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South West Yorkshire NHS
Mental Health NHS Trust

With all of us in mind

Mental Health and Learning Disabilities
Research and Practice

Volume **2** Number **1**
April 2005

Mental Health and Learning Disabilities Research and Practice is jointly published by South West Yorkshire Mental Health NHS Trust and the University of Huddersfield. It is published twice a year. Online articles: abstracts and articles can be viewed online at: www.hud.ac.uk/hhs/research/mhrg/journal/issue1.pdf or www.southwestyorkshire.nhs.uk/journals where full text current and past articles can be downloaded.

Aims and Scope of the Journal

Mental Health and Learning Disabilities Research and Practice is a joint publication between South West Yorkshire Mental Health NHS Trust and the University of Huddersfield. *Mental Health and Learning Disabilities Research and Practice* will encourage a wide range of material which is accessible to a broad audience. It will appeal to a wide range of mental health practitioners, social care practitioners, researchers, educators, users of mental health services, carers, and voluntary sector workers.

The function of the journal is to:

- Disseminate research findings related to mental health and learning disabilities;
- Provide an opportunity for practitioners to:
  - share research findings, service developments, and educational developments,
  - write review papers

that are relevant to mental health and learning disabilities.

Mental Health and Learning Disabilities Research and Practice aims to be a good quality peer reviewed journal with well presented material. The journal aims to be inclusive as possible and supportive of first time or novice researchers and writers.

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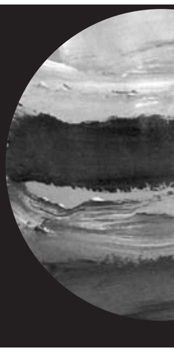


Editorial

Welcome to the second edition of Mental Health and Learning Disabilities Research and Practice. The journal was successfully launched at an event held in the Castle Hill Suite at the University of Huddersfield, on the 2nd November 2004. The launch was attended by the Dean of Human and Health Sciences from the University, the Chief Executive of South West Yorkshire Mental Health NHS Trust, the Editorial Board, peer reviewers and authors, in addition to guests from partner organisations. We have also received good feedback from people who were not able to attend the launch but had received and read a copy of the journal. The following are two examples of the feedback we have received so far:

"This is a valuable resource for anyone interested in these important issues – particularly the links between research and practice in an under-researched and under-provided client group. Your new journal has great potential." (Prof Glenys Parry)

“There is a gap in the market that could usefully be exploited now that the Journal of Mental Health has moved away from its traditional service development focus and more towards purest research. The MH&LDR&P could usefully exploit this gap and also provide a service development focus as well as that of practice development.” (Dr Tony Ryan).

The journal has received a great deal of interest since its launch and appears to be filling a niche in the market. Since the publication of the first edition, we have had expressions of interest from other organisations who are interested in becoming partners in the venture. We will be looking at possible expansion over the next twelve months.

In this edition we are introducing a new section called ‘Points of View’. This section asks authors to reflect on their personal point of view or experience of service delivery or practice, educational or service development, or involvement in a research project. In the article ‘The Most Horrendous Day of Our Lives’ we have a perspective on Post Traumatic Stress Disorder from both a service user and a clinician, together with a list of sources of help.

The Editors hope that once again you will find the range of articles in the journal interesting and informative. Finally, we hope that many more of our readers will put pen to paper, or finger to keyboard, and contribute to the journal.

The use of narrative in preparing mental health nursing staff to undertake clinical supervision

Steve Lyon[1]

[1]University of Huddersfield

The use of narrative in preparing mental health nursing staff to undertake clinical supervision

S R Lyon

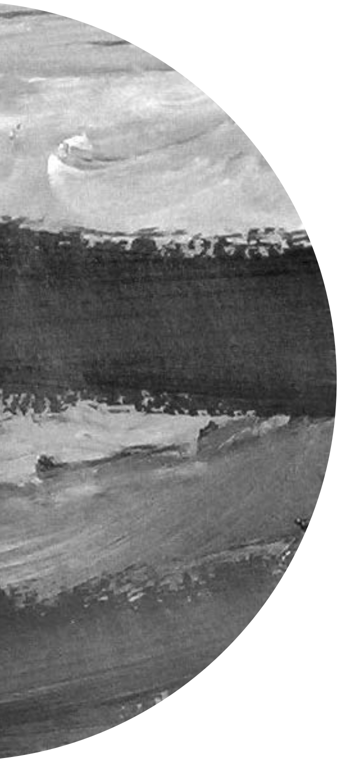
Abstract

There is considerable interest in the use of narrative by healthcare professionals. This ranges from those who are exploring its use as a therapeutic method through to those who are interested in its use within research. This paper examines, through a personal reflective account, the use of narrative as a method of engaging participants in the learning process within a training programme* preparing mental health nursing staff to undertake clinical supervision. The paper suggests that the use of narrative is a much more powerful method of facilitating learning than the use (and in many cases over use) of technology such as PowerPoint and overhead projector. This paper argues that effective clinical supervisors assist in the 'telling of stories' and therefore it makes sense to encourage story telling and story listening within the training programme itself. Here, I also describe the facilitator** style required to encourage the sharing of narratives. This paper discusses, albeit briefly, the use of group teaching methods that foster a 'sense of community' countering a sense of isolation and disengagement which, I suggest, is very much apparent in modern day society and a symptom of burnout, and frequently observed in mental health nurses.

Keywords: Burnout, Clinical supervision, Engagement, Narrative, Training programme

*the term training programme is used interchangeably with other terms such as training course, development programme, educational programme, and training workshop.

**Although the term facilitator is the preferred term used within this paper, others such as tutor and teacher also appear. The term facilitator, to me, implies a collaborative relationship between learner and other, and suggests an active as opposed to passive learning process.



Introduction: Facilitators as story tellers

Are you sitting comfortably…………………

"The most surprising part is that I qualified as a mental health nurse in the first place. It's not every student nurse on their first placement, stumbles upon a patient hanging dead by a tie, and goes on to complete the course. The lack of support I got at the time convinced me more than anything that nurses needed a supportive process like clinical supervision".

The above paragraph is a summary of a true story narrated in much richer detail by myself, with a great degree of sensitivity. The story, and other stories like it, are told at the beginning of a programme preparing nursing staff to become either clinical supervisors or clinical supervisees. They are used as a method for 'capturing the hearts and minds' of participants, some of whom may have not had a choice but to come on the programme. Clinical supervision training borders on being a mandatory requirement in many trusts, with all the 'baggage' that creates for the unwilling 'traveller'.

Compare the telling of a good story at the start of a training event with the bland recital of a list of objectives projected onto a wall in a classroom. This practice is one frequently encouraged on 'train the teachers' courses, where they are indoctrinated in the art of always reciting the expected outcomes at the start of every session. Its very blandness is suggested by the mantra 'first tell them what you are going to tell them, tell them, and then tell them what you've told them'. This monotonous process is temporarily offset by the monotonous use of technology to keep a flicker of interest.

Clarke (2003) describes how in nurse education there is an over reliance on 'teaching aids'. This has, according to Clarke, resulted in barriers to meaningful discussion between tutors and students, and resulted in diminished learning opportunities. It has quite strikingly been described as 'death by overhead'. Clarke appeals for a return to more traditional methods of teaching, what I would call "talk without chalk".

It is easy to appreciate the embrace of PowerPoint, by tutors, when faced with an audience fed regularly on (super) graphics, and whose palate is unaccustomed to a seemingly bland diet of reflective discussion. Here lies the challenge; to excite the participants through relevant and appropriate stories whilst avoiding the charge of over-stimulation and shallowness. Without due care, attention, and sensitivity the use of stories are mere substitutes for the technology from which we are attempting to wean them, but used appropriately, as McAllister (2001) observes, narratives have the "power to move and transform people".

Apart from its function as an initial engagement strategy, there are a number of other appropriate reasons for employing narrative on programmes preparing clinical supervisors.

The place of narrative within clinical supervision

A frequently told and popular joke unfolds as follows:

'Bill and Ted are walking down a street. Bill is accompanied by a dog, Ted asks "Does your dog bite?", to which Bill replies, "No my dog doesn't bite". Ted is most angry when attempting to pat the dog's head his hand is bitten. "I thought you said your dog doesn't bite ", to which Bill replies "He doesn't - that's not my dog".

I recall a similar tale involving an elaborately staged entrance to a group of students. The group of students are unknown to the author. The incident involved plenty of slapstick with the purpose of grabbing the group's attention but which resulted in classroom mayhem (I 'died on stage'). Once I had recovered I angrily challenged the group's 'normal' tutor: "I thought your class liked a good joke", to which the tutor replied, "My class does like a good joke - that's not my class. You were in the wrong classroom!" .

I tell this tale a lot to students when we first meet, with the intention of lightening the initial tension and establishing rapport. I learn something new every time I retell the story. Similarly, if I was reflecting and narrating this account in my own clinical supervision, I might explore the critical incident at different levels and from a number of different angles. The narrating of stories fires the fuel of clinical supervision and ultimately makes the thing work. I therefore suggest that any training intending to prepare clinical supervisors should focus on the task of storytelling.

Many books on clinical supervision emphasise the process of storytelling. For instance, Driscoll (2000) discusses the role of clinical supervisees in clinical supervision, and emphasises the need for supervisees to prepare for the process. One of the tasks of the clinical supervisee, he suggests, is to prepare a story to narrate and then tell the story. Johns (2002) also includes chapters on narrative in his book on guided reflection, and Ghaye (2000) refers to what he calls a 'clinical conversation' which takes place within clinical supervision.

Mcleod (2002) describes in detail the use of narrative as a method for learning and problem solving. For instance, he writes: "…everyone has experiences that are perplexing and somehow 'unfinished' until they can be told to someone else…". Later, in the same chapter he suggests that it is by recounting past experiences to some other that we learn to problem solve.

The example of the 'wrong class' described at the beginning of this section, provides an illustration of a 'somehow unfinished experience' which could be subjected to 'problem solving' explorations in clinical supervision. Using the 'wrong class' as a for instance, during clinical supervision, I could have been asked quite practical questions such as:

"On reflection, what could you have done that would have prevented the mistake happening in the first place?"
"If you were in a similar situation in the future, and obtaining a poor response from the group, what would you do?".

These are two good questions that help the person reflect on past experience and consider what can be done differently in future. This of course supports models of reflective practice which describe stages in which people reflect on experiences to do things differently (or indeed same) in the future as described by Schon (1983)

The need to work with narrative as a means to develop critically thinking health professionals is currently being evaluated. For instance, Khanna (2004) identifies narrative reflection as a basic requirement on a pathway to the development of critically thinking occupational therapists.

Hopefully, these examples help emphasise the benefits of using narrative in clinical supervision, and therefore, any training programme preparing both clinical supervisors and clinical supervisees for the process of clinical supervision, must include working with narrative. Clinical supervisors, in particular, need to acquire the skills and qualities that promote storytelling in their supervisees, and supervisees need to acquire the ability and willingness to share stories.

The development of effective story-listeners and story tellers

In 2002, I was involved with a clinical nurse manager in designing and facilitating a programme to prepare nursing staff to become clinical supervisors. We had in mind the following two intentions:

1 The programme would translate into practice; it would not be one of those training events that made no difference; trained clinical supervisors would continue to provide clinical supervision beyond the life of the training course.

2 The programme would inspire; the participants would be enthusiastic about the process both during and beyond the training programme. In this way, we believed, the clinical supervisors would be committed to the process of clinical supervision.

The translation into practice was achieved by training small groups of staff, who came onto a training workshop in pairs, predominantly from the same service (type and geography). The clinical supervisee and their clinical supervisor enrolled onto the training programme and were subject to the same learning material, and were provided with practice opportunities whilst on the course.

Altogether, we ran three separate workshops. These training workshops took place over a period of on average two months, and thus allowed the supervision pairs to transfer learning into practice, and to provide feedback on progress. At a follow up date, the supervision pairs came back to share their stories.

The feedback opportunity modelled the reflective process, and further developed their understanding of reflective practice. This of course, required much sensitivity and management especially in respect of keeping the content of clinical supervision confidential.

Translation into practice was assisted by both clinical supervisors and their clinical supervisees hearing and being inspired by the same stories. Together they explored and extended the stories they had heard. Together they checked out their understandings and how these stories had affected them. Together they struggled with some of the more difficult material presented on the programme and this helped facilitate the process of joint problem solving.

