological Society (BPS, 2015) standards document recommends that courses should provide adequate models for working with older people, the Faculty for the Psychology of Older People (PSIGE, 2006) produced additional guidance on topics (e.g. dementia) which should also be considered.

The survey results illustrate the extent to which selected areas from the PSIGE (2006)
guidance were covered. As can be seen from figure 4, the survey results indicate that areas such as dementia, mental health and neuropsychology were generally covered a lot or extensively. Death, dying and palliative care, carer work and physical health difficulties were also generally well covered during teaching. Attachment, relationships in relation to sexuality and spirituality, care home and voluntary service work, and supervising staff were less well covered. Of the trainees surveyed, 94.8 per cent felt that older adult psychology was relevant to working as a clinical psychologist, and 84.2 per cent reported receiving at least adequate training.

Trainees felt that dementia, mental health, physical health difficulties, neuropsychology and working with carers were either extensively covered or covered a lot (over 80 per cent for all) on placement. Over 50 per cent of respondents had a lot or extensive experience of working with attachment, sexuality, spirituality and care home work on placement. In comparison, dying, death and palliative care training appeared mixed, with trainees reporting either gaining extensive experience or no experience. Most respondents felt that they had little experience of supervising staff in older adult issues. Whilst most trainees reported having an older adult placement, a minority (17.1 per cent) reported not having one.

When asked about their confidence in working with the older adult areas, they felt that issues relating to mental health, dementia, physical health, neuropsychology and working with carers could be approached with confidence. Trainees generally felt confident in working with attachment, supervision and care home work, but were less confident in working with death and dying.

In terms of research, 11.8 per cent reported completing their thesis, 7.9 per cent reported completing a small scale research project, 2.6 per cent reported completing a thesis and a small scale project with older people. Overall, 34.2 per cent of people felt likely to work with older adults; 31.6 per cent reported maybe, and 34.2 per cent reported that they would not wish to work in this area.

The results suggest that training covers older adult psychology well, particularly ‘core’ aspects, such as dementia, mental health and neuropsychology. Whilst some areas (attachment, sexuality and spirituality) could be improved upon, overall standard of teaching and placements was high; the areas for improvement have informed future CPD ideas.

Conclusion
As a project team we understand that all courses are different and some may choose to place more emphasis on certain areas over others; we value this diversity. In the current context of funding cuts to many courses, it is understandable that courses cannot feasibly attain the highest absolute standards in every key area and that courses already undergo stringent controls regarding the overall quality of the training they provide. Furthermore, local services differ in what they can offer to clinical training, such as the availability of ‘experts’ to deliver teaching and offer placements.

Reflecting upon the low response rate, the project team has critically considered what may have created barriers to responding to the survey. Possible explanations may include: the distribution of the survey via course directors and admin staff, and thus possible delays in the circulation of the survey link; the timing of the survey being open when qualifying trainees are finishing thesis projects and writing article submissions; and qualifying trainees shifting their visions towards new employment posts rather than training needs. However, despite the low number of respondents we believe that the project has highlighted the trainee voice and experience of the teaching in specialist areas of clinical psychology, and created awareness of further training needs.

The survey was successfully presented by the project team at the DCP Annual Conference (2015) in the Pre-Qualification Group Symposia, ‘Shaping Things to Come: Understanding The Self, Team and Training’. The survey results will also be fed back to clinical training courses, including directors and trainees.

Course providers may wish to consider the particular strengths of their course as seen by
their own trainees, and which areas need developing. DCP faculties may use the survey results to consider future work as a faculty, such as generating interest in their specialist area, developing guidelines, and provision of CPD events to supplement training and post-qualification professional development.

The Pre-Qualification Group wish to ensure that the voice of its membership is considered in the development of training and the profession of clinical psychology. Therefore, the project informs the pre-qualification group, faculties and organisers of doctorate courses about future learning needs of trainees and newly qualified psychologists in these specialist areas.

Acknowledgements
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References
Experts by Experience Column

A simple guide on how to avoid receiving a diagnosis of 'personality disorder'

Recovery In The Bin

1. Try not to be female (for borderline personality disorder).
2. Do not argue your point-of-view with the professionals.
3. You cannot be seen to like some staff members more than others (this is splitting behaviour).
4. Do not under any circumstances harm yourself. This will more than likely be seen as:
   (a) manipulative, (b) attention seeking, or (c) a communication of your distress caused by your underlying personality disorder.
5. Do not make statements which can be interpreted as ‘black and white thinking’. For example, ‘The nurses all hate me’. Try instead to make unrealistic, robot like, rational statements such as ‘Enid, Mary, Silvia, John, Mark and Boteng have all shown epic distain at my presence on the ward, but an agency nurse once smiled at me in 1992.’
6. Do not admire or pin any hope to a professional who appears to understand the social context of your distress (this is idealisation, my dear).
7. Do not complain about anything. Ever.
8. Try to avoid working with professionals who look a bit tired. If they eventually go off sick you will inevitably be blamed for this. (Naturally, because you are a difficult patient.)
9. Things you can talk about: how medication is helping you, mood swings (but only extreme ones that last long enough to fit within a diagnosis of bipolar; that’s an okay one as Stephen Fry made it a bit edgy). Do talk about how much the system is helping you, be eternally grateful to every professional you meet, tip your hat slightly to the side and say the words ‘Thanking you kindly for your help, sir/madam’.
10. Things you should not talk about: abuse of any kind, patterns in your relationships because of this abuse, existential dilemmas, perceived flaws in the system or anything to do with individual staff members.
11. You never ever over/under eat, drink or exercise, and are never impulsive with sex, shopping or driving, and you love being alone.

12. If you are from cultures seen as ‘traditional’, never say you even think about sex unless you are in a proper family approved heterosexual marriage.

13. To avoid BPD diagnosis you must not point out that the psychiatric teams are blaming you for their own inadequacies, their ‘externalised locus of control’ and ‘refusal to take responsibility’.

14. Do not tell the psychiatrist you think you may have post-traumatic stress disorder. (Don’t be stupid now, everyone knows only soldiers can get this. Are you a soldier?)

15. They are addicted to using pro re nata medication to relieve their anxiety, instead of more ‘adaptive’ coping strategies. Only problem is, you have to take it.

16. Talk with enthusiasm at the idea of being abandoned. Relish the idea whether it’s real and/or imagined.

17. If you attempt suicide make sure you are successful or it will be deemed attention seeking.

18. If you do by chance happen to self harm, make sure it is a life threatening, Stephen King style canyon of a gash. Anything less than this will be clinically defined as ‘superficial’, adding to the likely hood of the personality disorder label being applied.

19. Borderline personality disorder diagnosis is a mirror to a professional’s behaviour, described as the personal characteristics of the service user.

20. Never phone the crisis team and say you’d like another visit (tick-box dependency issues).

21. Hide any teddy bears or such like when they come round to visit (‘too childish’).

22. Never refer to your psychiatrist’s affection for the Diagnostic and Statistical Manual as ‘ideas of reference’.

23. When they suggest cutting back on support, appointments, etc., pause and think and then say, ‘Yes, that’s good, I feel I am ready to be more independent’.

24. Be attractive but not ‘coquettish’.

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I'm sure we have meds for acronyms

It's not just for soldiers. War is not in the PTSD acronym! *sigh*
25. Do not at any point mention that you sometimes question who you are. You should know exactly who you are. Be definite and unchanging about this (only people with personality disorder ever question their identity).

26. Do not change your hair colour too frequently. This will be interpreted as evidence of the above.

27. Always repeat when questioned that your attachment with your mother and father was always loving and supportive.

28. All depression, voice hearing and suicidality is ‘pseudo’, so please ensure the death certificate is recorded as ‘pseudo death’, and according to Joel Paris MD it was a ‘career’, so make sure your CV is updated posthumously.

29. Remember that inequality does not exist; it is your perception that is flawed.

30. Never, if you can manage it, express anger to mental health professionals. Even when it’s understandable, genuine and valid!

31. The appropriate response following an overdose to the question ‘How much did you take?’ is not ‘Clearly not enough’. This is also likely to get you sectioned.

32. Never become a ‘skilled’ service user. Understanding the games that nurses play will only get you described as ‘playing games’.

33. Your mental health team believes in its adequacy, despite all evidence. Do not do or say anything that threatens professionals’ fixed delusional beliefs, they may ‘decompensate’, becoming either coldly punitive and violent, or weirdly smiley and dissociative, forcing you to have too much ‘service’ and then none at all.

34. Don’t ever ask a mental health professional to ‘see you all the time and kiss your cuts better’ (as stated by a personality disorder expert).

35. Act dumb as intelligence is viewed as a facet of personality disorder (unlike psychosis where its assumed you’re less intelligent).

36. Failure to respond to medication or to ‘recover’ (or the Community Mental Health Team needs to reduce numbers with discharges) means reclassification to personality disorder.

**Disclaimer**

You do not have the right to say anything without it being used against you. Anything you say can and will be used against. You have the right to legal assistance. If you cannot afford legal assistance, you are buggered. Do you understand the rights I have just read to you? With these rights in mind, do you wish to engage in our therapeutic relationship?
Recovery In The Bin

Recovery in the Bin is a user led group is for mental health survivors and supporters who are fed up with the way colonised ‘recovery’ is being used to discipline and control those who are trying to find a place in the world to live as they wish, and trying to deal with the very real mental distress they encounter on a daily basis. We believe in human rights and social justice!

We want a roust Social Model of Madness, Distress and Confusion, from the left of politics, placing mental health within the context of the wider class struggle.

We consider ‘UnRecovered’ to be as valid and legitimate as ‘Recovered’, and we accept and respect the political and social difference. So some of us have accepted a new word/signifier ‘UnRecovered’. However, this doesn’t mean we want to stay ‘unwell’ or ‘ill’ (whatever that means), but that we reject this new neo-liberal intrusion on the word ‘recovery’ that has been redefined, and taken over by marketisation, language, techniques and outcomes.

We recognise that the growing development of mental health ‘Recovery’ in UK/US during the past decade or so has been corrupted by neo-liberalism, and capitalism is the crisis! Some of us will never feel ‘Recovered’ living under these intolerable and inhumane social pressures.

We believe that there are core principles of Recovery that are worth saving, and that the colonisation of Recovery undermines those principles, which have hitherto championed autonomy and self-determination. These principles cannot be found in a one size fits all technique, or calibrated by an outcome measure.

We ask that mental health services should never be but anyone under any pressure to ‘recover’, by over emphasising or even imposing ‘Recovery Stars’ or ‘Wellness Recovery Action Plans’. We stand opposed to mental health services using ‘Recovery’ ideology as a means of masking greater coercion.

The British Psychological Society Division of Clinical Psychology

Clinical Psychology Forum
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Edited by Tony Wainwright & Steven Coles

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Residents' experience of ward rounds in a forensic rehabilitation setting

Rosanna Chapman, Niamh Ingram, Leigh Collyer & Shereen Brifcani

This survey explored service user’s experiences of attending ward rounds in a forensic rehabilitation setting. The findings highlight a need for clarity about the purpose, increased involvement of other professionals and greater efforts to reduce service user anxiety.

WARD ROUNDS are multidisciplinary team (MDT) meetings that aim to review and evaluate client treatment on a weekly or fortnightly basis (Baker, 2005). The ward round process forms an integral part of inpatient care, acting as a forum for both clients and professionals to discuss care in accordance with the principles of the Care Programme Approach. However, it has been suggested that up to half of psychiatric service users report negative experiences of their ward round (Foster et al., 1991), with some feeling that the process is uninformative (Ballard & McDowell, 1990) and can evoke feelings of intimidation, fear and interrogation (Labib & Brownell, 2009; Wagstaff & Solts, 2003).

Anxiety prior to ward rounds has been associated with a dislike of large groups and feeling unable to express opinions (White & Karim, 2005). The perception of ward round as being intimidating and stressful may also lead to inaccurate memories of the meeting itself (Wagstaff & Solts, 2003). In addition, the presence of many people during ward rounds is positively associated with service user dissatisfaction (Labib & Brownell, 2009; Wagstaff & Solts, 2003; White & Karim, 2005). Despite the finding that ward rounds are attended by many people, research has highlighted that the medical profession is often the sole communicator, with a under-representation of other MDT members (Wagstaff & Solts, 2003), including psychologists (Hodgson et al., 2005).