This notion of training pairs who come from the same part of the service echoes some of the work on designing learning organisations. Learning organisations are those which foster a culture of inquiry and the embracing of best practice. Senge (1994), writing on building a learning organisation, emphasised facilitating team building resulting in shared visions and mental models, and team learning. Learning in teams, it is suggested by Nonaka and Takeuchi (1995), is critical for the engagement with 'best practice'. Currently, there is considerable interest in the process of establishing what Wenger (1998) calls communities of learning practice; groups of people working together to introduce and support best practice. This initiative was an attempt to establish a community of learning practice in order to introduce and sustain the process of clinical supervision. It was a community established through the sharing of stories. McAllister (2001) describes how the use of shared stories evokes a "collective cultural wisdom" in nursing, and it was my intention to establish a local culture with the collective wisdom to embrace and maintain clinical supervision.

There are other, perhaps more obscure, benefits in using group methods of teaching that encourage the sharing of stories. Maslach and Letter (1997) describe the causes of burnout, and in particular discuss how the modern organisation has resulted in many employees feeling isolated and disengaged. The current growth in self help and life coaching books aiming to reduce the emotional cost of burnout would testify to the increase in its prevalence. Winstanley et al (2003), Hawkins and Shohet (2000) suggest that health professionals who are particularly prone to burnout may be helped through clinical supervision. The sharing of stories may help people feel part of the culture and hence less isolated and more protected from burnout.

Facilitators as story listeners

The teaching method and style adopted by both myself and my co-facilitator were those that encouraged 'story sharing'. Thus it was a conscious decision to avoid a prescriptive inflexible timetable of events, that we'd slavishly adhered to. Rather, we took on a style advocated by Musson (1998) for story listeners; that of a flexible non directive listener who is "fluid as the situation demands…….. rather than impose some rigid predetermined framework". Powerpoint presentation, with its pre-ordained sequence of learning slides efficiently matched with desired outcomes, does not lend itself to this person centred style of facilitating.

This said, I do not want to give the impression that the essential skills, qualities and knowledge necessary for effective clinical supervision were not addressed on the Workshop. Indeed, underpinning the course was a framework of competencies associated with effective clinical supervision which was used as a baseline benchmark, and as a tool to assist focused reflective practice and assessment. Still, I wish to emphasise the oral/aural methods of teaching method used to facilitate the acquisition of skills and knowledge that underpin a mainly oral/aural process.

Tutor, teacher, facilitator, lecturer; these titles are enough to turn people into quivering wrecks. The real tragedy is that the encounter between learner and teacher should be one of those transformational moments where the possibilities of real growth are possible. Put aside, for the moment, the 'tall poppies' (those obvious future leaders who stand head and neck above the rest) they will find their own growing opportunities; instead focus on nurturing the 'shrinking violets'. These are the majority, and the ones in need of fertile experiences. If only they weren't so afraid of the gardeners! The growing amount of rich writing on narrative is abundant with talk on listening to lone voices who whisper into and against the strong wind.

By now you will have caught a glimpse of the preferred facilitator style required to coax out narratives and nurture the 'voice on the edge'. Not surprisingly, they are those qualities associated with all caring and effective relationships: unconditional warmth, genuiness, and non judgemental regard. But of course balanced by the need for judicious challenge when required.

Roth and Fonagy (1996) have noted the amount of research suggesting that it is the qualities of the therapist rather than the actual technique used that result in positive outcomes from therapy. These qualities enable a therapeutic alliance to form, and that seems to be an accurate predictor of change and benefit at the end of therapy. Similarly, I suggest that in order for learners to learn about clinical supervision they should be exposed to facilitators with those qualities that allow them to forge a therapeutic learning alliance.

Conclusion

In this paper, I have argued in favour of an oral approach to developing qualified nursing staff to be effective clinical supervisors and clinical supervisees. The use of narrative in clinical supervision training is highly appropriate. Clinical supervisors and clinical supervisees can be prepared to both narrate stories and to encourage narration. It is through the telling of stories that people can revisit and learn from past experience, and become re-connected not only with their past life but life in general. The encouragement of 'story-telling' requires particular facilitator qualities which parallel those associated with helping relationships. This is in contrast to those styles thought to be effective in presenting information; where the all knowing lecturer uses technology to transmit knowledge to the passive consumer.

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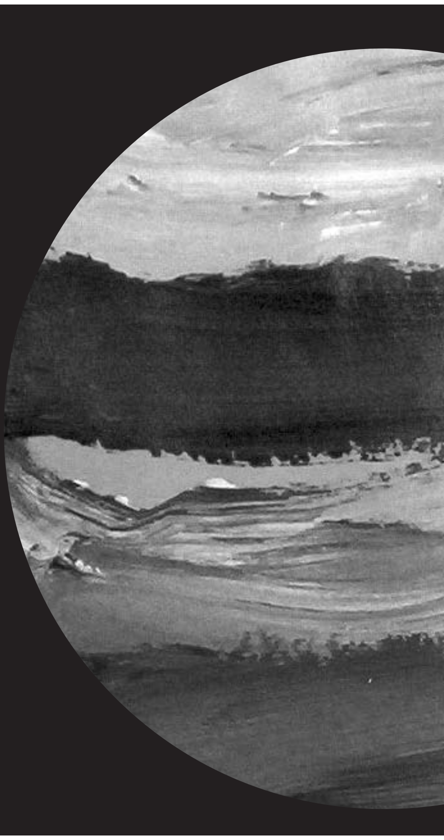

Rewiring efficacy studies to increase their relevance to routine practice

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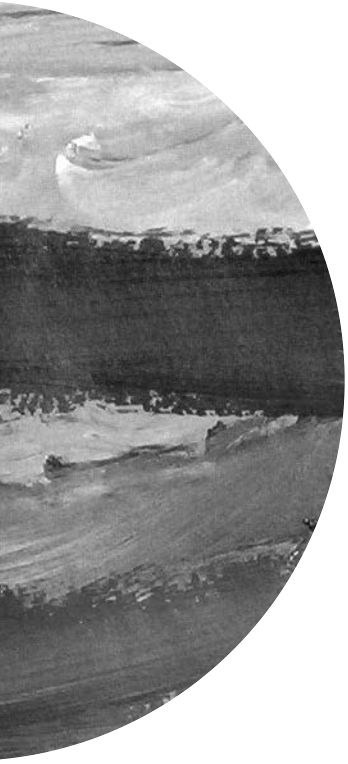
Rewiring efficacy studies to increase their relevance to routine practice

M Barkham, C Leach, D A Shapiro, G E Hardy, M Lucock & A Rees

Abstract

Current efficacy literature relies heavily on the Beck Depression Inventory (BDI) as the gold standard patient self-report measure. In contrast, the evaluation of psychological therapies in routine practice relies heavily on the CORE-OM. Although the two measures are conceptually distinct, they have been shown to be highly correlated. This suggests the possibility of replacing one measure with the other - a procedure we refer to as rewiring - in service of making the results of efficacy studies using the BDI have greater relevance of practitioners who routinely use the CORE-OM. We tested this proposition using transformation tables (Leach et al., in press) to convert BDI-I scores into CORE-OM scores and reran the analysis of a major efficacy study of depression - the Second Sheffield Psychotherapy Project (Shapiro et al., 1994). Results showed a near perfect replication of the original results and examples of benchmarks concerning the overall effects of treatment as well as differences between treatments are provided against which outcomes in routine practice can be contrasted. The implications for bridging efficacy and effectiveness research are discussed.

Keywords: CORE-OM; Beck Depression Inventory; efficacy; effectiveness; evidence based practice; practice based evidence



Introduction

The gap between research and practice in the area of the psychological therapies has been a continuing theme in the literature (e.g., Chawalisz, 2003). Traditional research has been built on evidence derived from efficacy studies (i.e., randomised or comparative trials) and has culminated in the paradigm of evidence-based practice. By contrast, research activity which is often seen as more relevant to practitioners is built on evidence from studies of the effectiveness of psychological therapies in routine settings (effectiveness studies) and has yielded the paradigm of practice-based evidence (see Barkham & Mellor-Clark, 2000). Rather than seeing these two approaches as competing, it has been argued elsewhere that they are complementary and that both paradigms are needed in order to build a more robust knowledge base and to help bridge the gap between research and practice (see Barkham & Mellor-Clark, 2003). For practitioners, the questions asked within efficacy studies are often not seen to be relevant to them. In other instances, the questions being asked in efficacy trials are relevant but the results cannot be directly transformed into clinical practice because of, for example, the use of different measures and the sampling of different client characteristics. Given this potential mismatch, any developments that facilitate comparisons between efficacy and effectiveness research will help bridge the gap between research and routine practice.

Accordingly, the purpose of this paper is to test a procedure which enables results from efficacy trials to be transformed from the original measure used into one which is widely used in routine clinical practice using formulae based on a large clinical sample and thereby provide a bridge towards making previous trials more relevant to routine services and everyday practitioners. This is a procedure we term rewiring - the simple idea being to replace the old measure with a new one such that the findings can use a currency similar to that used in routine practice.

Attempts have been made to provide some common language for the use of outcome measures in the psychological therapies, most notably the attempt to develop a core outcome battery some 30 years ago (see Waskow, 1975). However, this attempt was aimed solely at trying to identify a common set of measures within the research community and failed. Since then, on the one hand there has been a profusion of outcome measures (see Froyd et al., 1996) but also a freezing of measure development because of the continuing adherence within the research community to key outcome measures (see Horowitz et al., 1997). Adherence to, for example, the

Beck Depression Inventory in its original (BDI-I; Beck et al., 1961) or revised form (BDI-II; Beck et al., 1996) has occurred because of the strongly held view that successive research studies need to use the same measure in order to make comparisons with the existing literature.

In contrast to the use of proprietary measures in efficacy studies, which carry with them a considerable cost burden when used in routine service settings, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM: Barkham et al., 2001, 2005; Evans et al., 2002; Leach et al., 2004) has become a widely used outcome measure in NHS services. However, while efficacy research continues to use measures such as the BDI and routine practice uses measures such as the CORE-OM, this has the potential for continuing the divide between these research endeavours. If it could be shown that direct comparisons can indeed be made between the existing literature using, for example, the BDI, and newer studies using a different measure, then this is likely to both enhance the use of older literature and reduce the likelihood of a single measure freezing the field.

One recent development had reported procedures for transforming between scores obtained on the BDI-I and the CORE-OM with a high degree of accuracy (Leach et al., in press). This offers the opportunity to test whether the CORE-OM, a generic measure drawn from a pan-theoretical framework, can complement the BDI-I. The original report on the psychometric properties of the CORE-OM found a correlation of .86 with the BDI-I on a sample of patients completing both instruments (Evans et al., 2002). Leach et al. (in press) found an identical correlation between the BDI-I and CORE-OM for clients completing both measures prior to therapy and used their large data set (N = 2234) to devise gender-specific transformation tables for converting BDI-I scores to CORE-OM scores and vice versa.

While Leach et al. (in press) have provided evidence for transformation of scores within effectiveness research (i.e., within routine practice settings), we sought to test the transformation in an archived efficacy study of depression. Working at the interface between efficacy and effectiveness paradigms, we view the BDI versions and CORE-OM as exemplary efficacy and effectiveness measures respectively, whose convergence or divergence needs to be established in a range of different settings.

The aim of this paper was to test the proposition, given the high correlation between BDI-I and CORE-OM scores, that BDI-I scores can indeed be transformed into CORE-OM scores and yield equivalent results in the context of a previously carried out efficacy trial. To achieve this, we used archived data from the Second Sheffield Psychotherapy Project (SPP2; Shapiro et al., 1994, 1995) and kept all parameters of the original study other than substituting the BDI-I with the CORE-OM using the tables derived by Leach et al. (in press).

Method

Data set

The data set comprised the Second Sheffield Psychotherapy Project comparing cognitive behaviour therapy (CB) with Psychodynamic Interpersonal therapy (PI). A total of 117 patients had completed the BDI at 5 time points: screening, intake assessment (A1), session 1 (A2), end of treatment (A3), 3-month follow-up (A4), and 1-year follow-up (A5). Full details are reported elsewhere (see Shapiro et al., 1994). All BDI scores were transformed using the appropriate male or female tables available in Leach et al. (in press). These tables were constructed from transformations based on a combination of non-linear smoothing techniques and non-linear regression, but a good approximation to the transformation tables can be obtained from using the following non-linear regression equations alone: Females: $\text{CORE} = 0.309 \times \text{BDI-I}^{0.60} - 0.152$; Males: $\text{CORE} = 0.319 \times \text{BDI-I}^{0.60} - 0.142$. In the analyses reported here, we used the transformation tables for greater accuracy.

Scoring

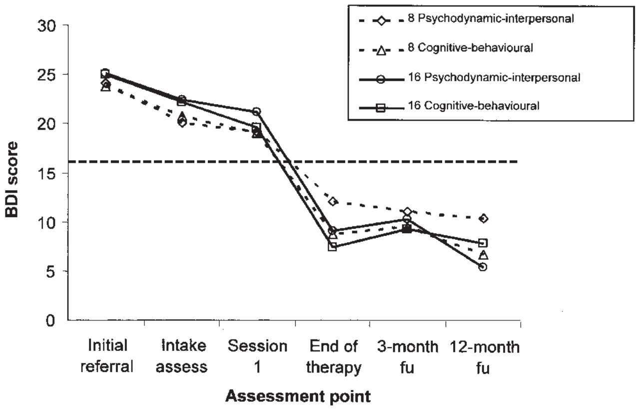
Following Leach et al. (in press), we aimed at enhancing the clinical meaning of CORE-OM scores to practitioners. Rather than working with the scale 0 to 4, we multiplied the mean item scores by 10 such that the range of human distress fell on a scale from 0 to 40. We termed this the clinical score. This decision was based on feedback from practitioners stating that they found it easier to assign meaning to a score using a 40 as opposed to a 4-point scale. This procedure does not affect the psychometric properties of the scale.

Analyses: Adjusted scores and covariates

All procedures carried out in the Shapiro et al. (1994) statistical analyses were first replicated on the BDI data alone to ensure the closest match between procedures and SPSS versions used in the analysis of SPP2 data in 1992-3. The procedures were carried out by the same person (AR) who undertook much of the analysis of the SPP2 data set for the Shapiro et al. (1994) publication. Identical procedures were then applied to the CORE-OM score.

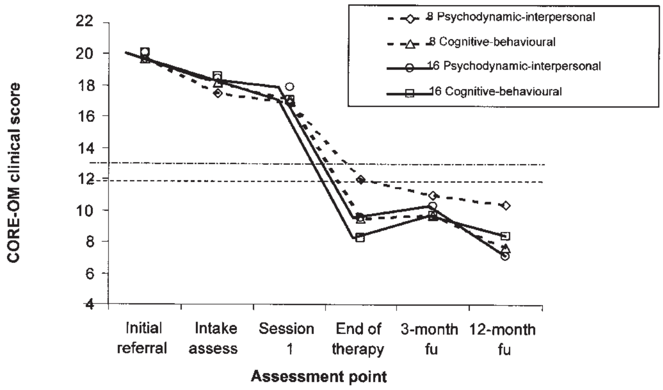
In parallel with the analysis used for the BDI in SPP2 (Shapiro et al., 1994), we partialled out Assessment 1 CORE-OM scores. We standardised the Assessment 1 score within severity groups, before entering it as a covariate, to eliminate confounding of the Assessment 1 covariate with the severity factor. To adjust for any mean differences in effectiveness amongst therapists, we used residual scores obtained by subtracting from each adjusted score the mean adjusted score obtained on that occasion by all clients seen by that therapist. All adjusted means reported below are adjusted as described here.

Results



---------------- Denotes clinical cut-off for the BDI-I

Figure 1: Original BDI-I scores for treatment conditions across treatment and follow-up.



---------------- Denotes male cut-off for the clinical CORE-OM score

—·—·—·—·—·—·— Denotes female cut-off for the clinical CORE-OM score

Figure 2: Transformed BDI-I into CORE-OM clinical scores for treatment conditions across treatment and follow-up.

Overall treatment outcomes

Figures 1 and 2 plot the BDI and CORE-OM outcomes respectively for the 4 treatment conditions at the main assessment points. The plot for the BDI was not included in the original publication. Visually, these plots for the BDI and transformed CORE-OM are almost identical.

Table 1 shows the overall unadjusted means and standard deviations on the BDI and CORE for the full sample of 117 clients at Assessment 1, end of treatment and 3-month follow-up; also shown are prescreening scores on both measures, and pre-assessment to post-assessment (pre-post) effect sizes for the change from Assessment 1 to end of treatment, calculated as pre-assessment minus post-assessment means divided by the averaged pre- and post-assessment standard deviations. There were no gender effects.

Table 1: Overall means, standard deviations, and pre-post effect sizes for BDI-I and core OM

	Prescreening			**Assessment 1**			**End of Treatment**				**3 Month Follow-up**		
Measure	M	SD	n	M	SD	n	M	SD	n	ES	M	SD	n
BDI-I	24.5	6.3	110	21.4	6.8	117	9.5	7.7	113	1.77	10.2	8.7	115
CORE-OM clinical score	19.9	3.1	110	18.2	3.6	117	9.9	5.7	113	1.77	10.2	6.1	115

Treatment Effects

Tests of treatment modality main effect yielded similar results to those reported for the BDI (Shapiro et al, 1994), with a marginal effect in favour of CB: Madj 9.2, versus PI, Madj 11.6 (F = 3.59, df 1,97, p = 0.06).

Duration of Treatment

Although 16-session treatment held a numerical advantage over 8 sessions, this was not significant, just as reported for the BDI: 8 sessions, Madj 11.3 versus 16 sessions, Madj 9.4 (F = 2.08, df 1,103, p = 0.152).

Interactions between Treatment Duration and Severity of Depression

Table 2 shows adjusted means for the two comparison measures with the same significant result.

Table 2: Adjusted Means and Tests of Severity x Duration Interaction

	High Severity		**Moderate Severity**		**Low Severity**		**P for simple effect of severity**		**Interaction effect**		
Measure	8	16	8	16	8	16	8	16	F	dfs	p
BDI-I	19.8	9.3*	10.4	6.4	4.6	8.1	.002	.41	3.54	2,97	.03
CORE-OM clinical score	16.2	10.8*	11.4	7.9	7.1	10.2	.01	.63	3.51	2,103	.03

*** significant at the .05 level**

Discussion

The aim of the present paper was to test the proposition that rewiring an archived efficacy study, which originally used the BDI-I, with a new measure - the CORE-OM - via transformation formulae/tables would yield equivalent results to those originally reported (Shapiro et al., 1994, 1995). It is important to note that our selection of the SPP2 data set was driven by the availability of the dataset and in particular by our ability to replicate absolutely the detailed process of analyses that were originally carried out. Carrying out such a replication on an independent data set might have led to slight variation in procedures or analyses from those originally employed, thereby introducing a confounding effect. Overall, the results showed a virtually perfect replication of the four main findings and effects.

The importance of the present study lies in its implications for helping to bridge the gap between efficacy and effectiveness studies. Although there have been attempts to provide rules for transforming rating scale scores (e.g., Aiken, 1987), we are unaware of any other test in the psychological therapies literature in which an efficacy study has been rewired. In this respect, the results from the present study can only apply to transformations between the BDI-I and CORE-OM and vice versa. Transformations between the CORE-OM or BDI-I and other outcome measures would require the collection of new data and new transformation tables.

In terms of the present study, we highlight three implications. First, and crucially, it challenges the myth that an established outcome measure should always be used in efficacy studies because of the existing body of literature that has previously used that measure. Although the reasoning behind this assumption is sound, the results of the present study suggest that it is possible, using transformations based on large Ns, to adopt newer outcome measures without losing comparability with existing literatures. Practitioners carrying out research in routine settings might feel encouraged to select the CORE-OM as a research tool knowing that there is a mechanism for translating these scores so that comparisons can be made with studies using the BDI-I. Direct transformations can then be made between the BDI-I and BDI-II using the BDI-II manual (Beck et al., 1996).

Second, our findings highlight the potential for using rewired efficacy studies as benchmarks for current practice-based activity. Two examples can be drawn from the current findings whereby results could be extrapolated to different treatment packages of care that might be considered comparable to those considered in this study. First, in terms of the overall outcomes in SPP2, the clinical score was approximately 20 at screening and 18 at intake assessment and then fell to approximately 10 at end of therapy. Hence, the overall pre-post change is of the order of 8 points using the clinical scoring method (or 0.8 using the 0-4 scaling). This provides a global benchmark against which to compare both intake severity levels and outcomes in routine practice. Second, we can consider the extent to which therapies might be expect to differ based on the difference obtained here between PI and CB outcomes. Our findings yielded a difference on the clinical score in the region of 2.5 between contrasting treatment approaches (or 0.25 if using the 0-4 scaling for the CORE-OM). Hence, the present study provides two initial benchmarks against which routine services can equate obtained effects in relation to (a) overall outcomes and (b) differences between types of therapies.

Third, at a technical level, the yield of a straight transformation of one measurement score to another would be unsurprising if there were a linear relationship between the two measures. However, while the BDI-I and CORE-OM are highly correlated in this and other samples, the empirical relationship is not linear. In addition, the two measures, while occupying the same conceptual space, differ in a fundamental way. The BDI-I is a specific measure of depression whereas the CORE-OM is a generic measure and its rationale was to tap the 'core' aspects of people's presenting problems (Barkham et al., 1998). The immediate implication is that the transformations yielded by the formulae and look-up tables reported in Leach et al. (in press) are sufficiently accurate and robust as to have widespread applicability in linking efficacy and effectiveness research.

Although we have developed a rewiring approach for transforming between BDI-I and CORE-OM scores, this is not the only means for obtaining a common metric. An alternative strategy would be to compare measures using standard scores (e.g., t or z scores) or effect sizes. However, although such procedures have existed for years, they are rarely used by practitioners. Part of the reason, perhaps, might be because such an approach effectively strips out the intrinsic or associated meaning captured by a particular score derived from a known measure. Most practitioners will, for example, have a tacit sense of the clinical gains implied in a BDI-I or BDI-II score moving from 32 at intake to 12 at discharge. By contrast, using a different case, the clinical meaning of reporting a pre-post effect size of, for example, 0.8 is less clear. The latter procedure masks the absolute levels at intake and discharge, thereby depriving the practitioner of valuable information. From a measurement perspective, standardised scores are useful for comparing between different measures when the precise relationship between those measures is not known. By contrast, the present procedures were possible because of precise transformations between the two measures drawn from the same sample of patients (Leach et al., in press). Not to use this information would entail losing a level of detail provided by the precision of comparisons gained by look-up tables that capture more of the fine detail of the relationship between the measures.

For both practitioners and researchers, the findings from the current study provide an empirical test of the precision of the transformations and evidence that using these transformations does not compromise the integrity of original findings. Recall also that the procedures used in this study could also be used to rewire a study originally using the CORE-OM and represent the results using the BDI-I. This may help to convince researchers either to adopt similar outcome measures as used by practitioners, or to rewire their analyses such that they present results in both original format (e.g. BDI) and transformed format (e.g. CORE-OM), thereby providing a key bridge between research and practice. Specifically, the findings reported here strengthen the potential relevance of an archival efficacy study to routine practice by translating its results into a metric that is widely used and hence readily interpreted by practitioners.

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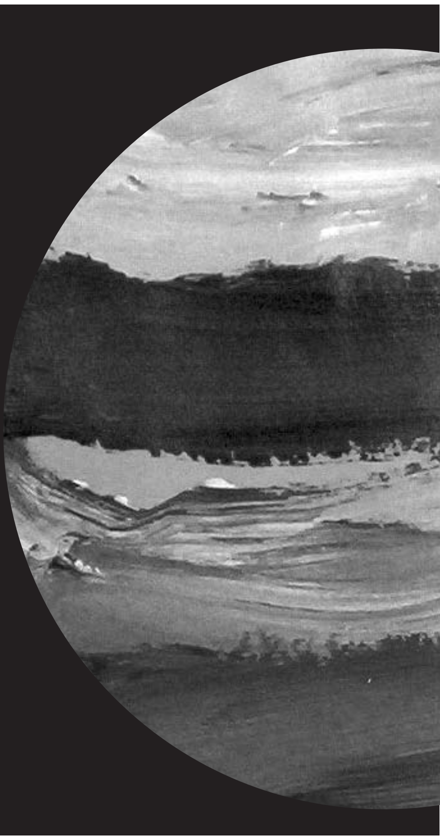
Psychiatric Day Hospitals for older adults - where have we been and where are we going now?



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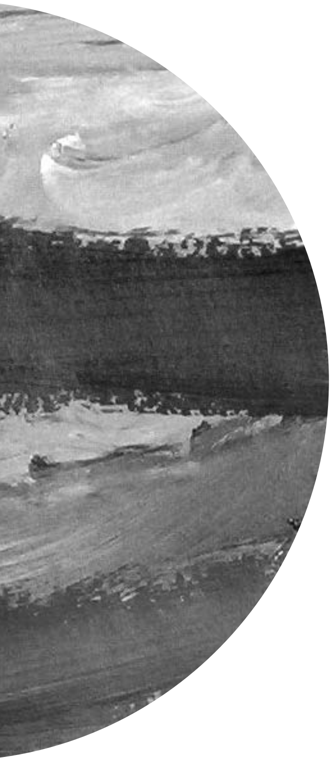
Psychiatric Day Hospitals for older adults - where have we been and where are we going now?