Other studies have highlighted the lack of clarity about the purpose of the ward round process, with around half of both staff and service users in a psychiatric setting being unable to explain the purpose of ward rounds (Milner et al., 2008). Clients have also reported the belief that information is withheld during ward rounds (Labib & Brownell, 2009) and have felt separate from decision-making processes (Wagstaff & Solts, 2003). The type of ward also impacted on feelings of inclusion: clients on locked wards were less likely to feel involved in treatment decisions than those on less secure wards.

However, previous research involving staff and service users have suggested various ways of improving the ward round experience, such as conducting shorter daily ward rounds rather than lengthy weekly meetings (Fiddler et al., 2010) and being given the option to invite people to the meeting (Baker, 2005). Also, providing timeslots and the opportunity to meet with their consultant prior to ward round have both been associated with higher ward round satisfaction (Labib & Brownell, 2009; White & Karim, 2005).

Project aim
The current project was initiated by a clinical psychologist (author 4) who worked at a 17-bedded private forensic rehabilitation unit based in the Midlands. The principal aim was to gain an overview of residents’ views and levels of satisfaction regarding ward rounds, with the intention of using the information to tailor the process to meet service user needs. This was timely given the level of dissatisfaction of the process reported in the literature.
and, to our knowledge, only one previous study has investigated the views of forensic service users about their ward round experience (Baker, 2005).

Method

Participants
Seventeen male residents from the unit (ages 25–70 years) were approached about the study, and 11 provided informed consent to take part in the survey in April 2010. One participant failed to complete the interview, and therefore 10 responses were included in the analysis, which represented 59 per cent of the residents at the unit. The majority of participants had a history of violent offences (none of a sexual nature) and diagnoses included psychosis, personality disorder and mild learning disabilities. At the time of interview, the length of admission of participants ranged from approximately three months to two years.

Measures
In ward round research, it has been found that quantitative and qualitative methods may yield different outcomes, with global satisfaction ratings being generally positive and more specific questioning yielding less favourable outcomes (Lovell, 1995). Therefore, a variety of data collection methods were used, with the aim of capturing a more accurate representation of resident opinions.

A semi-structured interview was developed using themes reported in the literature, as well as feedback from the independent patient advocate and a number of staff in Occupational Therapy, Social Work and Nursing departments (interview schedule can be requested from the author). Questions were designed to assess the residents’ experiences of five aspects of the ward round process, namely: (i) understanding of purpose; (ii) staff issues; (iii) practicalities; (iv) usefulness; and (v) feelings associated with the meeting. A sixth section was included to collect overall views, which allowed for areas that had not been addressed. All sections included open and closed questions, and 10-point Likert rating scales to provide satisfaction ratings.

Procedure
Semi-structured interviews were conducted by an assistant psychologist (eight interviews) and an independent patient advocate (two interviews). The assistant psychologist was based at another hospital and came to the current setting for one day per week to carry out interviews for the purpose of the current study, and also to provide a five-week group intervention. Responses were recorded verbatim and analysed by three independent raters (assistant psychologists) who were not part of the interview process. Residents’ quantitative satisfaction ratings were analysed and the median and interquartile ranges were calculated. Thematic analysis was applied to qualitative data, which was coded and themes identified. The current study is a service evaluation project and therefore did not require formal ethical review. The study was reviewed and approved in 2010 with the Unit Manager and regional Clinical Governance Lead prior to commencement. Principles of informed consent and confidentiality were adhered to and all patients were known to the clinical psychologist, and assessed as having full capacity to make an informed and rational decision regarding their participation.

Results

Quantitative data
Likert ratings for the six areas of inquiry are presented in Figure 1.

Each aspect of the ward round process was given a median rating of between 6 and 8. The area with most satisfaction appeared to be residents’ perception of staff-related issues, and least satisfaction was with their level of involvement within ward rounds. There was a maximum range (0–10) for satisfaction, with ‘Purpose’ and ‘Overall’ satisfaction indicating some discontent. However, the ‘Overall’ median satisfaction rating was 8, demonstrating an overall positive evaluation of the existing ward round process.

Qualitative data
Three key themes emerged from qualitative data, namely: (i) seeing the purpose and value, (ii) perception of the process as being intimidating and anxiety provoking, and (iii) a need for greater involvement of other disciplines.
Residents’ experience of ward rounds

1. Seeing the purpose and value
Residents were asked a number of open questions to explore their understanding of the purpose of the ward round process. Nine out of ten residents identified that ward round enabled the team to feed back their progress and to give a summary of their behaviour over the previous fortnight. Two residents reported that the meeting allowed them to ‘talk about the future’ and where they ‘want to go’, suggesting that ward round is a chance to discuss future options with regard to moving to another unit or into the community. Ward rounds were also viewed as a forum for requests to be granted or denied, and the most common request was asking for more community leave.

However, two residents felt that ward rounds should be less frequent, stating that ‘they are too often and don’t need to happen as much’ and ‘I don’t see why we have to do it every two weeks’. In addition, two service users were unsure of the purpose of the meetings, saying that they were ‘not sure of the point of them’ and another was left ‘wondering about the relevance’. One resident commented that some of the time was not used effectively, with staff talking about ‘irrelevant things such as activities, rather than medication’.

2. Perception of the process as being intimidating and anxiety provoking
Residents were asked questions about their experience of the ward round process and environment, including how they felt prior to the meeting and how many staff were present. It was found that seven out of ten residents found themselves feeling anxious prior to the meeting and worrying about what would happen in their ward round. One resident said that they ‘always felt anxious before meetings’, and for one person this was due to ‘worry about the news’. In addition, these respondents felt that the ward round was an intimidating environment which made them feel under pressure. One resident commented that the ward round room felt ‘like a court room’ and another felt that it was like a ‘grand inquisition’. It was also felt that speaking to a group of people was an uncomfortable experience, with one resident commenting, ‘I don’t like the fact that all of the staff are there staring at me’. However, the remaining three residents reported a positive experience of ward round. One respondent even commented that he felt excited about the meetings due to the perception that he could ‘usually get things granted’.

Figure 1: Box plot displaying the median and range of satisfaction ratings for each aspect of the ward round process.
3. A need for greater involvement of other disciplines
Residents were asked a number of questions regarding the attendance of the MDT during ward rounds, including information about who leads the meetings and who they felt ward rounds were for. Three residents felt that input from the team came mainly from the doctor. One resident felt that, aside from the doctor, the staff ‘don’t tend to contribute that much’ and therefore felt that the purpose of the meetings were for ‘the doctor and the patient’ only. One resident commented that they would like ‘more input from the other disciplines because they don’t tend to get involved’. The remaining residents reported that ward rounds were for all members of their MDT and themselves.

Discussion
The current study aimed to explore how residents of forensic rehabilitation services experience ward rounds. It was found that the majority of residents were satisfied with the way ward rounds were conducted. However, lower satisfaction ratings for specific aspects of the process at the time of the study indicated areas of improvement. Furthermore, the wide range of responses received for overall satisfaction highlights the heterogeneity of resident experience, meaning that individual needs and preferences must be considered when conducting ward rounds.

The majority of participants reported anxiety both before and during ward rounds. Whereas the anxiety prior to the meeting was due to feelings of apprehension about feedback on progress and requests, it appeared that during meetings residents felt intimidated about being questioned and uncomfortable with speaking in front of others. This is congruent with previous findings such as that of Wagstaff and Solts (2003), who reported that clients also felt anxious both before and during ward rounds due to a dislike of the meetings and feelings of interrogation, respectively.

Taking these findings into account, strategies to reduce anxiety prior to ward rounds were considered, namely providing distraction around ward round times, with ward based activities and allocation of set time slots, so that residents know when their ward round is taking place. Also, providing service users with opportunities to meet with their primary nurse to prepare for the meeting may be useful and could include agreeing on a list of questions or requests that could be passed on to the MDT prior to the meeting. In addition, staff could assist residents with managing anxiety prior to the ward round using cognitive behavioural methods of relaxation, distraction and cognitive reappraisal.

Residents’ responses implied that they were passive recipients of feedback from the clinical team rather than being able to provide their own perception of their progress. This is discordant with the recovery approach (NIMH England, 2005), which empowers clients to be involved in their own care and considers their views of progress as central. Therefore, it was deemed beneficial to encourage and facilitate greater resident feedback during the meeting (with the help of an identified advocate) to encourage a shared view of progress. Service users were also given the option of attending the entire duration of their ward round where possible (there may be instances where, for example, third party information needs to be discussed) to ensure that decision making processes are more transparent. However, the individual needs of each service user must be considered in terms of their intellectual functioning or psychological wellbeing and adjusted for accordingly. For example, those who have difficulty processing verbal information could be provided with a basic summary of the outcome of the meeting in a pictorial or written form.

In accordance with the previous findings (Wagstaff & Solts, 2003; Hodgson et al., 2005), residents also felt that there was little input from members of their MDT other that their psychiatrist. However, as the meetings are an important opportunity for all disciplines to contribute their perspectives, greater involvement of all the team may give a more holistic account of service user wellbeing. Therefore, the attendance and contribution of other MDT members should be ensured for each service user meeting. This could be achieved...
by setting a standard agenda at the beginning of each meeting to include the input of every member of staff attending the meeting, such as updating on process of individual interventions and planning of future goals.

**Limitations and future directions**

The sample used in the study represented 10 of the 17 residents at the unit, meaning that the experiences of a large proportion of residents were not expressed. This may have meant that there was a systematic difference between those who took part and those who did not in terms of satisfaction of the ward round process, nature of relationships with the staff team or severity of mental health difficulties. Also, the sample size was less than half of previous studies using primarily quantitative methods (Foster et al., 1991; Milner et al., 2008; White & Karim, 2005), meaning that the results may not be generalisable to other residents in this setting or in other psychiatric settings.

This survey has highlighted the strengths and difficulties of the ward round process in a forensic rehabilitation setting. However, it raises issues about the experiences of residents in other healthcare or acute psychiatric settings where ward rounds constitute a routine aspect of care, and whether residents’ needs are considered when conducting the process. Further research into the experience of ward round for service users in high or medium secure forensic services would help to ensure that ward rounds are a positive and useful experience for both staff and service users. Clinical psychologists may also play an important role in improving the ward round experience, by providing communication training to health professionals to ensure that interactions between staff and residents are collaborative, respectful and transparent (Brannon & Feist, 2004).

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**Authors’ note**

The first author was an assistant psychologist at Llanarth Court Hospital whilst completing this work, prior to starting Clinical training in October 2012. The work was closely monitored by Dr Shereen Brifcani who was the clinical supervisor at the time. Dr Brifcani has reviewed the final draft of the report has approved it for submission.

**References**


Psychological input within access services
Jayne Finch & Sara Hudson

Within Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), the current authors have been providing psychological input into the established Access services. Here we explore the perceived benefits of this input from the perspective of Access Team staff members.

Within Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), Access services are the main point of contact for referrals into secondary care community-based adult mental health services, and as such are responsible for providing a thorough assessment before signposting individuals to the most appropriate services for their needs. This takes place within the current political context of a need for better outcomes at a time of economic constraints. The Department of Health (2011) sets out six shared objectives to improve the mental health of the population as a whole, whilst also acknowledging the need for savings to be made by improving the efficiency of existing services. More recent Department of Health documents (e.g. 2014a, 2014b) emphasise the importance of improving access to and reducing waiting times for mental health services as well as a commitment that more people will benefit from psychological interventions in a timely manner.

Our Trust’s own strategic goals (TEWV, 2014) refer to the implementation of personalised care packages, delivered without unnecessary delays in starting treatment within ‘service models which are effective, responsive and supportive of the whole care pathway’. As within the national guidance, a focus upon cost effective and high quality clinical care that maximises productivity is a theme. This is underpinned by an emphasis on a valued and well supported workforce who have access to the right development opportunities and effective working relationships with our partner agencies.

Access teams within our Trust are staffed primarily by nursing staff, with input from a medic. The rationale for providing psychological input into Access teams (earlier on in the pathway of care) at a local level came in part from the potential loss of efficiency that was observed to occur when individuals were referred into a secondary care service for psychological interventions unnecessarily, as well as a need to be responsive to those commissioning services (e.g. GPs specifically requesting a psychological assessment). The psychologists providing the input (typically up to three hours per week) into the Access services were both working in the secondary care affective teams, and had negotiated this input with service managers to meet the needs already identified above. It was also felt that psychologists could have a valuable role in early assessment and formulation within the teams to assist in care planning and decision making; a role that is highlighted within the British Psychological Society’s document New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams (Onyett, 2007).