Jacqueline Nicholson, Karen Trusler & John Wattis

Abstract

Considering the increasing use of mental health provision by older adults it is important to assess the efficacy of services that exist as well as identify the particular needs of this client group. This review aims to put psychiatric day hospitals for older adults into a context of current thinking on service provision. It introduces some of the reasons why they were established and the debates that have ensued about their continued use. It summarises existing knowledge about what it is that day hospitals provide and how this compares with social services day care. It also discusses appraisals and efficacy research in psychiatric day hospitals. The review considers some of the alternatives to day hospitals, which are mainly community based or intermediate care. It then discusses the possibility of day hospitals adapting their structure and how they operate. Overall there does seem to be agreement in the literature about the need for standardised evaluative measures for psychiatric day hospitals for older adults as well as guidance on service provision.

Key words: Psycho geriatric day hospitals, function, evaluation, critique, alternatives, future.



Introduction

At least one in five people over the age of 65 suffers from a mental disorder and by 2030 the number of persons with psychiatric disorders in this older group will equal or exceed the number with such disorders in younger age groups (age 18 to 29 or age 30 to 44), (Jeste DV, Alexopoulos GS, Bartels SJ, et al 1999). Given older peoples' extensive and increasing use of health and social care resources, the provision of effective and appropriate services has become a national priority (DoH 1999). It has been addressed through specific initiatives such as Better Government for Older People (Better Government for Older People Programme) and the National Service Framework for Older People (DoH 2001). In the current climate of clinical governance and evidence-based practice it would seem that there is a greater need to determine whether psychiatric services for older adults are efficacious and cost effective.

There is a range of day treatment and day care provision available for older people. These include geriatric or medical services, psychiatric or psychogeriatric care and those provided by social services or the voluntary sector. Within older people's, as with many other services such as working age adult mental health, there seems to be a move away from the more traditional problem based model of care and a drive towards service provision that is more person centred or community based. Within a person centred or community based approach the focus is on providing integrated services which aim to meet individual needs (DoH 2001). Psychogeriatric day hospitals could potentially move in a similar direction. Within the South West Yorkshire Trust for example there are plans to replace some of the current older adult psychiatric services with a rapid access package that focuses on individual care plan needs. The proposed provisions will take the form of a Rapid Assessment Team and Home Treatment Team to run alongside a specialist day treatment service.
This review aims to:

i) Outline the purpose and aims of psychiatric day hospitals that have been highlighted in the literature so far.

ii) Summarise the appraisals that have been made of psychogeriatric day hospitals and comment on why evaluation has been problematic.

iii) Suggest possible directions for psychiatric services for older adults and future evaluation needs.

Psychogeriatric Day Hospitals

Why Established & Why Debate?

In many countries day hospitals have become a cornerstone of psychiatric care for the elderly (Kitchen et al, 2002). The first day hospital opened in the UK in 1946 and since then many have opened with the initiative of individual consultants as well as Government support (Vaughan, 1995). 20 years ago the growing awareness of the old age mental illness problem prompted the Government to issue guidelines of 2 to 3 places per day per 1000 of the elderly population for dementia alone, (DHSS, 1975), figures that were never reached, (Wattis, Wattis and Arie, 1981). Indeed so central to the theme of psychogeriatric services was the day hospital that some districts purported to operate with no need for inpatient beds (Rosenvinge, 1994). Despite the paucity of research evidence on the efficacy of day hospitals and studies on day hospital processes, they have continued to grow in number (Wattis, J., McDonald, A and Newton, P., 1999). With the development of alternative models of service delivery and the apparent blurring of boundaries with the role of the day centre, a debate on day hospitals started in the 1990's and has continued ever since. There are also no internationally or even nationally agreed guidelines for the type of service that old age psychiatric day hospitals should provide. On one hand there is an enthusiasm for newer and more modern service models and on the other the 'if it ain't broken don't fix it' philosophy. It seems that the day hospital is no longer uniformly or unreservedly accepted as an essential service component in old age psychiatry (Howard, 1995).

Functions of Day Hospitals

Consultants have always seen the main functions of the day hospital as assessment, treatment and the maintenance of the person in the community (Rosenvinge, 1994). Another role of the day hospital is thought to be providing respite for family, which can also delay or prevent admission to institutional care (Fasey, 1994). Day hospitals are usually divided into separate units or days for people with 'organic' (mostly dementia) and 'functional' mental illness (mostly depression but including a wide spectrum of disorders) (Rosenvinge, 1994).

One study (Bell et al, 2003) has attempted to capture the purposes, processes and outcomes of day hospitals by interviewing the different stakeholders involved. All those interviewed saw help with mental health problems and social interaction as the main purposes of attendance but beyond that, views diverged. Patients and carers stressed help with physical health problems and other practical assistance while staff chose process related variables such as assessment and monitoring. When interviewees were asked what happened to people attending the day units, patients and carers agreed social interaction, staff qualities, specific activities and educational activity were important processes. Some of the differences were that patients mentioned exercise and medication adjustment while carers mentioned expert attention, enjoyable experiences and support for the patient. It was noted that the differences in perceived purpose, processes and outcomes between the stakeholders might reflect different ways of conceptualising similar procedures. There was agreement in some of the perceived outcomes such as the importance of increased motivation and activation as well as respite between carers and staff. Patients saw improvement in personal well being as important while carers rated support and relief from pressure highly. Staff outcomes were more concerned with completing processes and care planning.

How Different from Social Services Day Care

In their short report Collier and Baldwin (1999) compared NHS day hospitals with non-specialist day care and found small but measurable behavioural differences between the two. However, greater differences were found when reason for referral was compared. They found the function of the day hospital and main reason for referral was primarily assessment, and referral tended to be medically controlled. The main perceived benefit reported by staff was respite for carers who were managing very difficult behaviours. The skills in day hospitals were commensurate with roles and aims and included skilled nursing, both physical and psychiatric, physiotherapy, occupational therapy and speech and language assessment, all within the context of a multidisciplinary team. The attendance was time limited, although a handful of patients were given aftercare. In the day hospital 30% were identified for whom staff had 'some' reservations about their attendance. These seemed to be people whose main benefit of attendance was social, some of who were also attending day centres.

Within day centres assessment and monitoring was not regarded as the primary function and its role was viewed as supportive with an open-ended commitment to attend. Difficult behaviours were tolerated but tended to be infrequent. The most commonly recorded reasons for attendance were 'reduce isolation' and 'support via community care package'. For 9% of the patients in the social services centres, staff had 'some' or 'considerable' concern about the appropriateness of their attendance.

Appraisal of Day Hospitals for Older Adults

Strong opinions have been expressed for and against their usefulness (Howard, 1994, Fasey, 1994) but published work has been almost entirely anecdotal (Rolleston & Ball 1994). Proponents of the Day Hospital claim that it is an acceptable alternative to inpatient hospital admission and delays institutionalisation. It could be suggested that elderly patients admitted to hospital are at risk of losing their support systems in the community, precipitating their admission to long-term residential care. In one study 68% of carers were found to prefer day hospital to inpatient care for their relatives (Jones & Munbodh 1982). Day hospitals bridge the gap between hospital and community, making services more accessible not only to the elderly person but also for relatives and staff (Peace, 1982). It has also been argued that the Day Hospital does not merely fill a gap in the community (Murphy, 1994) but has a role, which compliments day centres rather than overlapping with them (Collier & Baldwin, 1999). Pro Day Hospital writers suggest that despite the absence of data, most psychiatrists with access to day hospitals know that they can be used to prevent inpatient admission, particularly in functionally ill patients and that it facilitates earlier discharge (Howard, 1995). An evaluation of the effects of brief Day Hospital closure reported that the well being of carer and day hospital attenders fell during a closure period but quickly returned to preclosure levels after the unit reopened (Rolleston & Ball, 1994).

The criticisms made of day hospitals include the high capital and running costs as well as poor utilisation of the facility. Models of care are sometimes unclear with a lack of clarity regarding the most appropriate skill mix of staff (Collier & Baldwin, 1999). One of the most commonly cited views is that there is great overlap with day centre services and is suggested that day centres could do much of the work currently carried out by the NHS for a fraction of the cost (Currie et al, 1995). An analysis of day care on dementia patients, looking at costs and benefits indicated that although attending day hospital may reduce the use of hospital and institutional care resources, the cost of psychogeriatric day care is far more than that of the alternative care (Wimo, A et al 1990). Furthermore, although one of the proposed functions of the Day Hospital is to maintain elderly people in the community some studies have reported that 75% of Day Hospital attenders had previously been inpatients so it did not substitute inpatient care (Cross, et al 1972 Arie, 1978). Arie (1978) also described a permanent supportive role for day hospitals that does not sit well with modern models of short term NHS care. A high rate of admission (88% in some cases) to long stay care has also been found on average 6 months after initial referral (Green & Timbury, 1979), though this work also is very dated. Those against day hospitals suggest there is no evidence to show attendance prevents or delays admission to acute or continuing care placement for patients with dementia (Bramesfeld et al,

2001) and that many of these patients will be admitted to residential care sooner or later. Studies by Woods and Phanjoo (1991) and also Diesfildt (1992) concluded that day hospitals had little effect on the need for institutional care and that the attitude and well being of the carers and the patient's disability were more significant factors. Carer strain may be increased through preparation of the patient for attendance, which may disrupt the home routine a person has. Day hospitals may be just providing a day care service to people with dementia who are too severe for day centres because of the level of dependence and presence of behavioural problems (Fasey, 1994). Other possible drawbacks include the problems with transport to day hospitals, the fact that assessments could be done in outpatient clinics or the patient's home, and the fact that a false idea of functional level may be gained in an environment away from the patient's home (Fasey, 1994).

Research on Efficacy of Psychogeriatric Day Hospitals

As mentioned previously evidence for day hospital efficacy is sparse. The majority of literature has thus far been focused on the functions of and variety in the structure of day hospitals. Gilleard et al (1984) noted that there was no agreed criterion of the success of day hospital care. Still, almost 20 years on, researchers are struggling with the complexity and variety of the service provided and thus the absence of guidelines and evaluative studies become indicative of the difficulties in assessing day hospitals. (Corner L et al 1998). Some of the problems and lack of consistency in the day hospital service, includes assessing concepts such as quality of life and well being. It is also difficult to measure other factors involved such as staff capacity, attitude to dementia care and emotional interaction between patients and relatives. Problems have included lack of shared language and conceptual difficulties in the assessment of need (McWalter et al, 1998) and also the lack of standardised assessment tools for assessing both carers and patients needs (McWalter et al 1994, 1998). It has also been sited that numerous attempts have been made through uncontrolled audits of the service delivery of old age psychiatric services, however the simplicity of the measures have meant that they have been criticised as lacking in sufficient meaning (Draper, 2000).

In recent years there has been a shift onto a focus of the user voice. User satisfaction has therefore become a central key component to new government policies and guidelines. Gaining the views of dementia patients on services and the type of and levels of care they receive can be problematic, hence why there is currently a lack of research literature available in this area (Marshall, 1999). Research and policies have now been more geared towards the opinions of relatives of dementia patients and attempting to find techniques of staff and relatives working more collaboratively in assessing and implementing the care needs of all involved. A care needs assessment pack was devised (CarenapD) and evaluated by McWalter et al (1998). It brought together a number of currently used assessment tools and from evaluation and was found to have high inter-relater reliability. It was also said to be effective in highlighting unmet needs of carers and patients. However the assessment pack did pose problems in that the CarenapD cannot be used to assess severity of problems or the levels of patient functioning. Validation of the CarenapD has consequently proved problematic.

Alternatives to Psychiatric Services for Older Adults.

Central to European policies on the care of dementia patients is the notion that patients should be encouraged and supported to stay at home for as long as possible. New interventions have suggested that individual, barrier-free houses could be the key to assisting the elderly to remain independent for longer (Marshall, 1999). These have also been referred to as lifetime homes, which in effect would be designed to incorporate everything necessary to achieve this. However it would involve a great deal of technological design and housing modifications and although time and effort is being placed in such interventions, very little research has been conducted with regards to the efficacy and impact of these initiatives on people with dementia. On a smaller scale, design guides are frequently produced and modernised but again, research into the design and use of the equipment has been sparse.

A study in the Netherlands took a more cost-effective approach and evaluated the integration of mental health care into residential homes for the elderly, mentally ill (Depla et al 2003). The study concluded that the de-institutionalisation movement in elderly psychiatric care was questionable. It found that community integrated facilities did not necessarily imply community integrated patients and that including psychiatric patients in mainstream residential homes did not foster the expected community involvement. The study also pointed out that the additional needs of elderly care patients, such as functional, somatic and cognitive difficulties made effective community based services difficult to incorporate and define.

Multi-agency elderly mentally ill (EMI) units, based on an intermediate care (IC) model have also been set up in the UK. The units are designed to promote integrated care processes that encourage independence and prevent lengthy hospital admissions. The outcomes of one such unit were evaluated over a two-year period and it was found that it served its purpose in lowering the potential number of patients going into long term care with the cost of a short term in-patient stay being significantly lower than admission to long term EMI care. In addition, the work of the IC unit is currently being studied further by the Nuffield Community Care Studies unit and is looking at increasing the development of the units as part of the UK's NHS plan. The units aim to promote independence through person centred care. An assessment of whether these could be used to compliment day hospitals services could be a useful starting point to clarify the functions that would be needed by both services (Ackermann E, et al 2003).

The Future of Psychiatric Day Hospital Services

With the view of moving away from day hospital services to a more community based approach it would be important to evaluate the potential gains of the move. Little evidence has yet been produced to indicate that a change to community services could provide more service efficacy than with use of day hospitals. A possible alternative to changing the service given might be to re-focus on the structure of the day hospital and produce guidance on a more cost effective way of providing the service as a supplement to community services.

'Total quality management' is one methodology that utilises the workplace and the staffing team more efficiently. The emphasis of this approach is on work structures and interaction between the clinical team and systems of care. Mutch et al (2001) conducted a study through the implementation of a 'total quality management' system and found that improvements in assessment could be achieved when completed as part of a new management team where by all practitioners and staffs were provided with substantial training. As part of the improvement service delivery system, provision for standardised assessment and treatment tools were also incorporated. Whilst the implementation of such a management system proved successful at improving the service, it has a cost limitation since it required a large resource commitment in the short term as well as long term management commitment. The effects of the project and its generalisability to other services has yet to be discovered, nevertheless the rationale behind the system appears comprehensive and could be useful as a guideline for a more consistent day hospital structure. This would then allow for a consistent and structured method of analysing the need for the day hospital.

Need for Future Evaluation

In response and following on from the criticisms made concerning day hospitals many authors have highlighted possible research questions; whether it is in fact useful to avoid admission is one question, particularly as this is sometimes seen as the main function of day hospitals. Requests are also made to find out more about whether the service could be provided more economically and comparisons to be made of the efficacy of treatment at home, at outpatients and day hospitals (Fasey, 1994). Another call for research is in outcome measures. Comparisons of different ways of evaluating day hospitals have been made (see Kitchen et al, 2002) but yet the need for a standard measure of efficacy remains. Similarly there is a lack of research on the mix of staff skills and community support required for success (Beats et al, 2001).

Conclusion

It is clear that the published research on the purpose of psychiatric day hospital services to date has generally been inconclusive, fragmentary and contradictory. Attempts have been made to determine the purpose process and outcomes of day hospitals. Evaluations that have focused on the main functions and purpose of day hospitals have concluded that support and respite for carers and help with mental health and social interactions for the patient are forefront for the majority of stakeholders. However in terms of outcomes patients and carers perceptions were different in parts to those of staff.

Evaluations on the efficacy of day hospitals have been problematic due to the lack of guidelines and also inconsistencies in terms of the service they provide. This has meant that it has been difficult to measure the core aspects of day hospitals such as quality of life and emotional well being for patients and carers. It is also difficult to fully appreciate the opinions of patients with dementia as they may be limited in their abilities to communicate.

Psychiatric services for older adults are potentially facing a move from a problem based model of care to a person centred or community based service provision. The move could result in Day Hospital closure, before a sufficient evaluation of their potential use, efficacy and effectiveness has been achieved. Further evidence is required to assess the cost-effectiveness of day hospitals in comparison to other services. Therefore a more structured day hospital service nationally may allow for comparative studies to be completed reliably. In the event of a move to more structured day hospital service, development of national standardised assessments for the efficacy and outcomes of day hospitals should be prioritised.

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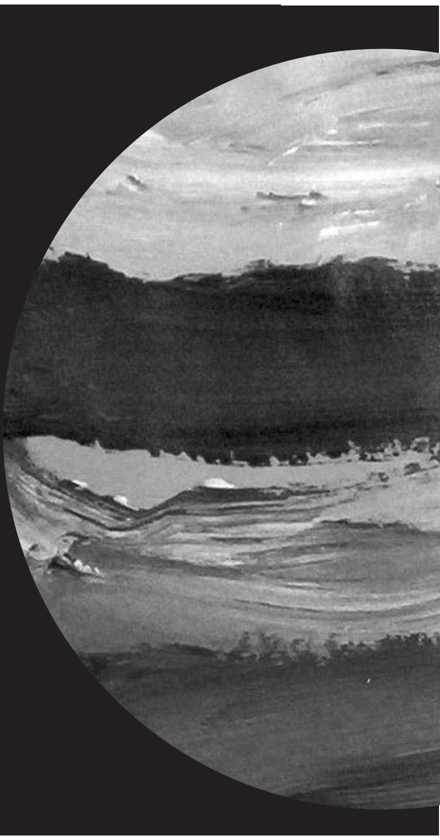
What does cognitive therapy change? - It makes you think more carefully about the bad stuff

Timothy Lister[1]



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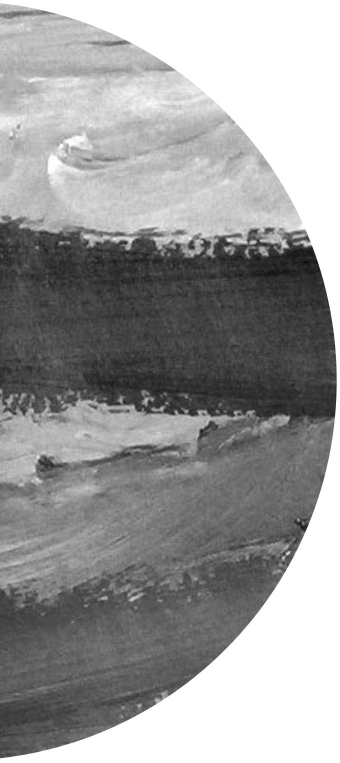
What does cognitive therapy change? - It makes you think more carefully about the bad stuff

Timothy Lister

Abstract

There is still a good deal of debate about the exact process of therapeutic change in cognitive therapy. The search for the definitive mediator has not yet provided any coherent answers. This investigation examines the possibility that cognitive therapy affects the way we retrieve negative memories, leading to more effortful processing and reappraisal of material that does not help emotional wellbeing. It is argued that this could be a key element of the change process.

Keywords: cognitive therapy; CBT; autobiographical memory; depression



Introduction

When a person becomes depressed and goes to their GP, they will be assessed using a number of fairly crude diagnostic criteria. How do they feel (hopeless/helpless)? How are they coping at work? How are their sleep pattern, appetite, concentration, and temper? The GP may note whether the person is weepy, self critical ('I'm useless!') and so on. Having decided that the patient meets the criteria for depression, the GP is most likely to prescribe an anti-depressant, request a review in a couple of weeks and then leaves the person to get on with it. In reality this process works reasonably well. The majority of sufferers recover within a fairly short time (generally less than six months) and most of these will go on to lead perfectly good and happy lives without further ado and without relapsing. Indeed, given that modern antidepressants work pretty well for many people, the validity of 'talking therapies' such as cognitive therapy may be open to question.

There is now a wealth of research papers comparing the efficacy of drugs and different forms of psychotherapy, many with equivocal findings. Indeed a comprehensive Health Technology Assessment research project (King, Sibbald, Ward, Bower, Lloyd, Gabbay and Byford, 2000) found that in primary care based treatment of depression and anxiety there was no difference between non-directive counselling, cognitive–behaviour therapy and usual GP care at 12-month follow-up. However, there does appear to be a consistent thread through the literature that supports the usefulness of certain kinds of psychotherapy. Thus, psychotherapy, in particular cognitive therapy, appears to confer some resilience to future episodes of depression, a resilience not conferred by the administration of antidepressants. In the jargon of depression research, it reduces vulnerability. Since a significant proportion of people who become depressed go on to have further episodes, any reduction in depression vulnerability sounds useful (see Ingram, Miranda and Segal, 1998 for a most elegant discussion of this area). The important question then surrounds the basic mechanics of cognitive therapy, thus: 'what does psychotherapy change inside my head that is not changed by antidepressants?'

The change process: How does therapy work?

The action of modern antidepressant medication is well described (Feighner, 1999). The general principle is this. Depression is caused by a neurochemical imbalance in the brain, which is corrected by antidepressant medication. So, if a depressed person's brain is short of serotonin, a Selective Serotonin Reuptake Inhibitor (SSRI) will prevent the brain absorbing so much serotonin, and the imbalance is corrected. There are one or two major flaws in the argument (see Andrews 2002) but by and large the logic is sound. Unfortunately for psychotherapy, cause and effect is not quite so obvious.

The research community has engaged in all kinds of interesting exercises to identify the important changes that take place inside people's heads as a result of psychotherapy and have not come up with much. There is good evidence that psychotherapy does have very positive outcomes. Research by colleagues in Wakefield (Lucock, Leach, Iveson, Lynch, Horsefield & Hall, 2003) highlight a range of indicators that suggest that people get better after different types of 'talking' therapy. For instance, routine measures like the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), or more recently the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE – OM: Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans, Connell, Audin & McGrath, 2001) show impressive improvements over the course of psychotherapy and at follow-up. Other measures such as self-esteem, social anxiety, and interpersonal functioning provide further testimony to the effectiveness of different psychotherapeutic approaches, particularly cognitive therapy (Blackburn and Twaddle 1996). Social indicators like employment are also useful as outcome measures (Billings, Cronkite, & Moos, 1983), but none of these 'outcomes' tell us much about the 'process' of psychological change, or what goes on inside a person's head after talking to a psychotherapist. Some researchers have tried to get a lead on this by predicting what should happen to a person if a particular model of psychotherapy really works according to the basic principles that guide it. Another term for this is its 'mode specific action'. Thus, psychodynamic psychotherapy, which aims to uncover and resolve unconscious conflicts, might be expected to lead to ego-strengthening. On the other hand cognitive therapy, which aims to identify and correct unhelpful thoughts, should lead to less dysfunctional thinking. However, investigations of the 'mode-specific actions' of different types of therapy for depression have failed to show much in the way of predicted differences (Imber, Pilkonis, Sotsky, Elkin, Watkins, Collins, Shea, & Leber, 1990).

A number of cognitive phenomena have been proposed as 'mediators' of change in depression, including automatic thoughts and underlying assumptions and beliefs (Whisman, 1993, DeRubeis, Evans, Hollon, Garvey, Grove, & Tuason, 1990). Such phenomena sound logical but are quite difficult to measure accurately and tend to be a bit unpredictable. There are instruments for exploring our cognitive distortions and unhelpful thinking patterns, for instance the Dysfunctional Attitude Scale (Weissman and Beck 1978) and the Automatic Thought Questionnaire (Hollon and Kendall 1980). These have been investigated in some detail over the course of an episode of depression, and there is some supportive evidence to the effect that, as people recover from depression, the scores on these measures subside (Ingram, Miranda and Segal, 1998). However, as Whisman (1993) points out, there are particular difficulties with global (overall) scores for measures such as the DAS. Thus, Power, Duggan, Lee, & Murray (1995) report a general insensitivity of the global score of the DAS, while subscales such as the dependency subscale (the sum of all responses about dependency) revealed differences between recovered depressed and non depressed groups.

The general conclusion is that self-report measures of cognitive vulnerability should focus on specific rather than global effects, a finding supported by a more recent longitudinal survey of depression (Farmer, Harris, Redman, Mahmood, Sadler, & McGuffin, 2001) which reported an inconsistent relationship between DAS scores and recovery from depression. Basically, sometimes the scores seemed to follow the path of recovery and sometimes they didn't change at all. Such findings suggest that recovery can take place in the absence of cognitive change, implying that in some people depression vulnerability remains long after overt recovery; in effect it is 'latent' or dormant. Indeed some researchers have explored this latent aspect of depression and have concluded that depressed thinking may not show itself unless the appropriate emotional state is also activated. Thus Miranda, Persons, & Nix Byers (1990) managed to alter DAS scores (creating depressed thinking) by inducing low mood in experimental participants. They concluded that depressed thinking styles were actually mood dependent, a finding that on the surface appears obvious, but suggests that moods create thoughts rather than the other way round, which is the standard line pushed by cognitive therapists. This is undoubtedly rather confusing.