Aim and method
Given this was a new service development, we were keen to explore, in the first instance, the Access staff’s experiences and perceptions of having a psychologist working within the service. To do this, a semi-structured interview protocol was developed by the current authors and five Access team staff members (representing the two different Access teams served by the authors) were then interviewed by a research assistant and the interviews were recorded and transcribed verbatim.
The resultant transcripts were then analysed by the authors using a thematic analysis in keeping with the guidelines of Braun and Clarke (2006). This involved active immersion in the data through reading and re-reading of transcripts. Data was then organised into meaningful groups, initially staying close to the raw data before sorting these codes into potential themes. Consideration was then given to how the codes may cluster together to form higher order overarching themes. Themes were reviewed by both authors for coherence and the definition/naming of themes.

Prior to proceeding with interviews, the project proposal was presented to local service managers and subsequently submitted to the Trust’s Research and Development Department for approval. As the project did not involve direct service user contact or any changes to the current delivery of care, it was deemed to not require further ethics approval over and above the approval that had already been sought.

Results and discussion

Five overarching themes were identified from the data: (i) the role and function of the psychologist in Access; (ii) benefits for the service user; (iii) benefits for staff; (iv) benefits for the organisation; and (v) the future needs of Access services. These themes are discussed below, with sub-themes highlighted in italics.

1. The role and function of the psychologist in Access

Within this overarching theme participants reflected on the range of functions that they observed psychologists fulfilling within the Access services. Sub-themes referred in particular to direct (face-to-face) assessment of individuals, as well as more indirect ways of working such as formulation and supervision/case discussion.

There was recognition that psychological assessment provided early on in access rather than later on in the care pathway was a more direct and efficient way of working and that it constituted a move towards a truly multidisciplinary assessment process (‘You’ve got a patient who’s having a mental health assessment, having a medical assessment and a psychology assessment’ (Participant 2). A key sub-theme here referred to the role of the psychologist in making recommendations regarding therapy/onwards signposting. For example:

‘People who have had involvement with the psychologist… we were able to send them or refer them on to the most appropriate services where as in the past we might of struggled to, sort of like, to think, I don’t know what to do with this person.’ (Participant 3)

This related closely to the role of the psychologist in providing a care plan informed by psychological thinking. Lastly, participants commented on the function of the specialist skills/expertise that psychologists brought to the work – this seemed to range from identifying the presence of a psychological need through to offering direction on complex or unusual cases. This echoed the sentiments of New Ways of Working for Applied Psychologists (Onyett, 2007), which argues that using formulation in the wider context can be a good use of psychologists’ limited time and is often ‘appreciated by staff whose training does not equip them with these skills’ (p.23).

2. Benefits for the service user

A key sub-theme here was the way in which the psychologists’ input could result in a quicker/more efficient service for the user, minimising waiting and inappropriate referrals. For example:

‘It helps us at the very early stage of the assessment so that things aren’t being drawn out and the clients not being sent incorrectly.’ (Participant 1)

Avoiding unnecessary delays and repeated assessments for the patient is a key theme throughout the local and national documentation guiding improvements within mental health services (e.g. TEWV, 2014; DH, 2011). Crucially, it was also evident that participants felt that psychological input provided an increased psychological understanding for the patient, often normalising their experiences.
and offering a coherent explanation for why they had developed the particular difficulties they had. In some cases it was apparent that this intervention itself was enough, and a more restrictive (and costly) referral into secondary care services was no longer necessary. Lastly, being seen specifically by a psychologist also seemed to meet client expectations and preferences in some cases. This speaks directly to the patient choice agenda as well as the idea of being seen by the right person at the right time in the care pathway.

3. Benefits for staff
Staff felt that having the psychologist assisted their development in terms of assessment and formulation skills:

‘It has given us a better understanding of psychological formulation and sort of like what areas we need to look at when we are assessing somebody with psychological needs.’
(Participant 3)

Participants also felt that the input left them feeling more supported (for instance, reference was made to staff feeling supported in thinking about their own feelings and reactions to individual service users) and with an increased level of confidence in their decision making processes. Lastly, a particularly dense sub-theme here was around the learning and increased knowledge that the psychologist afforded for staff. For example:

‘I have a better understanding of the therapies that are provided and what their aims are and how they would work. ‘From a professional point of view I now learn a great deal more, I get a great deal from spending time with the psychologist.’ (Participant 1)

There was a general sense that psychological input helped staff to see things from a different perspective and added a valuable extra dimension to existing skills. The benefits for staff here are clearly in keeping with our Trust’s own strategic goals (TEWV, 2014) surrounding retaining a workforce who feel supported and have development opportunities available to them.

4. Organisational benefits
Reduced wastage and greater efficiency within the system was referred to here; in particular, reducing inappropriate or unnecessary appointments. For example:

‘We are able to refer people to the appropriate service, it saves time ’cause a lot of people go round services engaging in lots of different things which may not be particularly beneficial, so I think having that sort of input in there may get us to do the formulation right to signpost the person to the appropriate place really.’ (Participant 4)

This speaks specifically to the fourth stated objective within No Health Without Mental Health (2011), which states that ‘services should be designed around the needs of individuals, ensuring appropriate, effective transition between services when necessary’ (p.26). Linked to this sub-theme, participants also felt that the addition of psychologist input within Access services would be likely to result in cost savings for the organisation. Lastly, participants felt that having a psychologist within Access would increase confidence and satisfaction with our services from the point of view of external agencies/customers, both on a practical level (for example, in terms of providing GPs with direct guidance on how best to manage individuals within their care), as well as being seen as adaptable and providing a holistic and thorough assessment.

5. The future needs of Access services
In terms of the future of psychology within Access, all participants interviewed were of the opinion that psychological input was of value and should continue both for their own Access teams and Access services trust wide. For example:

‘It would be helpful if we could continue to have some form of psychological input in the future.’ (Participant 3)

‘We’d struggle if we lost our psychology input. I think it would have a knock on effect on the affective and psychosis teams.’ (Participant 2)
‘From an organisational point of view I can’t see that there would be any sort of drawback from having a psychologist service front-loaded at this end, of the sort of, the patients journey.’ (Participant 1)

There was also an acknowledgement of the need for more therapy provision in the future in order to aid efficiency:

‘We need to be offering patients the therapy to get them through and out. I think probably if we have more therapists, we would get people seen quicker and through.’ (Participant 2)

Critique

Whilst interviews with service staff gave invaluable information about their perspective of the role of the psychologist within Access services, this was based on a small \((n = 5)\) number of staff, although they were from two different Access services. It would be advantageous to increase the sample number, but one of the project drivers was that not all Access services have time of a psychologist, and therefore could not participate. The perspective of service users would also be an invaluable source of information to help confirm whether the perspective of the staff about the service user’s experience is validated. This could be problematic, as service users typically are assessed within Access for a very brief period before signposting on, so any capture of data would need to occur at approximately the same time as the input, which could influence the type of information provided.

There is also the possibility that staff’s feedback was influenced by their desire to ensure service input continued, and this could account for data being favourable in its content. With both services being small, there may have also been a bias towards positive feedback, as the chances of staff being identified by the authors would be increased. This was addressed by the use of a neutral person (the research assistants seconded for the purposes of undertaking and transcribing the interviews), so that the authors did not actually know which participant number on the transcribed interview related to which member of staff, and had not listened directly to the recorded interviews (to prevent voice recognition).

As interviewing and transcribing is time consuming, there is the potential to use the data from these interview results to form a questionnaire if other Access services were to be evaluated, and this would allow future data to be gathered to include larger numbers in a shorter time frame. This, of course, would also depend on other Access services having the need to undertake such an evaluation if they were to have specific time of a psychologist.

Recommendations

Based on the findings from this evaluation, staff’s perception of having a psychologist input into Access services is that the role fulfils a number of functions which add to the experience of those delivering, receiving and commissioning the service. It is therefore recommended that all Access services across the Trust would benefit from considering whether to include a psychologist, which would be consistent with the standardisation of good practice. This would be better supported if the service user experience could be incorporated directly into future evaluations. However, if staff are more confident that their skills are enhanced and that services are acting more efficiently and effectively for the benefit of the service user, then this could be construed as a sufficient starting point for ensuring the continuation of the psychologist in this role.

Summary

The addition of psychological input into the established access teams within TEWV was seen as beneficial by the members of staff interviewed. As well as experiencing a range of different functions of the psychologist within this role, staff also perceived that this service development had benefits for their own professional growth, the service user’s journey and the organisation as a whole. It was felt that this model should be retained and spread to other access services. A potential drawback of the current study is that findings are based only on...
staff opinions. Whilst this is a highly valuable starting point, it may be useful in the future to look at service users’ experiences of this model, as well as more quantitative measures of efficiency savings pre and post intervention.

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We would also like to thank the Access service staff who participated in the interviews and provided the information on which this project is based.

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The use of outcome and sessional measures in clinical psychology training

Jan Hughes & Gary Latchford

This article is the first in a set of three looking at the use of outcome and sessional measures in clinical psychology. This collaborative project between the three Yorkshire clinical psychology programmes aims to explore current practice and then establish a system by which all trainee clinical psychologists on the three programmes. It is hoped that this information will be used to expand the new practice research network to include measures applicable across clinical specialities.

MANY TRAINEES will routinely use measures to monitor the success of their interventions, but anecdotal evidence suggests that this is not consistent. Though trainees are required to demonstrate competence in the use of measures under the new British Psychological Society accreditation criteria for clinical psychology training programmes, use of measures by trainees on placement has not been investigated in the UK. Most would agree that assessing outcomes is an important part of clinical practice, but research has suggested that this may be particularly important during training: Reese et al. (2009) showed that routine (session by session) monitoring of progress in therapy contributes to better outcomes for service users, and greater increases in competence by student therapists (Reese et al., 2009).

In 2011 a project was established to encourage the systematic use of sessional and outcome measures in clinical psychology training in Yorkshire. This article aims to summarise this work, in particular the pilot data collected during the 2012–2013 academic year with first year trainees. This is the first of three papers. The second paper focuses on the setting up of a centralised system for the routine collection of data using CORE Net which followed the pilot. The third paper is written by first year clinical psychology trainees who have been using the new system. They share their experience of routinely using measures with clients, and of using CORE Net to record them.

A project on the use of measures in training

Following discussions between the three Yorkshire Doctor of Clinical Psychology Programmes at Hull, Sheffield and Leeds universities, a common interest emerged in how measures were used in training. This led to a project which aimed to explore current practice and then establish a system by which all trainee clinical psychologists on the three programmes collected regular feedback (usually every session) from service users in all their therapeutic work. A steering group was set up to oversee the project, consisting of trainers, trainees, supervisors and service users from the three courses.

If the project was to be successful, trainees would need to become familiar with the full range of instruments and approaches that are currently available to facilitate the use of service user feedback. An important principle was that this initiative should be applied to all specialties, and that trainees develop ways of incorporating user feedback into their practice with all service user groups whom they serve (including people with learning difficulties, older adults and whole family groups). Supervisors are clearly a crucial part of trainee clinical experience, and the project aimed to ensure that the clinical supervision provided for all trainees on placements is informed by up-to-date detailed feedback from the service users with whom they are working. We were mindful too that a good deal of the work carried out by
Trainees on placement is indirect, such as staff training or consultancy, and trainees were to be encouraged to consider ways of obtaining and acting on feedback in these situations.

Finally, the long-term success of the project clearly depended upon establishing a reliable and valid system for recording data. The final aim was therefore to keep a cumulative record of (appropriately anonymised) data collected across the three training programmes and establish a practice research network to support clinically relevant research to be undertaken using the feedback provided by service users, trainees and supervisors who have participated in the project.

The pilot project
The first step in establishing a system by which all trainees record outcome data for each service user was to investigate current use of measures during training. A pilot project began at the beginning of the academic year in 2012, in which all first year trainees on all three programmes were asked to record every measure they used during the year.

All first year trainees and supervisors were sent detailed information about the pilot project. This explicitly stated that they were not being directed towards any particular measures and that the aim was to gather information on current routine practice across first year placements. The majority of these were adult, with the second placement for two courses (Leeds and Hull) being with child populations, and for the third (Sheffield) being older adult services. At the end of placements 1 and 2, first year trainees were asked to complete a spreadsheet with the following information on all service users:

1. The measures used with the service user.
2. How often the measure was used.
3. Over what time period.
4. What the data showed.
5. Whether this was discussed in supervision.
6. How this discussion in supervision influenced practice.

<table>
<thead>
<tr>
<th>Measure</th>
<th>No. placements used (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Rating Scale (SRS)</td>
<td>36 (40%)</td>
</tr>
<tr>
<td>Outcome Rating Scale (ORS)</td>
<td>32 (36%)</td>
</tr>
<tr>
<td>Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)</td>
<td>28 (32%)</td>
</tr>
<tr>
<td>Patient Health Questionnaire – 9 item (PHQ-9)</td>
<td>22 (25%)</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder – 7 item (GAD-7)</td>
<td>22 (25%)</td>
</tr>
<tr>
<td>Hospital Anxiety and Depression Scale (HADS)</td>
<td>18 (20%)</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI)</td>
<td>15 (17%)</td>
</tr>
<tr>
<td>CORE 10 item version (CORE-10)</td>
<td>15 (17%)</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>9 (10%)</td>
</tr>
<tr>
<td>Obsessive Compulsive Inventory (OCI)</td>
<td>8 (9%)</td>
</tr>
<tr>
<td>Geriatric Depression Scale (GDS)</td>
<td>8 (9%)</td>
</tr>
<tr>
<td>Rosenberg Self-esteem Scale</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>Inventory of Interpersonal Problems (IIP 32)</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>Brief Symptom Inventory (BSI)</td>
<td>7 (8%)</td>
</tr>
</tbody>
</table>
Results
The results reported here are summary data from the first three questions, starting with a review of the different measures used and then summarising how many measures were used and with how many service users.

Popularity of individual measures
A total of 86 different measures were recorded as being used across a total of 89 placements. Data were missing from five placements (one first and four second placements).

Three measures (each used on one placement) were service specific user satisfaction tools. Five measures (used on six placements) were neuropsychological tests. Some 14 measures were specific to child or adolescent work and used on 29 placements. Of these, the most popular by far was the Strengths and Difficulties Questionnaire (SDQ), used on nine placements. Ideographic measures were widely used, with trainees citing their use on 40 placements, though trainees may not always have recorded non-standardised measures in responding to the survey, so this figure may be an underestimate.

The most popular measures used by trainees were the Session Rating Scale (SRS; used on 36 placements) and Outcome Rating Scale (ORS; used on 32), both ultra-brief measures designed to be used for sessional feedback. These may be used in any speciality, though tend to be more widely used in adult placements.

Standardised adult measures were the most common type of measure recorded, with 61 different measures being used on at least one placement (range 1–28). Many of these (such as the Hamilton Rating Scale for Depression) were not used very widely: 39 were only recorded as being used on one or two placements. The most widely used standardised outcome measure was the CORE-OM, used by trainees on 28 placements. This was followed by two measures popularised by IAPT services, the PHQ-9 and GAD-7, both used on 22 placements.

Table 1 lists the most popular measures used by trainees on the 89 placements for which there was data.

Trainee use of measures
Trainees used measures with an average of 6.6 service users across both placements in year 1 (range 0–24 in placement 1, 1–18 in placement 2). Each trainee used on average 4.2 measures in placement 1 and 4.6 in placement 2 (range 0–8 in placement 1, 1–10 in placement 2). Details are shown in Table 2.

One trainee used no measures on placement 1. There was a trend towards more use of measures in placement 2, with many more trainees routinely using at least one measure.

Discussion
The results indicate considerable variation between trainees in terms of the number of different measures used and how often they were used with service users. Though a large number of measures were recorded, many of these were used infrequently. Many were only recorded as being used on one or two placements. One explanation for this is that many of these measures were symptom specific, such as post-traumatic stress or panic, and may have been used to supplement a more general outcome measure when appropriate. Other choices seemed to be more idiosyncratic, perhaps influenced by supervisor or service preference. There were, however,
some key measures that were more frequently recorded. Those used the most were sessional feedback measures (SRS and ORS), and those from the CORE suite of measures (CORE-OM, CORE-10). Interestingly, many of the measures recommended by IAPT (PHQ-9, GAD-7, OCI, HAI, WSAS, PSWQ, IES) were also popular with trainees. Though many of these are easily available (and promoted) elsewhere, their use may have been popularised by IAPT, either through prior experience of trainees or wider adoption in adult services. Ideographic measures were also frequently cited. Though few details are available on the variety of ideographic measures used from this survey, it was clear that most used these in combination with standardised measures.

Overall, the pilot project revealed important information on the most widely used measures, and confirmed the current variability in the use of measures by trainees on clinical placement. The pilot also revealed a problem if trainees are to use and benefit from widespread use of assessments in therapy: that a technological solution was needed to make measures easily available to trainees and – crucially – make data easy to record and available for use in supervision. It was also recognised that it would be useful to create a usable system for training programmes to centrally collate this information. How we solved these problems, and how we moved to the next stage of setting up a Yorkshire trainee PRN is described in the next article.

Meanwhile, the pilot project investigating routine use of measures by trainees continues for second year placement populations as the 2012 intake continue to collect information in the same format as above in their second year placements – this time with two additional questions about the use of the measures directly with service users and how this influenced practice. It is hoped that this information will be used to expand the new practice research network to include measures applicable to second year populations, such as people with a learning disability, meeting the initial aim of the project that trainees be supported in incorporating user feedback into their practice with all service user groups whom they serve.

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References
Developing a CORE system for use in the training of clinical psychologists

Gary Latchford, Jan Hughes & James Macdonald

This is the second of three linked papers. It reflects on the process of setting up a centralised system for recording routine sessional and outcome data for trainee clinical psychologists across Yorkshire. Comments are included from two trainers involved in setting this up (GL and JH) and also a colleague from CORE IMS (JM) involved in developing the system used.

Beyond the pilot: Establishing a Yorkshire trainee practice research network

THE PILOT STUDY revealed the most frequently used measures across first year placements in Yorkshire and gave a sense of the size of the task in setting up a system for trainees to record outcomes on one system: trainees use a lot of measures and gather a lot of data.

The pilot also generated local interest in the project from trainees and supervisors. It dovetailed too with growing interest in practice based evidence: the idea that practising clinicians can group together to measure the outcomes – and more – of their services. Together with discussions that took place in the project steering group over that year, by the end of the pilot there was a real desire to take the next step and establish a practice based network (PRN). Unlike previous PRNs in psychological therapy, however, this one would consist of trainee clinical psychologists, and focus on engaging service users to record outcomes of therapy and obtaining client feedback from every session.

The next step – How do we actually do this?

As was clear from the pilot project, for the PRN to work trainees would need a straightforward way of recording the data they would get from their clients. Ideally, they would be encouraged to track client progress and use feedback from their client in their therapeutic work. An important part of this is making that data easily available to their placement supervisor, so that it may be used in supervision.

To make all this happen clearly requires a system that is potentially very sophisticated but also easy to use and – most importantly – very accessible. We initially compared different ways of doing this, from adapting databases and spreadsheets to adding functionality to Mike Berger’s ACE system, an online database designed to record placement experiences. In the end, a chance meeting led to an agreement between the three universities and CORE Information Management Systems (IMS) to develop a version of CORE Net for use in training. This meant that for the duration of a three year PRN project, our trainees could use the CORE Net system.

CORE Net is a system for recording outcome and process measures in psychological interventions. It is web based and therefore met our requirement of being easily accessible. It is well established and used by a large number of NHS and non-NHS psychological therapy services. This meant that some trainees may already be familiar with it. CORE IMS are licensed to provide secure database services to the NHS, using password protected access for individual clinicians and managers, and though all data would be anonymised, this provided reassurance concerning data protection. CORE Net allows session by session data to be entered relatively easily, and enables immediate access to feedback and...
outcomes tracking for individual clients and therapists that makes sharing information with supervisors easy.

The early stages of the project used information from the pilot to develop a trainee version of CORE Net and populate it with the measures that trainees had indicated were the most frequently used. This trainee version of CORE Net then formed the basis for a new practice research network of trainee clinical psychologists in Yorkshire. This was implemented for use by the new intake on the three programmes in the 2013–14 academic year, on all first year placements.

Ethics
An early question was: ‘What are the ethical implications of this?’ The answer may surprise you. In essence, our query was ‘can we set up a system to record anonymised outcome data from our trainee clinicians’? The answer was that this sounded a lot like a ‘research database’, and there were already very many examples of this in the NHS (recording outcomes from hip replacements and cardiac surgery, for example). Such anonymised databases do not require ethical approval. The subtext, perhaps, was ‘why aren’t you doing this already?’ There are still implications if anyone wants to do research using this database, and at that time research and development approval will need to be sought. We felt more comfortable ensuring that all of the service users seen by trainees in the PRN have been given information about it, and their consent asked.

Implementation with trainees
From the beginning of the 2013–14 academic year all of the trainees in the new cohorts started recording outcome and process measures with every client in every session using CORE Net. The paper-based records of all assessments are kept in the client’s files in the placement base, but CORE Net data is available for use in every clinical supervision session. Training programmes have access to outcome data for each trainee, but this database contains no identifying client characteristics.

The trainees clearly needed training in the new system at the beginning of the year. At first we were struck by the fact that trainees were more familiar with the use of online systems to record outcome measurement than were many members of staff, but as described by James below, with hindsight we underestimated the need for more training on the practicalities of using the system, and have since developed clear protocols and redesigned the training and support available.

Implementation with supervisors
We felt it was important to communicate with supervisors about the intended changes, and this was done in three ways. Firstly, our project manager Dave Green wrote two very helpful papers that were circulated to first year trainee supervisors (and also given to trainees) prior to the start of placement. One was on the background to the project and outlined the literature on the use of sessional and outcome measures with service users. The second had a more practical focus and discussed the potential measures that could be used.

Secondly, we prioritised the project as a topic for one of our regional advanced supervisor workshops, and a number of supervisors attended this. That day included presentations from James from CORE IMS, and Terry Simpson, a valued service user member of our steering group. It also addressed the issue of how the new system would manage complexity of cases, and there was extensive discussion of how to record outcome and the process of change for people who are in potentially more complex situations, and where the work of the psychologist may be indirect (e.g. working with people with a learning disability).

Third, we made it clear at our placement visits with supervisors that we wanted to support them and hoped that the project might be mutually beneficial – many were in services under increasing pressure to demonstrate outcomes, and trainee participation in the project may contribute to a response to this.

It is important to note that we emphasised in all our communications with supervisors that we were interested in how our trainees were thinking about and measuring change, but that we were not prescribing the measures that were used by them to do this. Indeed, if the organisations in which the supervisors
worked already routinely utilised different measures, trainees were encouraged to use these rather than add additional ones. It was a priority to not overburden service users.

Implementation with service users
The spirit informing this project is one of collaboration between therapist and client, with the therapist seeking regular feedback from the client on how well they are doing so that the client and the therapist improves. Trainees were asked to explain the background to the project to every client. In addition, however, we wanted to engage these clients in seeking their feedback on their participation in the project – feedback on feedback. This is a surprising omission in the literature. Terry Simpson and Dave Green (on behalf of the steering group) had approached a number of service users groups around the UK to get their views on this, and we felt that we wanted this established as a key part of the project. A small working group led by Terry and Dave have therefore been meeting to discuss ways of ensuring it is easy for clients to give the trainee and the courses feedback on the new system. They have developed paper, web-based and telephone methods to do so, which will be piloted in the 2014–15 academic year.

Reflections from CORE IMS
At CORE IMS, we were excited about working with the Yorkshire PRN for a number of reasons. Firstly, we were already fans of Dave Green and Gary Latchford’s book Maximising the Benefits of Psychotherapy (2012), the only clinician friendly UK book on using measures as a means of improving the quality of therapy. Secondly, we expected that trainees would respond well to features we are developing or have developed in CORE Net that are designed to assist clinicians in reflecting on their clinical work with a view to improving outcomes, especially for those clients who are not showing an initial positive response to treatment. We wanted to find out whether this was true and we wanted feedback from the PRN on how the software was used as a reflexive and supervisory tool, and how we could increase its usefulness. Thirdly, we felt that our partnership with the universities in the PRN would stimulate valuable research on the use and development of measurement tracking in psychological therapies – especially in the area of training and supervision.

A year in to the project and our enthusiasm remains undimmed. However, we have learned some lessons from the initial implementation of CORE Net with the trainees. The most significant issue was that the universities needed to provide more support than we initially thought would be necessary in order to ensure that all the trainees are clear about what they need to do and how to do it using the CORE Net software. We were perhaps over-deferential to the idea that, being younger than us, the trainees would automatically grasp how to use the software! We realised that there was a training gap between the rationale for using sessional measurement (provided to the trainees by Dave Green) and the more technical skills required to operationalise this using CORE Net. Furthermore, it became clear that the trainees were not uniformly clear about the PRN’s expectations. For example, which clients should they enter into the system (all of them) and how were they to maintain satisfactory data quality (e.g. using data quality functions and ‘closing’ cases after concluding the work)?