Whisman (1993) also laments the relative lack of what he calls 'nonintrospective' (not directly examining one's own thoughts or feelings) experimental paradigms being used in the exploration of mediation in cognitive therapy. He cites examples from the literature of non-questionnaire methods that have been developed for the assessment of self-schema (Safran, Segal, Hill, & Whiffen, 1990). Many of these methods involve such measures as memory response latencies or recall scores (how long it takes to recall a memory or the amount of the memory recalled). Indeed, memory has become well established as the cornerstone in depressed thinking (Williams 1997). Firstly, it can become biased so that a depressed person only tends to recall negative events (Lloyd & Lishman 1975). Secondly, memory can become 'overgeneral'. In this case a depressed person may find it very hard to recall specific events, tending to lump things together into categories. They remember 'being at school' but find it hard to remember a particular day at school - the detail seems to have disappeared. The tendency to recall negative events more easily is not, apparently, simply because depressed people have fewer positive events in their lives. Teasdale and Fogarty (1979) demonstrated this by studying a sample of student volunteers who were not depressed and manipulating their mood using a 'mood-induction procedure'. They replicated the negative recall tendency with depressed mood, but also discovered that negative moods did not so much speed the retrieval of negative events as slow down the recall of positive events. Interestingly, in a recent article, Sheppard & Teasdale (2000) used speed of response to the Dysfunctional Attitude Scale and neutral statements to investigate the different ways these items were judged by depressed and non-depressed people. They found that non-depressed people tended to slow down when confronted with responses that veered towards a negative item or event (e.g. "People should be criticised for their mistakes"), whereas depressed people showed no selective slowing of this sort. This finding suggested that depressed people are prone to absorb negative thinking into their lives without a second thought (as it were) while the non-depressed population tend to spend a bit more time weighing it up.

All of this points to the complexity of depression, depressed thinking and the inherent difficulty understanding the mechanics of cognitive change. However, it bodes well for Whisman's (1993) conclusion that support for the cognitive mediation hypothesis would be enhanced if it could be shown that cognitive therapy produced specific effects on these nonintrospective measures of cognitive operations and structures, as well as producing effects on the other 'outcome' measures mentioned above. The findings above suggest that the impact of cognitive therapy (and other talking therapies) may more reliably be reflected in such 'nonintrospective' measures, but as yet no study has used them as a way of comparing the outcome of different therapeutic approaches in the treatment of depression. In particular, it would be interesting to compare talking treatments to anti-depressants.

Aims of the study

This study focused on response latencies to autobiographical memory recall (the time taken to recall a memory about particular events in our lives), a nice solid nonintrospective measure as referred to by Whisman (1993). The design was what is known as 'cross-sectional', aiming to compare recall response latencies in the following three groups of people.

- People who were currently depressed at the time of the study. (CD)
- People who had recovered from depression using antidepressants alone. (RAD)
- People who had recovered from depression using cognitive therapy. (RCT)

This report is based on findings that were part of a broader study to be reported elsewhere (Lister, Barton and Morley 2003). The broader investigation used the Autobiographical Memory Test (Williams and Broadbent 1986), which focuses on the ability of depressed people to recall specific events from different parts of their lives. This involves the use of record cards with single words on them as 'cues' for memory retrieval. The study included two additional variables, the positive or negative tone of the cue word (otherwise known as valency) and the time period (otherwise known as epoch) from which the memory came (recent or remote). So for the purposes of this report, cue valency refers to the word used to elicit the memory (happy, sad, shame, treat etc), and epoch refers to one of 2 time periods; recent (the last 12 months), or remote (5 to 10 years ago). The time taken to retrieve a memory was of interest because of its non-introspective qualities. The point of this was to use naturally occurring data to test a particular theory. Previous studies using the Autobiographical Memory Test have not found particularly revealing results in relation to latency. Some investigators (Kuyken & Dalgleish, 1995; Williams & Scott, 1988) did not find any differences in the time taken to retrieve memories for groups of depressed and non-depressed people, regardless of whether the cue words were positive or negative. Other investigators, (Pierce, Morley and Trepka, 1995, Williams & Dritschel 1992) did find significant effects across both groups according to the time period (epoch) from which the memory was being sought. This showed (perhaps not surprisingly) that more remote memories took longer to retrieve than recent memories. Thus, it seemed to take more time to access a memory that was further away in time. The difference between this investigation and prior studies was the nature of the groups under scrutiny. In this study direct comparisons could be made between a depressed group (CD) and two 'recovered' groups that had experienced different treatments for their depression (RAD and RCT). This would hopefully highlight any differences in the impact of the two treatments.

Hypotheses

The main hypothesis was that there would be a difference between the three groups in the time taken to retrieve memories when dealing with negative material. In keeping with the study by Shepherd and Teasdale (2000) the experimental assumption was that depressed people would have faster latencies to negative cue words than the two groups of people who had recovered from depression. The group receiving cognitive therapy would show the slowest response latency. Thus, the depressed group would very rapidly latch onto miserable memories whereas the cognitive therapy group would slow down as they encountered something that led them down that path, perhaps (as a result of therapy?) trying to steer away from negative memories or interpretations of the world.

The performance of the group of people who had recovered from depression using antidepressants alone would lie somewhere in-between. Where positive cue words were used it was expected that this difference would disappear.

Participants

Participants were recruited through a local primary care service, and from the caseloads of practitioners in an adult psychological therapy service. Practitioners of CBT included 2 CBT trained nurse therapists, two clinical psychologists with a background in CBT, a counsellor with additional CBT training and a General Practitioner who worked in the department as a cognitive therapist. A standard letter of invitation was sent to potential participants who could opt-in if they felt inclined. The two groups who had recovered from depression were treatment and symptom-free at the time of testing, and had been so for at least three months. The currently depressed group were recruited from both services. All participants were paid a small honorarium to cover their expenses. A total of 51 people joined the project with exactly 17 in each group.

Criteria for inclusion and allocation of participants to groups

The Inventory to Detect Depression over a Lifetime (IDDL: Zimmerman and Coryell, 1987) was used to establish that all participants had experienced at least one episode of major depression within their lifetime. The Beck Depression Inventory (BDI-2: Beck, Steer, & Brown, 1997) was used to validate their current depression status (depressed versus non-depressed). A BDI score of 17 was used as the cut-off for depression. Whilst this may appear high (10 is often viewed as a cut-off for depression), it is quite consistent with other research and provides greater differentiation than lower scores. Thus, a BDI score of 17 almost guarantees an accurate diagnosis of depression (see BDI -2 manual). The mean Beck Depression Inventory Scores were as follows: CD=25.06, RAD=8.35, RCT=9.0. This meant that whilst there was no (statistical) difference between RAD and RCT, at the time of testing both these 'recovered' groups were significantly different to the CD group in terms of symptoms of clinical depression. Although this may seem a bit obvious, it was important to establish that this was the case. In other ways, the groups were very well balanced. They were equivalent in terms of IDDL total symptom score and there was no difference in average age (mean = 45.5). There were more women than men in all three groups, this proportion being slightly greater for the CD group.

Measuring the time taken to retrieval of memory

The latency to first retrieval was recorded in seconds for all memories using a conventional stopwatch. After some dedicated practice to orient them to the time period (last year, 5 - 10 years ago), participants were given cue words (e.g. happy, funny, shame, misery) on a record card and asked to indicate verbally ("got one!") as soon as they had found a memory associated with the cue. Mean latencies for individuals and groups were then calculated according to epoch and cue word tone, as detailed in table 1.

Table 1 – Mean (average) time to first retrieval

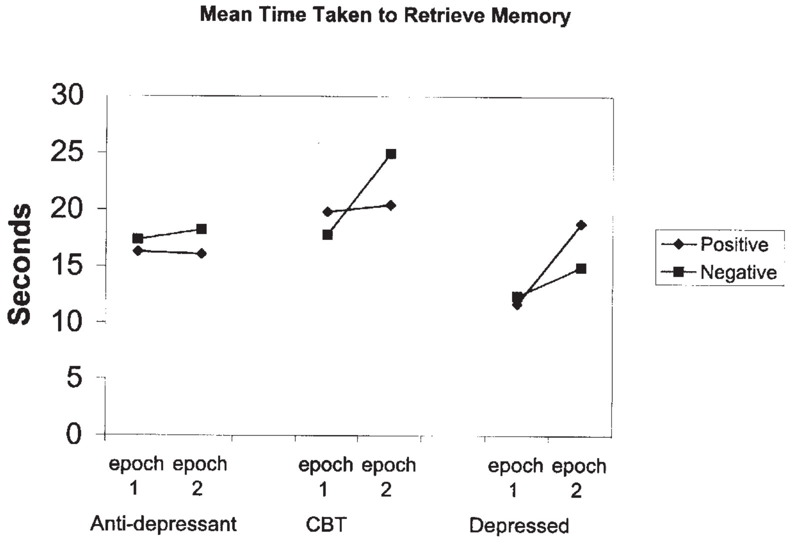
Time to retrieval (secs) (Standard deviation)	Recovered Anti-depressant	Recovered CBT	Currently depressed	Total
Epoch one (last year)				
Positive valency (tone)	16.3 (10.0)	19.8 (9.0)	11.7 (5.2)	15.9 (8.8)
Negative valency (tone)	17.4 (7.2)	17.8 (8.7)	12.4 (6.2)	15.8 (7.8)
Epoch two (5 to 10 years ago)				
Positive valency (tone)	16.1 (8.3)	20.4 (8.8)	18.8 (10.5)	18.4 (9.2)
Negative valency (tone)	18.2 (9.9)	25.0 (12.0)	14.9 (9.0)	19.4 (11.0)

Results

Simply observing Figure 1 gives a pretty good impression of any differences between the groups. Thus, there appear to be clear differences between the depressed group (CD) and the recovered cognitive therapy group (RCT) in the speed of retrieving negative memories from both the recent and remote epochs. Differences between either of these two groups and the recovered anti depressant group (RAD) are not so clear. This seems to support the hypotheses above that depressed people are faster than people who have recovered from depression. However, the aim of this study was to demonstrate that any differences were 'real', and not just due to chance. This involved the use of well-tried mathematical procedures that can calculate the probability of these findings being meaningful.

A repeated measures Analysis of Variance (ANOVA) was used to explore within group and between group differences in the time taken to retrieve a memory. Essentially this tells us whether the three groups differ in speed of recall taking into account the

Fig 1 – Mean time to retrieve memory



emotional tone of the cue word, and the epoch from which the memory came and all of the combinations of valency and epoch that could possibly exist. The results of the ANOVA are set out in table 2.

Table 2 – Repeated measures ANOVA on latencies to first retrieval

Effect	df	Mean square	F	p
Between subjects				
Groups	2	684.20	3.585	.035*
Error	48	190.87		
Within subjects				
	1	461.10	6.596	.013*
Epoch	2	95.72	1.369	.264
Epoch * group	48	69.91		
Error	1	9.28	.320	.574
Valency	2	51.69	1.781	.179
Valency * group	48	29.02		
Error	1	14.14	.471	.496
Epoch * valency	2	132.30	4.409	.017*
	48	30.01		
Epoch x valency x group				
Error				

Main analysis

The important numbers in Table 2 are the ones with an asterisk beside them. These indicate a difference between the groups that is beyond chance. This kind of difference is often referred to as a 'significant' difference. Having spotted a potential difference between the groups further calculations need to be done to see which group or groups are different from which. Comparing and contrasting groups like this is often called 'post-hoc' statistics'.

In this study there were significant differences between the three groups in speed of retrieval. Further examination using post hoc tests revealed that the only real difference was between the CD group and the RCT group. The RAD group was hung in between and showed itself to be no different to the RCT or the CD groups. In keeping with the results of other studies, all three groups were significantly slower at retrieving memories from the remote epoch (5 to 10 years ago) as opposed to the recent (last 12 months), but this slowing seemed more or less the same across the three groups.

However, the most interesting and meaningful finding emerged when the emotional tone of the cue word and the time period (epoch) of the memory were considered together. In this analysis, the post-hoc tests revealed that, with more distant memories, the RCT group were significantly slower than the CD group in the retrieval of recollections that were responses to negative cues. This may seem a bit of a leap of faith, but in this case we were looking at the impact of two different variables and combining them. Firstly we looked at the effect of the positive or negative attributes (valency) of the cue word, and secondly we examined the effect of the recentness of the time period from which the memory came. This let us look at somewhat more detailed questions. We knew from the first 'trawl' of results that the recentness effect (more remote memories take longer to retrieve) affected all three groups about the same. However, was this effect consistent if we took into account the valency of the word that was acting as a cue for the memory? This study revealed a very pronounced difference in the way the groups behaved, best described as a relative slowness on the part of the RCT group in retrieving memories that came from a more distant time period and which were cued by words that were negative. For the most part (about 99%), these memories were themselves emotionally negative. The following is an attempt to summarise these results and make sense of them in terms of different responses to treatments.

Discussion: what's this got to do with cognitive therapy?

In cognitive therapy the process of change is brought about through a range of techniques that may well affect the way events are remembered. Tools like automatic thought records and positive data logs (Greenberger and Padesky, 1995) help people to look carefully at their memories of past events and to reappraise difficult (negative) emotional experiences. The therapeutic process also involves identifying the assumptions and core beliefs an individual holds with a view to changing those that are clearly unhelpful. The way a person makes sense of their world is bound to depend on their past experiences and therefore, by default, beliefs and attitudes will be shaped by personal memories The idea that personal memory is important in shaping expectations about the self, the world and the future ("I think this way because of how I remember things") is fundamental to the content and process of CBT (and most other forms of psychotherapy). It is also consistent with much academic dialogue on the nature of psychological distress (Williams, 1996; Williams, 1997; Teasdale, Segal, & Williams, 1995; Teasdale, 1996; Brewin, 1989; Brewin, 1996).