These teething problems became apparent several months after the first cohort of trainees using the new PRN CORE Net site embarked on their first placement. Whilst preparing for a review meeting with the PRN leaders, we noticed that the trainees’ data quality suggested patchy and inconsistent use of the system. This is not an uncommon problem in services, but rather surprised us given that we knew the project was strongly supported by the leaders in the training courses. Our subsequent meeting enabled us to problem solve and effectively close the gaps through which the data seemed to be leaking. The PRN appointed a day-to-day project lead, Clare Dowzer, who would monitor data quality, feedback to trainees if they were falling...
short of expectations and be available as a resource for anyone who were struggling. Clare and Dave also undertook to document more precisely the PRNs expectations of trainees, laying down a standard protocol that could be used in training and as a reference. Finally, it was determined that the initial induction and training for beginning trainees needed to include a greater emphasis on hands-on use of the system.

To date, these initiatives have resulted in significant increased participation in the PRN by trainees and they have greatly improved the quality of the information that is being collected. We remain optimistic that the PRN will fulfil its potential. The signs are that it will become a milestone in the development of best practice in the use of feedback systems in the training of psychological therapists.

**Concluding thoughts**
The primary aim of this project was to routinely collect feedback from clients and use this to improve therapy, and potentially supervision. So far it seems as if it will meet that aim. Where else might it go? One feature of the system is that training programmes will be able to monitor trainee competencies more closely; trainees will be aided in the development of key clinical competencies and their supervisors given a tool to use to support this. It’s also true, however, that they will also have access to the outcome data for each trainee. This is, of course, what happens in surgery, and there is an argument that we really should have been collecting these data anyway. The key perhaps is how it will be used. Outcomes in therapy are not just determined by the actions of the therapist, and there is no intention to use this to assess any trainee. More likely will be the use of the database for research in the future on what happens when therapy is provided in training.

Perhaps the most important outcome so far, however, has been the way in which course staff, trainees, service users and supervisors have come together to recognise that, although there are undoubtedly many problems along the way, there is a real appreciation that getting regular feedback and measuring outcomes should be an important part of what happens in therapy, and that clinical psychologists ought to be trying to do this wherever they work and whoever they work with. The experiences of our trainees, as described in the next article, suggest that this is not only possible, it’s genuinely useful.

**Acknowledgements**
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**References**
Trainees’ experiences of the use of sessional and outcome measures and CORE IMS

Elizabeth Gilley, Joanne Crossley, Michelle Connor & Jan Hughes

This is the third article in a series of three looking at the implementation of the regular use of sessional and outcome measures using CORE-Net within the training of clinical psychologists. A trainee from each university involved in the project (Hull, Sheffield and Leeds) was asked to give their reflections on this process.

Michelle Connor, University of Hull

AS A FIRST YEAR clinical psychology trainee initial placements can be daunting. We now have to transfer our skills learnt via roleplay to our work with real clients. Questions surrounding risk can be particularly difficult to ask. However, I have found that by using the CORE measures I can assess a client’s level of risk without having to ask ‘that question’ directly. If a client’s response on the measure has indicated potential risk, then this provides an opening for further questioning. Using the CORE measures also helps to identify other areas that we might not enquire about every session. For example, sleep is one area that we might ask about in an assessment session but not in every session.

One of my clients recently told me that she did not like completing the CORE-10 measure every session. I asked her why she did not like completing them and she told me that it made her problems seem more ‘real’ when on paper. I revisited the purpose of why I asked her to complete them and told her I would bring a copy of the graph with an overview of her responses. Upon showing my client the graph, she could see where she had made progress and conversely she could identify weeks where her symptoms had worsened. Showing my client the graph helped her to understand her therapy journey.

I would recommend that from time to time trainees take a client’s graph into session with them, so that they can see their own progress and to help their understanding of why they have to completed these measures in every session.

With one of my clients I completed a short-term structured piece of work. In our final session I was able to show my client his progress from start to finish. He found this really useful to see how far he had come and how his problems had decreased and his functioning improved. He asked to keep a copy of the graph, so that if he experienced any of the problems in the future, the graph would provide a reminder that he could overcome them. Using the graph to track his progress was also beneficial in a review session with his case manager and other members of the team. Often, information presented in a visual format has more of an impact upon an audience.

My only concern in using the CORE measures is that there is the danger that clients may not be completely honest in their responses. I would recommend that from time to time trainees take a client’s graph into session with them, so that they can see their own progress and to help their understanding of why they have to completed these measures in every session.

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My only concern in using the CORE measures is that there is the danger that clients may not be completely honest in their responses. They may answer in the same way each session, irrespective of how they are truly feeling. Alternatively, they may feel like the client I mentioned earlier and not want to see their problems on a piece of paper. However, I do believe that using the CORE measures has aided my practice by providing me
with a tool I can use to identify any problems a client might be experiencing, which I can then probe further.

**Joanne Crossley, University of Leeds**

Prior to clinical training I had worked on a research project analysing health-related quality of life data collected as part of a large randomised clinical trial. I recognised the value of patient-reported outcomes in evaluating the effectiveness of pharmacological treatments. However, I had not worked in a psychological therapy setting or had any experience of collecting outcomes on my own practice. When we had our teaching on CORE Net, I thought it seemed a really useful system to be able to track service user’s progress. I also like graphs, so the fact that it created summary charts intrinsically appealed to me!

My first placement was in an adult psychological therapy service. Whilst the service did not regularly use sessional measures or CORE Net, my supervisors were supportive of me doing this. I collected sessional feedback from all the service users I worked with, but found I approached this differently with different clients.

In my work with one client, we set aside 10–15 minutes during every session to complete and discuss the measures (CORE-10, GAD-7, ORS, SRS). The client would input her answers directly into CORE Net and we would look at the summary graph together. It was useful to discuss what had impacted on the symptoms of her anxiety during the week and reflect on how well she had managed some stressful situations during our work together (e.g. moving to live on her own) and how this differed from what she would have predicted. Looking at the output together also led to a significant conversation about accepting responsibility for change and fears for the future, which led to us spending several sessions talking about tolerating uncertainty.

I took a mindfulness-based CBT approach in this work and the SRS also became an opportunity for a behavioural experiment. During one session she shared that she would not want to rate the session badly. We explored this and a few sessions later she rated that she had not found part of a session useful and was able to reflect on that experience of giving negative feedback.

The SRS also became an important measure in my work with another service user. We were exploring the impact that childhood sexual abuse had on her forming intimate relationships. The patterns that she was describing in her relationships with others were being mirrored in our therapeutic relationship. Discussing the SRS helped us to talk about our relationship: how it had changed; how that had happened; reflecting on issues such as trust; and making links to her other relationships. However, it was interesting that at times I felt almost apologetic about asking her to complete the other measures (CORE, PHQ-9, ORS), as I felt it did not fit with the person-centred approach that I was using. I asked about her experience of completing them and was surprised when she said she found them helpful, as it made her reflect on what had been going on for her that week. It has made me more confident of using these measures in the future, even when I’m not using cognitive-behavioural approaches.

During this first placement, I have found sessional measures and CORE Net a useful tool to start conversations rather than seeing them as a quantitative concept that should be analysed – which is a big shift for a quantitative researcher! If service users were not making progress within therapy, I think having the graphical output helped me to externalise the conversation and gave me more confidence to share it with clients and think about what may be going on. In my next child health placement, I want to continue to have these discussions, but I think the challenge will be thinking about how to incorporate idio- graphic measures into CORE Net.

**Elizabeth Gilley, University of Sheffield**

I was sceptical at first about using routine measures with clients. I wasn’t convinced that...
Trainees’ experiences of the use of sessional and outcome measures and CORE IMS

Routine measures provided meaningful information that would help therapy or reflect where progress had been made. I think that some of my initial reluctance was due to my anxiety about how clients would react to me asking them to complete measures.

As it happened, my experience using measures whilst working in a Community Therapies team was more mixed. The majority of clients didn’t appear to mind filling them out, though one commented that in her last therapy she felt all the therapist cared about was ‘ticking her boxes’. This was a reminder to me of the importance of having a proper discussion with clients about using measures, so that they could make an informed decision about whether or not to fill them in. Over the course of my first placement I gained confidence in asking clients to fill in measures, as well as explaining the rationale for their use and deciding when it was appropriate to use them and when it wasn’t.

I found that it was important not to just take the results of measures at face value. For example, while I was keen to think that high session ratings meant that I was a wonderful therapist, I also had to consider that they might reflect that something else was happening. This challenged my view that sessional measures did not provide any information about process issues in therapy.

I found the ‘Helpful Aspects of Therapy’ form particularly useful for gaining feedback on how clients were finding our sessions together. It seemed to enable clients to say things that they might not want to say directly. I was able to take feedback to supervision and to help me reflect on and improve my practice. I also found that clients were sometimes more willing to disclose some issues on paper than they were in session, and this was a helpful tool for initiating discussion.

Having an objective means of assessing how therapy was going was very helpful, particularly at times when I felt subjectively that things weren’t progressing and I got lost in the hopelessness that the client was experiencing. I also found that some clients liked to see the graph showing their changes in scores across therapy – though I discovered the hard way that it was important not to give the impression that I felt that this was proof that all was well and the client was ‘cured’. There were times when the measures didn’t pick up small improvements and changes that clients had made as a result of therapy that were very significant for the client themselves. Although there was something that jarred with me about reducing the effectiveness of therapy to a set of scores, I can see how useful this information can be, when in context or as a part of wider research. Using routine measures from the start of training has certainly ‘got me into the habit’ of incorporating this into my clinical work, and is something that I am sure I will continue to do moving forward.

Conclusions

It is clear that our three trainees were approaching the use of regular measures in therapy from different perspectives, based largely on their previous experience. However, all three reflected on the positive impact of the use of measures, including being able to track changes across time and the use of measures as a reflective tool within a therapeutic relationship.

We are now planning to look more systematically at the views of a number of different stakeholders on this project. We are conducting service evaluations on the attitudes of both trainees and supervisors across the region to the use of measures and of CORE Net. We are working with service user colleagues on a pilot to gain feedback from service users on the use of feedback in therapy. We hope to be able to disseminate the results from this work in the future.

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Health locus of control and wellbeing of individuals experiencing acute mental health problems

Natalie Isaia & Nadezda Nath

This study investigated health locus of control and wellbeing of individuals experiencing acute mental health problems in an inpatient ward. No direct relationship was found between these variables; however, differences by demographic variables such as age and ethnicity were identified.

SUBJECTIVE wellbeing is a broad construct comprising psychological, social and physiological aspects of life satisfaction (Diener et al., 2000). In recent years it has been a construct of interest within research and public policy. Health locus of control (LOC) describes the extent to which an individual perceives that their health is under their own control (internal LOC) or under the control of external agents such as doctors (external LOC). Previous literature has found LOC to be a moderator of wellbeing and recovery in both physical and mental illnesses. For example, Harrow, Hansford and Astrachan-Fletcher (2009) suggested that people experiencing psychosis are more likely to have an external LOC and that an internal LOC is associated with increased recovery.

The past few decades have seen significant transformations in the way inpatient mental healthcare is provided in the UK; reports and government strategies have highlighted the importance of improving service user wellbeing and outcomes within these services (Gilburt et al., 2014). Qualitative research examining service user experiences of inpatient care has highlighted coercion and lack of freedom (constructs inferring an external LOC) as salient aspects of the experience which impact negatively on wellbeing and experience of care (e.g. Gilburt et al., 2008).

In the context of ongoing change within health services, this study aimed to examine relationships between health LOC, wellbeing and demographic factors in individuals experiencing acute mental health problems on two London inpatient wards. Based on previous literature it was hypothesised that a higher internal LOC would be associated with greater wellbeing. Additionally, it was hoped that results would create a snapshot picture of participants’ LOC and wellbeing in the participating wards. (Note: data was collected between 2011 and 2012, so may not reflect the current environment.)

Method

Design

This study employed a cross-sectional design and collected data using self-report questionnaire measures. Ethical approval was obtained from the National Research Ethics Service.

Participant characteristics

A convenience sample of fifty-eight participants was recruited from one male ward and one female ward in a London mental health hospital. Inclusion criteria for the study required participants to have sufficient English language ability and cognitive capacity to complete the questionnaires. Individuals who ward staff considered too unwell to participate were excluded. The final sample included 27 males and 31 females, aged between 24 and 71 years old (M = 44.57).

Ethnicity was recorded in the format corresponding to medical notes. However, analysis revealed significant homogeneity in results across the ethnic descriptors of black Caribbean (n = 11), black African (n = 4) and black British (n = 17). Due to the small number of individuals in each category and...
the apparent homogeneity within this data subset, subsequent analyses were performed using three amalgamated categories: black ethnicities (n = 32), white ethnicities (n = 25) and other (n = 1). This amalgamation was used purely to achieve analytical concision within a small sample and does not imply a lack of diversity across these ethnicities; results referring to differences by ethnicity should therefore be interpreted with caution.

Diagnostic categories were recorded in the format corresponding to medical notes. These included schizophrenia (n = 32), schizoaffective disorder (n = 5), bipolar affective disorder (BPAD; n = 6) and ‘other diagnoses’ (n = 15, including brief psychotic episode, organic psychosis, depression with or without psychotic symptoms, and unspecified diagnoses). These categories were used as they represent the current classification system used within the NHS; however, the utility of such a categorisation system is currently under debate, as it may over-medicalise natural responses to psychosocial factors experienced by individuals (Cromby et al., 2012). Results referring to differences by diagnosis should therefore also be interpreted with caution.

**Measures**

Health LOC was measured using the Multidimensional Health Locus of Control Scale (Wallston et al., 1994). Questions are divided into three independent subscales of LOC: (i) internal, (ii) external (e.g. doctors), and (iii) chance (e.g. fate). Subjective wellbeing was measured using the Psychological General Wellbeing Index (Dupuy, 1984). Medical records were used to collect the following demographic data: age, gender, ethnicity, diagnosis, duration of illness (in years), number of admissions into mental health hospitals (over a lifetime), duration of current admission (in days).

**Procedure**

Individuals who agreed to participate in the study were given an information sheet and signed a consent form. Both questionnaires were completed with the assistance of the researcher, in one sitting, in a quiet and private room on the ward. Participants were able take a break if they were unable to concentrate for the required duration or if they became distressed. Ward staff were available in case participants experienced any distress while completing the questionnaires. Participants were provided with a verbal and written debrief upon completion of the questionnaires.

**Statistical analysis**

Data analysis was completed using IBM SPSS Statistics 19. Non-parametric tests were used in analysis due to uneven group sizes and significant violation of the assumption of normality in the data.

**Results**

**Descriptive Statistics**

Participants had a mean of 3.78 admissions into mental health hospitals over their lives. Duration of current admission varied from 2 to 315 days (M = 80.34, SD = 79.05). Mean illness duration in years (M = 14.69, SD = 12.52) indicated that the majority of the sample experienced chronic mental health difficulties. Wellbeing scores ranged widely from 16 to 104 out of 110 (M = 59.60, SD = 24.42), as did the three LOC measures which covered the full range of possible scores from 6 to 36 (Internal LOC: M = 21.09, SD = 7.69; External LOC: M = 25.34, SD = 7.45; Chance LOC: M = 19.16, SD = 7.72).

**Correlations**

No correlation was found between wellbeing and health LOC. Results of a Spearman’s Correlational Analysis indicated that illness duration was significantly positively correlated to age (r = .65, p < .01), number of admissions into psychiatric inpatient wards over a lifetime (r = .35, p < .01) and duration of current admission in days (r = .37, p < .01). Internal LOC was significantly negatively correlated with age (r = -.34, p < .01); correspondingly, external LOC was positively correlated with age (r = .26, p < .05).

**Group differences by gender**

A difference was found between internal LOC by gender, indicating that male participants reported higher internal LOC. A Kruskal-Wallis test showed this difference to be significant ($\chi^2(1) = 7.76, p < 0.01, \eta^2 = 0.14$).
Group differences by diagnosis

Kruskal-Wallis tests indicated differences across diagnoses in mean current admission duration ($\chi^2(3) = 26.04, p < 0.001, \eta^2 = 0.46$) and mean number of admissions into mental health hospitals ($\chi^2(3) = 20.52, p < 0.001, \eta^2 = 0.36$). For current admission duration, post hoc tests indicated that significant differences existed between ‘other diagnoses’ and schizophrenia ($p < 0.001$), schizoaffective disorder ($p < 0.01$) and BPAD ($p < 0.01$). For mean number of admissions post hoc tests indicated that significant differences existed between ‘other diagnoses’ and schizophrenia ($p < 0.001$), schizoaffective disorder ($p < 0.01$) and BPAD ($p < 0.01$).

Group differences by ethnicity

A Kruskal-Wallis test showed a significant difference in wellbeing between participants of black ethnicities (including black Caribbean, black African and black British) and white British participants ($\chi^2(1) = 5.60, p < 0.05, \eta^2 = 0.10$).

A Pearson chi-square test compared group differences between ethnicity and diagnosis. Significant differences were found in diagnoses between participants of black ethnicities (including black Caribbean, black African and black British) and white British participants ($\chi^2(6) = 16.41, p < 0.05, V = 0.38$), suggesting that black ethnicity participants were more likely to be diagnosed with schizophrenia, while white British participants were more likely to receive diagnoses of BPAD or schizoaffective disorder.

Discussion

This study aimed to examine relationships between subjective wellbeing, health LOC and demographic variables within a sample of inpatients experiencing acute mental health problems.

Features of admissions

The low mean number of admissions over participants’ lives could indicate that aftercare provisions within the trust are generally effective. However, high mean duration of admissions may reflect delayed discharges due to difficulties such as finding suitable accommodation after discharge, or a high number of individuals with chronic and treatment resistant illnesses. Differences in admission length by diagnosis may reflect the varying amenability of different presentations to inpatient unit interventions. For example, individuals diagnosed with BPAD appear to have relatively short admissions, possibly suggesting effective interventions for episodes of mania.

In this study, participants of black ethnicities (including black Caribbean, black African and black British) were more likely to be diagnosed with schizophrenia (as opposed to BPAD or schizoaffective disorder) than white British participants. It is beyond the scope of this study to draw conclusions about the reasons for the discrepancy in this sample; however, literature suggests that in the UK, schizophrenia is more likely to be given as a diagnosis to black African and particularly African-Caribbean individuals (Fearon et al., 2006). A variety of potential explanations for this discrepancy in African-Caribbean individuals include factors such as migration, socio-economic disadvantage and diagnostic bias (Pinto et al., 2008).

As mentioned above, results concerning diagnosis and ethnicity should be interpreted with caution, as they are hampered by the narrow definitions used within this study. The utility of the current diagnostic categorisation system has been debated (e.g. Cromby et al., 2012); these categories cannot account for individual experiences of illness, severity of illness or other social and historical factors, which are likely to impact on current wellbeing. The amalgamated category of ‘black ethnicities’ used by this study is problematic as it does not allow for exploration of the cross-cultural differences between the ethnicities included.

Locus of control

As LOC subscales are independent, the high mean scores across subscales are difficult to interpret, but perhaps indicate a balanced...
view of how much of participants’ care was under their control. For inpatients of mental health services, much of their daily routine and decisions about their care are genuinely out of their control, so the high external LOC reported in this sample may be realistic. Many admissions are involuntary under Sections of the Mental Health Act, and coercion can be a significant factor in the inpatient experience (Gilburt et al., 2008; Whittington et al., 2009), including significant infringements of freedom and choice over things like medication, meal times and cigarette breaks.

Results suggested that older participants reported a lower internal LOC (and correspondingly a higher external LOC) than younger participants. This may indicate a moderating effect of chronicity of illness through failure to achieve improvements in symptoms, or decreasing levels of functioning that may cause individuals to feel more helpless over time. Internal LOC was also moderated by gender, with males reporting significantly higher internal LOC. However, literature suggests that the relationship between LOC and gender is complex and is moderated by many other factors (e.g. Armitage et al., 2002) that were not included in this study; thus, this finding is unlikely to represent a straightforward gender difference in LOC.

Wellbeing
The mean wellbeing score in this sample was 59.6 out of 110, which indicates that inpatients in this study had similar wellbeing to outpatients with similar diagnoses (Thunedborg et al., 1995). However, as this measure is subjective it is possible that participants may have reported unrealistically high wellbeing for a variety of reasons: experiencing an elevated mood at the time of completing the measure, experiencing a distorted sense of reality at the time of completing the measure, or motivation to report greater wellbeing in order to expedite discharge. Participants of black ethnicities (including black Caribbean, black African and black British) reported higher wellbeing than white British participants; this finding may be due to limitations in the categorisation used, or it may reflect cultural factors that could affect both the presentation and experience of symptoms such as hearing voices (Loewenthal, 2007).

Limitations and further research
No significant correlation was found between LOC and wellbeing, which may be due to a lack of power resulting from the small sample size. In order to further investigate the impact of LOC on recovery in inpatient wards, future research could utilise a longitudinal design and measure changes in LOC over time against improvements in clinical symptoms and perceived wellbeing.

In addition to the small sample size, a number of methodological limitations may have affected validity of results: participants experiencing psychosis were over represented in the sample; assumptions of data normality were significantly violated; categorisation of ethnicity and diagnosis were problematic (this has been discussed above).

This study did not explore additional moderating factors which may be important to investigate in future research and may explain potential links between wellbeing and LOC. For example, low perceived self-efficacy (Eklund & Backstrom, 2006) may result in a sense of hopelessness and decreased wellbeing when combined with a high internal LOC, whereas a combination of high internal LOC and high self-efficacy may improve wellbeing, as this implies the possibility of being able to take control of the recovery process.

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The development and facilitation of a social skills and relationship group run in an adult community learning disability service

Natalie Startin, Rachel Stretton, Julie Taylor & Michelle Haslam

This article describes a 12-week social skills and relationships group within a multidisciplinary learning disability community team that seeks to offer opportunities for people to develop and maintain friendships in their wider social circle.

The importance of the role of meaningful friendships on a person’s quality of life and wellbeing has been widely recognised in research (Knox & Hickson, 2001). However, there are often limited opportunities for people with intellectual disabilities to develop and maintain relationships within their social networks. This is something that has been recognised in the Department of Health Valuing People Now (2009) strategy. Although the de-institutionalisation of care from hospital to community settings for individuals with intellectual disabilities within the UK has led to increased access to social networks, it has not necessarily led to increased social inclusion (Beadle-Brown et al., 2007). Ralph and Ulser (1995) found individuals living in the community continued to interact more with support staff and other people with intellectual disabilities than those without.

Literature has highlighted that individuals with intellectual disabilities often have significant impairments in the application of social skills (Matson et al., 2009). Intervention that focuses on developing functional skills in real-life settings has indicated increased social integration for people with significant intellectual disabilities (Thorn et al., 2009). O’Reilly et al. (2004) highlighted several methods for teaching social skills within this population, including opportunities to observe others, practice in role play scenarios, and being taught rules to act as prompts to engage in socially appropriate behaviours.

Group work is a cost and time efficient way of delivering interventions and provides an opportunity for individuals to engage in social interactions with peers (Whittall & Courtney-Brisbane, 2012). Olsen (2009) suggested that group intervention can be an enjoyable process for the development of skills and highlighted the importance of empowering service users to contribute to the development of such intervention.

The aim of this paper is to outline the development, facilitation and evaluation of a social skills and relationships group run on three consecutive occasions within an adult learning disability team.

Method

Participants

The group was advertised to all healthcare professionals within the Learning Disability team and to colleagues in local social care teams and organisations. A total of 17 individuals with a mild to moderate intellectual disability (12 male, 4 female; aged 20–46) attended one of three groups run consecutively. All individuals who attended had difficulties making and maintaining friendships or understanding boundaries in their relationships, or lacked awareness of keeping safe.

Planning

All individuals referred to the service were sent accessible information about the group. Individuals who expressed an interest were assessed prior to the group by one of the facilitators. The purpose was to establish preferred methods of communication, reasons for wanting to attend, ability to work with others in a group setting and whether they required addi-
tional support in the group. Pre-group questionnaires were also completed.

Day services in the local area supported the running of the group by offering facilities such as room hire and use of computer equipment.

All resources produced for the sessions were presented in an accessible format to enable individuals with limited verbal skills the opportunity to understand the information presented, engage with all activities and express their views and opinions.

Structure
The Psychology team, with support from colleagues in Occupational Therapy, facilitated the group. The 12-week programme aimed to improve social skills through discussion, games, role play and other activities. By focusing on social skills, it was hoped that individuals would improve the skills needed for developing friendships. Each session was highly structured to establish a familiar routine, incorporating a warm-up activity, recap of skills taught in the previous week, introduction of a new skill, and break and session feedback.

The sessions introduced skills such as eye contact, personal space, appropriate touch, greetings and conversation skills. The final group sessions also covered relationships, and in particular making and maintaining friendships. The Talkabout DVD (Kelly, 2006) was an excellent resource used throughout the group.