Whilst the status of CBT's 'mode-specific' effects may still be open to question, consideration of the role of memory in the therapeutic process presents us with a subtle shift away from a directly identifiable mediator such as scores on the Dysfunctional Attitude Scale, to something much more subtle and interesting such as the way potentially depressing thoughts are reviewed, interpreted and processed. These changes, as Whisman (1993) proposes, may not be immediately apparent, but they do have a significant impact on our emotional experience, affecting the way that we think, feel and act. The idea that latency of retrieval might reflect effortful processing is certainly not new within the field of cognitive psychology (McCloskey, Aliminosa, & Sokol, 1991). However, the use of latency measures to infer attitudinal or behavioural responses in the field of social cognition is relatively new territory.

Sheppard & Teasdale (2000) propose that there is a relationship between speed of processing and the type of material that is being accessed. Thus, faster responses reflect rapid access to 'precomputed' beliefs that are consistent with a particular attitude, whereas slower responses might indicate a higher degree of thoughtfulness about whether an attitude or behaviour applies to, or makes sense to that person. In their recent study they refer to this process as 'metacognitive monitoring'. They suggest that slowing down in response to material that challenges emotional wellbeing reflects a controlled process. Thus the non-depressed participants were evaluating potential responses to each DAS item in relation to prevailing predominantly held beliefs. When the non-depressed participants detect a mismatch they double-check the response before translating it into action, hence the slowing of their responses. The tendency for depressed people not to do this is described as a 'deficit in metacognitive monitoring'. In this study the slowing of the recovered CBT group in response to negative cue words on the Autobiographical Memory Test draws an interesting parallel with Sheppard and Teasdale's (2000) findings. Thus, it could be argued that for the RCT group, the process of retrieval on this task (distant memories from negative cues) was for some reason, much more effortful and therefore slower than for the other two experimental groups, perhaps reflecting a kindred tendency for people who have had CBT to reject material inconsistent with their core beliefs or aspirations at that time. In this case the task might lead to the retrieval of distant negative memories, which may well make me feel bad. This fits in well with the idea that cognitive therapy does indeed develop cognitive skills, getting people to rethink dysfunctional thoughts. Memory retrieval might be particularly painful if the memories were from a time period which clearly predates any therapeutic change, hence the difference in the remote (5-10 years ago) epoch.

As Barber & DeRubeis (1989) suggest, cognitive therapy may be effective because it inculcates the habit of having second thoughts about negative thoughts rather than accepting them as valid statements about reality. This particular notion provides the theoretical underpinning for a new but well researched form of treatment, 'Mindfulness-Based Cognitive Therapy' (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000, Segal, Williams, & Teasdale, 2002) which aims to help recovered

‘Mindfulness-Based Cognitive Therapy’ (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000, Segal, Williams, & Teasdale, 2002) which aims to help recovered depressed patients to disengage from negative thought patterns arising in the presence of low mood. However, it is interesting to note that the authors of the new mindfulness-based approach to CBT propose that it may not be useful in the acute phase of a depressive episode, and that the techniques are best taught in a non-depressed state. This suggests once again that mood plays an important role in determining whether we can accept these cognitive changes in the first place!

Conclusions

This study provided some evidence that cognitive therapy might affect the way people respond to negative memories. In comparison to people who were clinically depressed at the time of the study, people who have recovered from depression using cognitive therapy seem to slow down considerably when asked to retrieve a distant memory from a negative cue. This slowing down by RCT was more significant than any tendency for the CD group to ‘speed up’ to negative cues, or, for that matter, to slow down to positive cues, since this group showed no difference to the recovered antidepressant group on any of these measures.

It goes without saying that these observations leave lots of questions unanswered and the conclusions must be regarded as speculative rather than concrete proof of anything. However, given that the two recovered groups were clearly very similar in terms of depression status (8.35 vs. 9.0 on the BDI-2) it must raise the questions about whether the effect is a result of the treatments the two groups received. It could be argued that educational or social differences were responsible, but these were analysed in detail and no obvious differences emerged. Another speculation involves what is sometimes referred to as the ‘differential sieve’ effect. This would contend that people who are appropriate for cognitive therapy are somehow ‘naturally’ going to behave differently than the other groups. Although this is of course possible, it seems a bit unlikely. From a methodological viewpoint two more charges could be levelled against this investigation. First, it could be argued that cross-sectional studies do not necessarily reflect a valid change process. In other words the difference between RAD and RCT may be due to other, random factors and not therapy. The only way to counteract this argument would be to undertake a prospective study - following up people before and after cognitive therapy to see if they did indeed slow down on their recall of distant negative memories. Secondly, it could be argued that the effect is not specific to cognitive therapy. Thus, any form of talking therapy may have the same impact and it is therefore unreasonable to accord therapeutic rights to cognitive therapy alone. The way to test this would be to introduce another ‘talking therapy’ group into the study and make direct comparisons. This is ongoing.

Taking all these criticisms into account, this study does suggest that CBT for depression really does affect the way a person thinks. A CBT survivor will tend to slow down on encountering certain types of negatively cued material. It would be nice (for practitioners and clients alike) to think that this was both a therapeutic effect and one that conferred some resistance to future episodes of depression. Perhaps, to repeat Barber & DeRubeis (1989), cognitive therapy is effective because it inculcates the habit of having second thoughts about negative thoughts rather than accepting them as valid statements about reality. In other words, it slows you down when you hit the bad stuff and gives you the time to think it through.

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Stakeholder perceptions of older adult mental health NHS day services in Huddersfield

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Stakeholder perceptions of older adult mental health NHS day services in Huddersfield

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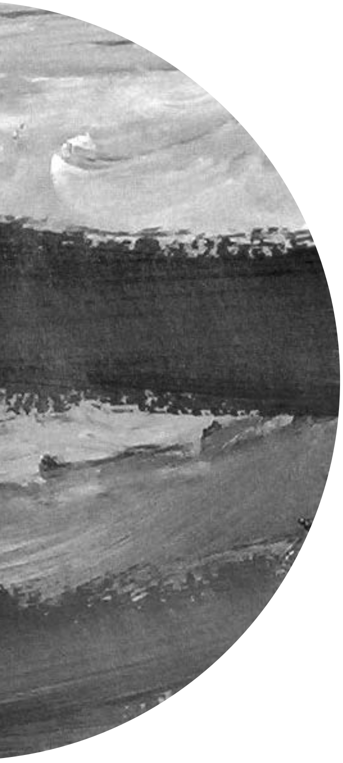
John Wattis

Abstract

This report presents the findings of a qualitative inquiry into the purposes, processes and outcomes of NHS day services for older adults with mental health problems in Huddersfield. The study canvassed a variety of viewpoints amongst patients, carers and staff as a first step to developing further research into NHS and social day services for this patient group. All interviewees perceived help with mental health problems as the main purposes of attendance. Other views diverged: patients and carers stressed help with physical health problems and other practical assistance whilst staff chose process-related variables such as assessment and monitoring. The divergence between patients, carers and staff was even stronger when we asked about the processes and the perceived outcomes of these facilities. These different views of purposes, processes and outcomes provide a starting point for developing further exploratory and evaluative research of different NHS day services for this patient group. This may also be useful in future comparisons between NHS and social services day provision.

Keywords: Day hospital, day care, partial hospitalization, geriatric psychiatry



Background

Day hospitals have been regarded as a core part of old age psychiatry (Baker and Byrne 1977, Wattis, Wattis & Arie 1981, Wattis 1988, Wattis, Macdonald & Newton 1999). They are usually divided into separate days or units for people with "organic" (mostly dementia) and "functional" mental illness, (mostly depression but including a wide spectrum of disorders) (Rosenvinge 1994). Functions vary depending on client group and location. Local provision and the relationship with social services day care vary and opinions have been expressed for and against their usefulness (Howard 1994, Fasey 1994). Published work has been almost entirely anecdotal (Rolleston 1994), or focused on a particular issue such as carer strain (Cantley 1983, Gilleard 1984), or how to improve attendance (Wright, Lunt, Harris & Wallace 1995). An old but detailed study published in 1985 (Smith and Cantley 1985) looked at day hospitals from user, carer and provider viewpoints. A national multi-disciplinary network of Day Hospitals, initiated by the Royal College of Psychiatrists Faculty for the Psychiatry of Old Age, provides a vehicle for future research (Wattis, Wilson and Curran 2004).

The current project was suggested by a number of factors. These included the emphasis on intermediate care in the National Service Framework (NSF) for older people (Department of Health (Department of Health) 2001), research on the effectiveness of psychiatric day hospitals for working age adults (Creed, Black & Anthony 1989, Creed, Black, Anthony, Osborn, Thomas & Tomenson 1990) and the results of a survey presented at a the first national network conference in June, 2001. Furthermore, given the current emphasis on research-based evidence (Department of Health 1997), it is important to determine whether services do in fact benefit service users and carers. In 2000 the NHS Plan (Department of Health) set out the vision of a service where care would be shaped around the convenience and concerns of service users, and where users, carers, and the public would have more say over their own treatment and more influence over the way in which the NHS worked. Involving the public, service users and carers therefore became an important element of clinical governance (Department of Health 1999) and today is central to the planning and provision of services.

Methodology

The Study

The aim of this study was to identify patient, carer and staff views about the purposes and outcomes of NHS day services for older adults with mental health problems in Huddersfield.

Design

The study used qualitative in-depth interviews to investigate participants' perceptions of the following:

1. Purposes of attendance
2. Service processes
3. Outcomes of day attendance

Sampling and participants

At the time of the study, NHS day services for older people with mental health problems in Huddersfield were provided in three main settings. These comprised an acute day hospital for people with functional mental health problems, a longer term day hospital for people with chronic functional disorders and an assessment unit for people with dementia. The sample was essentially an opportunity sample of staff and patients/carers in the three day hospital settings. An attempt was made to include staff in a variety of settings and grades.

Patients who appeared to have capacity and willingness to participate were nominated in all three settings by staff. Those who could not communicate verbally and were judged unable to give valid consent or did not have a carer who could potentially be interviewed were excluded. Patients were otherwise unselected and were provided with information about the aims of the study and confidentiality. Those interested in participating in the study were asked to send their signed consent forms back to the research team in the enclosed pre-paid envelopes. The first seven patients to give valid consent were interviewed by the researcher. The carers of these patients and the professionals also involved in their care were also approached, given information and invited to be interviewed. Seven interviews were conducted with carers and eight with staff members.

The limited time and funding available meant that a wider and more systematic sample could not be obtained. However, as the study was qualitative in nature and intended as a first stage in elucidating different stakeholder views about the purposes, processes and outcomes in day hospital services, the adopted sampling method was considered acceptable.

Interviews

In total, twenty-two semi-structured interviews were conducted using an interview schedule covering topics about day service attendance, purpose, service processes and outcomes. The tape-recorded interviews lasted twenty to forty minutes and were transcribed verbatim.

Ethical considerations

The local research ethics committee approved the study, and participants gave informed consent after receiving assurances about anonymity, confidentiality and the right to withdraw at any stage of the research process without prejudice.

Data analysis

Qualitative content analysis of the anonymised text was conducted (Downe – Wamboldt, 1992). Each transcript was read and considered by the principal researcher. The text from each of the twenty two transcripts was then divided into units of meaning i.e. groups of words/statements, using Nvivo 2.0 (QSR International Pty Ltd, Cardigan, UK). The meaning units were then coded inductively, allowing the text to dictate the emergent themes. The codes were arranged into categories and subcategories, which were then organised in relation to the themes. As a dependability test, some of the text was coded again according to these categories by other members of the team. Minor discrepancies were discussed until agreement was reached (Lincoln & Guba 1985).

Findings

We aimed to give equal weight to the views of patients, carers and staff in achieving a view of why older people with mental health problems attended NHS day facilities in the area, what happened in these facilities and how outcomes could be assessed. This was intended as a first step towards facilitating future research. In each of the areas examined there was an overlap between patient and carer perceptions with a lesser overlap with staff perceptions. Staff views were largely related to concepts of complexity and risk, referring to prospective attending patients as requiring something more intensive than "outpatient" but less demanding than "inpatient" care. Apart from the fact that Day Hospital attendance is not rigorously time-limited, this fits well with the concept of "intermediate care" in the NSF for older people.

Our findings regarding stakeholder perceptions of NHS day services for older adults with mental health problems are summarised into three main categories. The categories are labelled: reasons for referral/ purpose; day service processes; and outcomes. The various subcategories describe different aspects of these categories.