The group had access to a café after the session had finished. The majority of group members chose to stay for lunch, which allowed skills taught in the structured sessions to be practised and generalised to unstructured settings.

Measures
Qualitative and quantitative methods were used to evaluate the success of the groups. The Maslow Assessment of Needs Scale – Learning Disabilities (MANS-LD) (Skirrow & Perry, 2009), including the Adapted World Health Organization Quality of Life Measure (WHOQOL-8) was administered pre and post intervention. This questionnaire looks at how an individual feels about their life, focusing on being safe, being happy with their relationships, and whether their basic needs are being met. Pre and post measures of the Social Skills Checklist, a measure designed by the Psychology team, were also obtained. This self-report measure relates specifically to the topics covered during the group (e.g. ‘I know the difference between a stranger and a friend’ and ‘I ask questions when talking to people’). Finally, individual and carer feedback was collated post intervention during follow-up visits by the facilitators. Group participants were asked their thoughts about the group (e.g. What did you learn from attending? What would you change?).

Results
A paired-samples t-test was used to examine the differences between mean scores on the Social Skills Checklist pre and post group intervention. Mean scores from the post group administration of the Social Skills Checklist (mean = 14.06, SD = 2.09) were significantly higher than mean scores from the pre group administration of the Social Skills Checklist (mean = 11.73, SD = 3.41).

Further findings indicated improved scores from pre (mean = 1.40, SD = 0.74) to post (mean = 1.80, SD = 0.41) measures on the statement: ‘I know who it is OK for me to hug’ (t(14) = -3.75, p < 0.01) and improved scores from pre (mean = 1.13, SD = 0.92) to post (mean = 1.67, SD = 0.62) measures on the statement ‘I ask questions when talking to people’ (t(14) = -2.26, p < 0.05).

No significant differences were found between pre (mean = 60.20, SD = 7.94) and post scores (mean = 64.60, SD = 10.63) on the Maslow Assessment of Needs Scale – Learning Disabilities (MANS-LD) (Skirrow & Perry, 2009) or on pre (mean = 26.60, SD = 3.10) and post (mean = 26.90, SD = 3.98) measures of the Adapted World Health Organization Quality of Life Measure (WHOQOL-8) (t(9) = -0.20, p > 0.05).

Qualitative feedback obtained from service users, carers and fellow professionals has been extremely positive and suggested that all individuals who attended enjoyed it and had benefited from attending. Comments such as ‘I feel more confident at home’, ‘I have made friends at my gardening club’, ‘I feel better at talking to people’ and ‘it has given him a tremendous amount of confidence to strike up a conversation without prompting’ were common.
Discussion

There are two possible explanations for the non-significant results obtained on the MANSLD measure. Firstly, only 10 out of the 17 participants completed both pre and post measures of the questionnaire, which is a relatively small sample size. Secondly, this measure may have not been sensitive enough to capture positive changes following group intervention. The questionnaire focuses on all aspects of an individual’s life, not just their relationships. A number of individuals accessing the group were experiencing changes and difficulties in other aspects of their lives which may have explained a decrease in their scores. Although significant improvements were obtained from the Social Skills Checklist, these results should be interpreted with caution, as the validity of the questionnaire has not been established.

The groups run so far have provided an enjoyable process for both the individuals attending and the group facilitators. Qualitative feedback from both participants and carers suggest that the group has provided a valuable experience, which was reflected in the commitment to the group, with only two people over three groups not completing the course.

Visiting clients prior to commencement of the group provided an opportunity to present information about the session structure and topics that would be covered. Accessible information letters were also sent prior to the group starting. This also gave an opportunity for individuals to meet one of the facilitators and ask any questions. This appeared to help alleviate anxieties about attending and meeting new people. To improve the return rate of outcome questionnaires in the future it was decided to complete these with the individual as part of these visits.

Although the group was structured in terms of the topics covered, the length of the sessions, etc., there was flexibility by the facilitators as to how the information was delivered. This ensured that the information presented was adapted to meet the needs of group members. This occasionally highlighted the challenges of only having two facilitators for the group, particularly when the ability of participants was varied and some individuals with moderate intellectual disabilities needed additional support. The increasing interest for the group has allowed for participants of subsequent groups to be matched on ability.

It became apparent early on in the sessions that there was a discrepancy between knowledge and application of the skills being taught for a number of individuals. Practice activities provided context similar to those experienced outside of the group and helped the group members to identify the skills they found easy to implement and those they found more difficult. It also enabled the group facilitators to make observations and provide feedback to the group members.

To encourage generalisation of the skills, skills summary sheets highlighting key rules taught were handed out at the end of each session. The majority of group members reported that they had kept these and used them for reference following completion of the group. The co-location of the group with a café encouraged positive interactions outside of the group environment (e.g. making eye contact when ordering food, and remembering to ask questions and practice listening skills when engaging in conversation at lunchtime with peers).

Carers/professionals (e.g. community nursing and community support workers) were asked to support some individuals in the group for a number of reasons (e.g. to manage risks presented by some clients with forensic histories, whilst other individuals lacked confidence to access the group without support). This appeared to be an invaluable experience, with support staff playing a pivotal role in the generalisation of skills taught and the transference of these skills from one setting to another. During group follow-up visits, a number of carers reported that they were keen to continue to prompt the individuals they were supporting to apply the skills they had learnt from the group. In addition, they have also assisted other individuals that they support, but who did not attend the group, to improve their own social skills. However, this could also present challenges during sessions. On a few occasions support staff were observed to inconsistently demonstrate appropriate social skills (e.g. boundaries around touch), which sometimes led to confusion for participants. This issue was addressed with staff outside of the group setting.
Follow-up evaluation visits were completed one month after completion of the group. This provided an opportunity to complete post intervention questionnaires, but also to obtain feedback about the group. All individuals spoke positively about the group and were able to identify something they had enjoyed and learnt. Many individuals liked the activities in the sessions, particularly the games and the Talkabout DVD (Kelly, 2006) clips. The majority of the individuals had retained information and rules taught in the group (e.g. asking permission before touching friends). This is likely to be due to the repeated presentation of the skills throughout the course and the accessible skills sheets which meant that information could be disseminated after the group to parents/carers. Feedback about changes focused more on the structure of the group (e.g. the room, number of members, number of sessions), as opposed to the content. Two individuals expressed a wish to help co-facilitate future groups. This is something that the Psychology team are looking forward to implementing.

Multidisciplinary team facilitation of the group was beneficial because it encouraged other professionals to share their experience of running groups. The Speech and Language Therapy team offered time to discuss the development of accessible information and presentation of material to ensure language was simplified to deliver the group content. Occupational Therapy have co-facilitated all three groups.

In conclusion, the success of the group appears to have led to a ‘ripple effect’. A number of professionals commented on the benefits of the group with individuals they continue to work with. Firstly, it has been helpful in supporting individuals who have been hard to engage in individual therapy to access intervention and take an active role in the group. Secondly, the group has also provided a foundation for further one-to-one therapy for a number of individuals. One participant was able to draw upon the sessions that focused on emotions to express their own feelings within therapeutic sessions more effectively. Finally, running the group in community settings has strengthened the development of relationships with wider social care services (e.g. day centres).

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References
Psychosocial development in young people with cystic fibrosis

Charlotte Wilson, Rachel Pearce, Stephanie Summers, Lucie Taylor & Charles Haworth

Seven young adults with cystic fibrosis (CF) and five professionals working with them were interviewed about CF and the impact it has on their psychosocial development. Themes of identity, relationships, impact on life and dealing with CF were identified.

Young people with chronic illness often struggle to meet developmental demands (Pinquart & Teubart, 2012), with negative consequences for mental health and social relationships (Pinquart & Shen, 2011). Little research examines these processes in young people with cystic fibrosis (CF). CF is a multi-system disease, clogging the lungs and digestive system with thick mucus, making it hard to breathe and digest food. Recurrent chest infections and malnutrition are common and outcomes of CF, include poor growth, delayed puberty and liver problems. Physical and functional limitations of CF increase throughout adolescence and young adulthood. However, life expectancy for people with CF continues to increase and transition into adulthood is now commonplace. Studies have explored how young people with CF experience this transition, focusing on the impact on treatment adherence and healthcare (Badlan, 2006). However, despite focusing on health provision, studies often identify factors that can be best understood from a lifespan developmental psychology perspective. For example, the physical effects of CF impact on the process of building body confidence, sexual identity and forming adult relationships (Pepfler et al., 2003). Frequent hospitalisations can interrupt relationships and the ability to establish supportive peer networks. Social pressures may encourage non-adherence in adolescents putting their health at risk. Periods of ill-health can require individuals with CF to accept dependence on adults, and increased awareness of death may affect desire to separate from parents. However, few studies have explored the experience of the young people with CF from their own perspective and this was the aim of the present study. In line with recent research (Iles & Lowton, 2010), the study also explored staff perceptions of how young people negotiate the transition to adulthood when they have CF.

Methods

Ethical approval was granted by NHS and university ethics committees. Ethical procedures were adhered to throughout.

Of 30 patients who met inclusion criteria (aged 18 to 25, CF diagnosis for at least a year, well enough to take part, fluent English and able to give informed consent), seven participated (three women). In addition, five staff members participated (physiotherapist, dietician, consultant doctor, specialist nurse and staff nurse).

The primary aim of the research was to explore the views and experiences of young people with CF and the staff working with them, and so the study employed an exploratory qualitative methodology. The study aimed to identify themes that could be taken forward into future research and so a post-positivist rather than interpretative approach was used, with thematic analysis being used to identify themes emerging from interviews (Elliott & Timulak, 2005).

Semi-structured interviews, comprising open-ended questions about the impact of CF on everyday life, were developed by all authors and two clinical psychologists specialising in CF. There were two parallel interviews with identical content; one for patients, and one for staff. The interviews lasted approximately an hour, and
were conducted on a one-to-one basis in a private discussion room in the hospital. Interviews were recorded on digital voice recorders and then transcribed verbatim. These interviews were subjected to an analysis process that is common to many qualitative approaches (see Elliott & Timulak, 2005): data were transcribed and read in depth, initial codes were developed and reviewed by the research team, and domains or themes were identified by the team, which were then individually reviewed with the interview data using a process of constant comparison.

Finally, the team reviewed the themes for the presence of over-arching themes and sub-themes and for examination of links between them. A final data check was completed and quotes extracted to illustrate themes and sub-themes. The interviews from patients and staff were analysed in the same way and were compared with the aim of triangulation. A resonance check was undertaken with the psychologists who helped develop the interview. The themes that emerged did so in both patients and staff accounts unless otherwise stated, but the patient’s quotes are privileged.

Results
Four main themes were identified: relationships, identity, impact on life and dealing with CF. These, and their sub-themes, are described below.

Theme 1: Relationships
All participants spoke about peer and family relationships being central to their lives and how CF can impact on these relationships.

1.1 Making and maintaining relationships: There was balance in the patient’s reports of their friendships: The majority reported past difficulties, but only two patients felt that they had fewer friends as a result of their CF. The women saw the physical symptoms of CF as an issue when engaging in romantic relationships, but not when in committed relationships. Some patients reported difficulties because friends lacked knowledge of CF, but the majority of patients reported having supportive and knowledgeable friends and partners. Staff and less-well patients regarded time spent in hospital as the biggest barrier to building relationships, but fear of rejection and peer acceptance were also prevailing themes: ‘It is hard to keep a friend when you are only there [school] for two weeks and they are there for a month. It is like they have forgotten you.’

1.2 Impact of relationships on health status: In contrast to staff, only a few patients saw a link between relationships and health status. Patients did report that relationships were sometimes negatively impacted when they were not open about their illness. Staff members further hypothesised that this led to lower treatment adherence.

1.3 Others’ level of involvement: The level of other people’s involvement and patients’ satisfaction was variable. One patient, diagnosed late in his teens, felt his parents did not understand his diagnosis and consequently were not involved. In contrast, three patients diagnosed in early childhood reported contentment that parents were no longer involved in the day-to-day management of their CF, but were still involved in important care-related decisions. Staff felt that some young people needed less involvement from their parents, as did three of the young people themselves. Staff and young people alike recognised that when they were well, and as they got older they would become more autonomous and the parents would relinquish control, but that this would occur later than would be expected in non-CF individuals.

Theme 2: Identity
All patients spoke about the formation of their adult identities and the impact of CF on the development of this.

2.1 Accepting CF into one’s sense of identity: Many patients reported recognition that they were ‘different’, and although initially they wanted to be seen as normal and ‘fit in’ they gradually accepted this difference. Supportive open relationships both helped the process of acceptance of CF and were a result of it. Non-acceptance of CF into one’s identity was linked to treatment non-adherence, either by skipping medication while with others or by denying that you need it: ‘I like to not think about my illness. It’s kind of a way of dealing with it, and doing nebulisers makes me think about it more.’
2.2 How others identify them by their CF: The patients spoke about how they were defined by others, often being given the ‘ill’ or ‘sick’ label, or their CF being an over-emphasised part of them by others: ‘I have always been known as the sick little sister.’

2.3 Comparing self to others: A large part of identity seemed to be formed by comparison to others, mainly peers, and a marked feeling of being ‘different’ was expressed. Comparison to other people with CF was common, with patients feeling they were better off than many of those around them. This downward comparison seemed to help elevate esteem but some staff reported that such a belief was linked to lower treatment adherence: ‘I’ve got what they have got but not as bad… I feel quite bad for them, but lucky for myself.’

Theme 3: Impact on life
Those whose disease was more severe expressed significantly greater impact in the past and present. However, considerations about the future impact of CF on their lives were expressed by all patients.

3.1 Past impact: All participants reported specific events that they had missed or ongoing activities they could not take part in. Having time off school and university, missing exams and not being able to participate in extra-curricular activities and sports were recurring themes: ‘I played for a team for 10 years… I got to 15–16 and my lungs couldn’t handle it anymore.’

3.2 Present impact: The impact in the present spanned domains including work, leisure, body image and mood. CF impacted on patients’ career choices, but also on their capacity to work, and thus their finances. CF also had an impact on how patients felt about their bodies. They often discussed outward signs of the disease (low weight), or treatments they had undergone (scars) or were undertaking (peg for feeds): ‘I do get very embarrassed because I have scars and I have my peg.’

Staff were also concerned about the impact CF could have on patients, and reported that limited social experience and poor body image was associated with patients’ low self-esteem.

Patients clearly described how their disease status impacted negatively on their mood, with some describing low mood, anxiety, worry and irritability. The physical manifestations of CF could impact on mood quite directly, and at other times it was end of life issues or rumination about the future that were linked to mood disturbances: ‘Fed up for having to do everything all the time, like if my chest is bad, just fed up, coz you actually have to think about breathing.’

3.3 Predicted future impact: Predictions about the future were prominent in the interviews with patients. One patient regarded the future as too difficult to discuss, but the remaining six reported thinking about having children, careers and pensions, or about the physical implications of CF such as death and lung transplants. Some patients reporting avoiding thinking about the future and others approached it confrontationally.

Theme 4: Dealing with CF
All patients spoke eloquently about how they managed their illness.

4.1 Control of life and independence: Staff reported that patients found it difficult to achieve independence, partly because of their parents’ anxieties about relinquishing the role of caregiver. Several patients described it as a two-way process in that their parents had to relinquish control and they had to accept more responsibility. Difficulties occurred when either party did not engage with this: ‘My mum is, she’s always nagging me to do it, and then when I don’t do it dad will moan at me, and sometimes I will rebel and say no I’m not doing it due to the moaning.’

4.2 Decision making
The majority of staff felt that patients showed differences in their ability to make sensible, mature and well informed decisions, but it was clear that they considered this variation to be normal. Patients described using multiple sources to be informed, valuing others support in making them and owning their decisions, which were sometimes contrary to medical recommendations.
4.3 Coping: Patients most frequently cited having a supportive social network as key to coping. CF peers were in a unique position to understand the challenges of CF, but non-CF friends allowed patients to ignore or avoid thinking about it: ‘I just talk to my friends and family and they are strong for me, so I know that I have their support.’

Two of the patients appeared to use avoidance as a primary coping strategy; they knew very little about their illness and medication, ignored treatments and refrained from discussing their condition. Practical coping strategies included having routine, looking after themselves and taking risks as a means to escape and to enjoy the life they have left. Emotional strategies such as humour, laughter, avoidance, and a ‘matter of fact’ attitude were both observed and talked about: ‘I’ve got a laid back attitude and will laugh it off... it’s my way of getting through it.’

Discussion
Although key themes of relationships, identity, impact of CF and dealing with CF were identified, within these themes participants reported a spectrum of responses. The effects of CF were concentrated on common themes. In line with previous research (e.g. Badlan, 2006), a sense of difference was recognised during development by all the young adults with CF, and the integration of CF into their sense of identity was associated with positive adaptation. Unlike previous research, both men and women with CF reported body image concerns. In addition, although peer relationships have not emerged strongly within the CF literature, the patients’ reports in this study were consistent with research with people with other chronic illnesses (La Greca et al., 2002).

Limitations of the study
This is a small exploratory study of psychosocial development as experienced by young people with CF, and thus generalisability is limited. Involving the staff in the study is both a strength and a weakness. Most of the themes were expressed by both young people and staff members, suggesting that the data were triangulated to some extent. However, different themes may emerge if larger groups of individuals with CF and staff members who work with them are analysed separately.

Implications
The present study highlights several issues that are pertinent to working with young people with CF: the importance of working with the young person and parent towards independence, allowing for times when young person needs less independence and more support from family, paying attention to mental health difficulties, and accepting that there are a variety of responses are all noted. Furthermore, it is hypothesised there may be a reciprocal relationship between CF symptoms and social relationships that warrants further research.

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Book Review

Being Mortal

Atul Gawande


Review by: Stephen Weatherhead

There is without doubt a resurgence of the narrative in medicine, and Being Mortal merges narrative and medicine beautifully. Atul Gawande, the clinician who developed the pre-surgery safety protocol which has saved countless lives in operating theatres across the world, now gives us a book which has the potential to shift how we think about death. Being Mortal is a wonderful narrative of Gawande’s exploration into how we prepare ourselves and others for the later stages of life. The book has chapters with titles such as ‘Dependence’, ‘Letting go’, ‘Hard conversations’ and ‘Courage’. These titles could just as easily be descriptions of what seems to be Gawande’s own journey from thinking purely about saving lives to a close connection with the emotional, practical, social and existential aspects of death and dying.

Don’t worry though, it isn’t as miserable as it may first appear. This book is as much about life as it is about death. I hadn’t really noticed this until I was mid-way through and my seven year old son asked me what it was about. I explained that it’s a book about how we don’t really think much about life until it’s nearly gone. ‘Being mortal’ encourages us to deeply connect with our lives and the decisions we make about our future and that of others. The author facilitates this by introducing us to his patients, his family, friends, clinicians and the countless others from whom he has gained his insights.

There are incongruences in Being Mortal, as one would expect with any book that presents a personal as well as a professional narrative; life stories aren’t clean and congruent. For example, he seems to gloss over the way Western cultures often lose respect for older people, suggesting the older generation holds significant social and political capital which doesn’t seem to match the stories he shares. One can forgive this though, because any great book should encourage us to do our own thinking whilst also guiding us along a path.

This isn’t an academic text, filled with empirical research. Nor is it a clinical text guiding us through therapeutic technique. It is however, a rich exploration of later life, by a clinician and academic. Here, Atul Gawande presents data in a human way, and human experience in a form which envelops one in a literary duvet from where we can safely ask ourselves what it is to be mortal.

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Notes from the Chair
Richard Pemberton

Mapping the future
It has been a real pleasure to contribute to recent birthday celebration conferences in Exeter and Belfast. Both events reflected on our development and contribution as a profession but sought to chart the way forward and set out new horizons in psychologically informed care. At both I argue that in order to realise our ambitions, reduce premature deaths and the numbers of people living unnecessarily restricted lives we need to continue to invest in and strengthen the division and the Society.

Obesity
The Society, at the divisions prompting, is revising its obesity guidance. We don’t however just need new guidance to strengthen our contribution and tackle the many life limiting illnesses associated with obesity, we also need to bring together in better alignment our eating disorder and bariatric surgery faculty and the health and sport psychology divisions. Our overly divided professional house is self limiting and I would argue costs lives.

Outcomes
Esther Cohen Tovee has been representing the Society on an important NHS England outcome reference group. I sit on the NHS England mental health payments group. There are profound moves being made to transition away from block contracts for mental health services to payments based on the outcomes services achieve. This is of course not an easy or simple area. It is fraught with complications and if one isn’t careful, perverse incentives. Outcome measurement and improvement is however our natural territory and the IAPT programme has led the way here. We are also supporting a linked initiative on coproduced formulation. If we get this right the gains are potentially huge, not least a significant reduction in the scandalous 15 to 20 year premature death rate for people described as seriously mentally ill. A new group is forming in the division and the society to take this work forward and this will be a key area for the new division leadership to progress.

Educational and child clinical psychology
The report to ministers on the review of Educational and Child Clinical Psychology training has still, at the time of writing, not seen the light of the day.

Regardless of what the report says we clearly need much stronger links, shared objectives, work programmes and joined up workforce planning. This shouldn’t be that difficult as, for example, the educational division are running an important demedicalising childhood work stream, which could and should inform and strengthen our beyond diagnosis work.

London DCP
The DCP London Branch annual general meeting and its Future London Psychology Workforce event was an important milestone in the capital. Al Beck the Head of Psychology at Slam was voted in as the new Chair, along with many new and senior committee members. In order
for our English structures to be effective we need a vibrant and outward looking London Branch. Many thanks to the outgoing committee members, particularly the long standing chair Zenobia Nadishaw.

**The future**

London psychology workforce this event built on our survey results and the previous workforce events in Durham, Bristol and at our annual conference. There have been some savage cuts to leadership posts in London but also lots of new developments and opportunities. The profession is changing very fast. Many of the new posts are in children services, neurology, forensic provision and physical health. We need to protect and strengthen our work in adult mental health but the centre of gravity seems to be shifting to other specialities and new roles. Anne Richardson helpfully outlined her project to review our influence and policy impact in London. Her recommendations may well have relevance well beyond the capital.

**Special general meeting**

Notices have gone out for our special general meeting on 10 May in London. The newly elected leadership of the division formally take over at that point. Please make sure that you use your vote. We have not called for nominations to the positions of policy and research directors or PR and Comms as we wanted the new executive to have an opportunity to review its membership and streamline its workings. The delay in the call for nominations in these areas does not in anyway reflect a lack of commitment to strengthening our work in these areas.

It is still unclear what the new recompense arrangements are going to look like and how they will work in practice. We are going have to cut our cloth according to the new set up. As the trustees still haven’t settled on a new recompense policy we have asked for the current levels of recompense to rolled over for another year and for transitional arrangements to be put in place.

**DCP conferences**

Whilst the London annual conference was very successful, there are lots of way we wish to improve it. We are reviewing all this with the BPS Conferences team. We want to better align the annual event with faculty and branch conferences and the Society’s annual conference, and we also need to be thinking about our connections with the other divisions’ conference activities. Details of the outcomes of the review will be posted on our website as will the videos of the great keynotes at the conference and the very lively annual general meeting of the division. We are plan to make a raft of changes and reduce costs for the next annual conference which is likely to be in Liverpool next January.

**The Palace of Westminster**

As part of our ongoing 50th birthday celebrations Lisa Cameron, our first clinical psychologist MP, is hosting a reception for us in parliament. It will be on the evening of 9 May. Invitations will be going out to a broad cross section of the profession. The event will mark the end of Jamie Hacker Hughes’ Society Presidency and the beginning of Peter Kinderman’s. It will also be a great opportunity to raise our and the Society’s political profile.

**Sad news**

More sad news about colleagues and division members. Joan Kirk a leading figure in the Oxford Cognitive Therapy Centre, and a friend of my family, has died following a long illness. We need to agree some better ways of marking people’s contribution and death. The division, for example, supported a two-day conference for David Smail but other members, who in their own ways have made really important contributions, go unreported. We would welcome ideas from members about how we could improve the way we mark and celebrate members lives.
Notes from the Chair

The End of Leadership
I have been reading Barbara Kellerman’s new book *The End of Leadership*. It should be required reading for all trainees and psychology leadership development programmes. She takes aim at the leadership industry and argues persuasively for a radically changed balance of power between leaders and followers. She says as a result of cultural evolution and the technological revolution ‘Leaders have become weaker and followers stronger’. I strongly recommend it to you. It has tangible implications for the way we build a stronger and more progressive professional house, full of empowered leaders and followers.

Richard Pemberton
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Annual Conference 2016
East Midlands Conference Centre, Nottingham, 26–28 April
Themes:
Faces ● Ageing ● Impact ● Wellbeing
Confirmed keynotes so far:
Dame Vicki Bruce & Professor David Clark
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