Table 1. Stakeholder perceptions of NHS day services for older adults with mental health problems: Categories and subcategories of the data analysis.

Catagories	**Subcatagories**
1. Reason for referral/purpose	**Staff**
	1.1 Assessment
	1.2 Ongoing monitoring, support and maintenance
	Patients & Carers
	1.3 Mental and physical problems
	1.4 Respite
2. Day service processes	**Staff**
	2.1 Treatment (including therapeutic activities)
	2.2 Tests and assessments
	2.3 Needs led programmes
	2.5 Therapeutic relationships
	2.6 Monitoring/supervision
	Patients & Carers
	2.7 Medical/expert attention
	2.8 Social interaction
3. Outcomes	**Staff**
	3.1 Appropriate referral within system
	3.2 Recovery/discharge with care plan
	Patients & Carers
	3.3 Respite
	3.4 Satisfaction
	3.5 Increased motivation
	3.6 Education

The categories and subcategories are presented in table 1.

Reason for referral/purpose

Older adults suffering from a variety of problems, depth or persistence of difficulties, which could be physical, psychological or social, as well as their presenting mental health problem are most often referred to day hospital care. The facilities under study each had different remits:

'The broad aim is that we are an assessment unit for ladies and gentlemen having some sort of memory problems and it's a holistic assessment which is basically looking at their mental health needs. How we can best support them now and in the future' (Staff member).
And
'The functional day units… the aims are to deliver some kind of therapy and make major changes in people's symptoms, functioning and coping' (Staff member).
And
'Our aim and purpose, as far as I understand, is assessing and ongoing treatment of acutely ill people. Partly helping to fast track discharging them from hospital and partly to keep people out in the community and prevent admission' (Staff member).

Staff

All stakeholders described the day units as relaxed settings. Such an atmosphere was cultivated to allow staff to make naturalistic assessments of patients, monitoring and supporting their everyday needs:

'A lot of it is observational and actually seeing how people interact in a one to one with nurses and in group activities and situations such as having lunch… simple things like that' (Staff member).

There was strong agreement on the need for social interaction to support this group of patients, emphasising the therapeutic value of peer relationships, more easily delivered in a group setting than in the patients' homes: 'Apart from anything else they make friends here, they make social friends, they arrange things between themselves and it's a nice day out for them' (Staff member).This was an area where there may well be overlap with the function of social services day care.

Patients and carers

In the area of purpose of attendance there was strongest agreement about the need for help with mental health problems. However, it was apparent that a high proportion of patients attending day hospitals and indeed those patients interviewed, suffered from a combination of mental and physical problems: 'I am on medication for my heart, cholesterol, arthritis and I'm on medication for my nerves' (Patient). And 'A community nurse came to see me to look at my mental illness as well as my medical problems and they thought it would be good for me to come here' (Patient). Carers and particularly patients put more emphasis on physical health problems than did staff. However, staff probably took these physical problems "for granted" in a setting where the more acute day facilities had good access to medical attention and where staff emphasised assessment, treatment and meeting individual needs.

The importance of how day hospitals provide respite for carers of patients with such complex needs was recognised by all: 'It gives me a chance to be separated from her… we are together twenty four hours a day and we get on top of each other' (Carer). And 'It gives my husband a rest' (Patient). Again, this is probably an area of overlap with social day care.

Day service processes

In this area there was no overt overlap between staff perceptions and those of patients and carers. However, this may have reflected different ways of conceptualising similar processes.

Staff

Staff when questioned about processes within the day hospital, mainly discussed patterns of treatment, therapeutic activities and methods of assessment. 'The nurses do some core assessments' (Staff member). These discussions centred on the benefits of day hospital provision in delivering a service not met by other forms of provision: 'We treat people with mental health problems that are too complicated in one way or another to be dealt with merely on an outpatient basis' (Staff member). It was claimed that such provision promoted therapeutic relationships between patients and practitioners and allowed practitioners to observe and monitor patients more closely in order to make more accurate assessments of their well-being. The flexibility of the teams working within these centres was emphasised. Staff promoted day hospital provision as providing patient-centred care and needs-led programmes: 'We try and find out what personal needs there are and use a person centred approach' (Staff member) And 'We will follow various tests and assessments depending on the client's problem' (Staff member). However, although half of the staff mentioned that the services they provided were client centred, one participant urged caution regarding uncritical acceptance of this view

'I mean it is very easy to say that they are client centred, but actually they are still, in many ways, service focused. They are designed to make the clients fit to that rather than the other way round and it is very easy to think that you are providing a client centred service when it is not necessarily' (Staff member).

Whatever the situation may be, there was patient support in comments pertaining to staff being very flexible, accommodating and meeting their requested needs.

Patients & Carers

In contrast to the staff interviews, patients and carers focused on the processes of day hospital services in relation to the medical and expert attention they received, rather than specific interventions and in relation the kindness of the professionals they see: 'The doctor, she tells you things, which help you … you can go to her and talk to her and when you come out you feel one hundred percent better. She's really good' (Patient). And 'They look after you here and the carers are nice people, cheerful people' (Patient).

All patients and carers also discussed the benefits of the social interaction patients' participated in whilst there: 'You can talk and have a bit of fun. People all don't sort of talk so you don't annoy them, but otherwise they like to listen to you' (Patient). And 'Helps me to be amongst company and talk over things' (Patient). And 'He's feeling more of a man again and it's all come from people communicating with him. I think so anyway, I mean a wife can only do so much' (Carer). And 'I think it does him good to see other people and hear what they have to say' (Carer). It was evident that morale was increased amongst patients through the structured daily routine of the units aiding social interaction with peers and professionals

Outcomes

There was a difference in language between staff and other groups with staff tending to see outcomes as completed processes whilst patients and carers took a more immediate view of improvement in well being, increased motivation and relief of pressure. One outcome that was implicit in all groups was a sense of the importance of enduring relationships in mental health services.

Staff

Staff understandings of outcomes were more concerned with completing processes and care planning. The two main points of discussion referred to the success of day hospital provision leading to appropriate referral and care planning: 'There's a much closer level of monitoring and supervision than there is if someone is discharged to say community follow up generally' (Staff member). And: 'The best outcome would be that they finish attending the hospital with a treatment plan that included the other support they needed and perhaps drugs if appropriate' (Staff member). Professionals stressed day attendance helped them to better organise a future pathway of care for the patient and their carer where the day hospital staff could be still accessed for support and used as a resource if any problems were encountered after discharge: ‘We always do leave them the number to say that we could easily pick up whenever. So although we are saying goodbye we are there for a phone call if they need us or there are problems’ (Staff member).

Patients & Carers

There was agreement between patients and carers regarding increased motivation, satisfaction with health care services and improved respite and care arrangements as day service outcomes. Resolution of problems were reported: ‘They’ve done fine for him, they’ve done fine for us both’ (Carer); ‘I’m not as depressed as I was’ (Patient). And the level of ongoing support provided after discharge relieved any anxieties or worries patients and carers may have held about the future:

‘They’ve arranged for home helps to come out and get us up and things like that because there is no way he could go in a shower without some help. I mean we could manage when I was alright, but as I say I broke my hip, I can’t cope because I couldn’t manage if he fell’. (Carer).

Patients and carers did not always go into any detail about their discharge from day care and their current care package but instead spoke of their satisfaction with the day service they attended and the support and knowledge they had received whilst attending.

Discussion

The study focuses on the personal perceptions of NHS day services for older adults with mental health problems, and has combined the views of stakeholders to achieve an understanding of why older adults with mental health problems attend these facilities, what happens within these facilities and how outcomes could be assessed. The in-depth interviews produced rich and interesting data, and the qualitative content analysis method (Downe-Wamboldt 1992) was found to be useful in consideration of the aims of the study. Most importantly it was evident that these units were able to meet the spectrum of needs of patients and carers; delivering health care and psycho-social support during attendance and in organised care plans after discharge. It is apparent that day hospitals are well suited to providing relationship framing aspects of care.

Generalisability to other day hospital settings would have to be established by further studies. However, the study has helped define some of the areas where further research could inform service development. The findings also support the notion of the importance of seeking service user views in order to appropriately evaluate and develop services (Department of Health 1999, 2000). Future research in this area needs to encompass a variety of different domains to do justice to the varied perceptions of patients, carers and staff. For example, a future study could address the following questions:

- Is it appropriate to try to meet physical as well as mental health needs?
- How can we identify which patients are likely to benefit most from social interaction and how do we measure this benefit?
- Can we identify the staff qualities that are important in the day hospital context and whether they differ from staff qualities needed in other parts of the service?
- Which specific activities have most benefits for particular patients?
- How important is access to medical and other specialist intervention?
- How can we measure outcome including measures of overall improvement in well-being, motivation and activation for the patients?

Areas such as needs and outcomes have been the subject of recent research in the day hospital context (Ashaye, Livingston & Orally 2003). Some questions are specific to day hospitals (such as whether certain staff qualities are especially useful in this setting). Others concern the wider health system (for example is it useful to try to meet physical as well as mental health needs: at least one day hospital provides both specialist medical and psychiatric input at www.dayhospitals.net). Funding limitations have stopped us from exploring the differences between different NHS and social services facilities but an appreciation of the costs and benefits of such services in relation to one another is needed for future service development.

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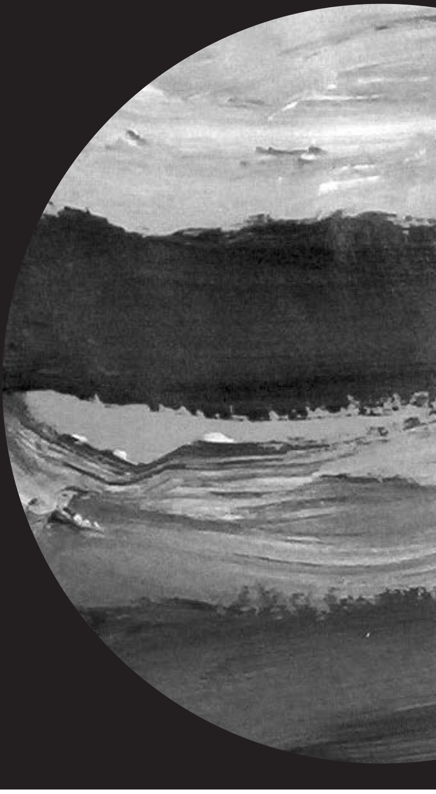
Using evidence to improve Psychological Therapies Services



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Using evidence to improve Psychological Therapies Services

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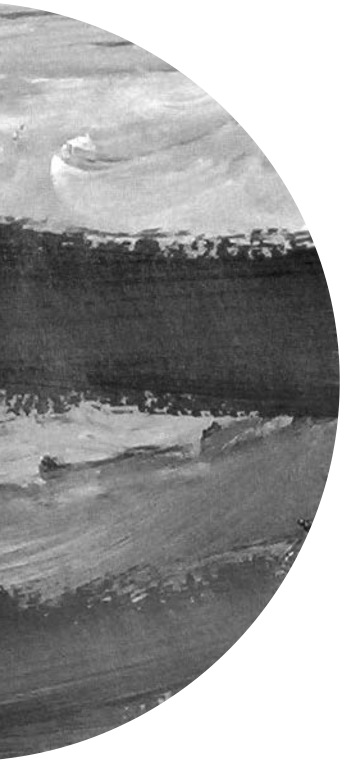
Abstract

Psychological therapy services offer help to clients with many different sorts of mental health problems using a variety of therapies provided by a range of different professional groups and are supported by a large amount of research evidence. However, applying evidence-based practice in routine clinical settings presents particular challenges. This paper outlines some of the difficulties applying research findings to routine settings and argues for a more inclusive approach to linking evidence with practice. It describes a systematic approach to service evaluation and practice based evidence within a large psychological therapies service. This approach is integrated into the service delivery. It enables clinicians to become engaged in the process of reflecting on evidence in a non-threatening way and allows innovative ways of enhancing reflective practice by linking evidence with practice in routine settings.

Keywords: Evidence-based practice; practice based evidence; psychological therapies; psychotherapy; clinical effectiveness; reflective practice.



Introduction

Psychological therapy services offer help to clients with many different sorts of mental health problems using a variety of therapies provided by a range of different professional groups. As with other health service interventions, providers of psychological therapies are encouraged (and increasingly required) to apply this research evidence in routine service conditions, offering only treatments shown to be effective, so-called evidence-based practice. However, applying evidence-based practice in routine clinical settings presents particular challenges because of limitations in the evidence and because routine settings are often more complex and deal with a wider range of client problems than are typically studied in research clinics. In this article we review the arguments for using evidence-based practice, look at some of the difficulties and describe a complementary approach known as practice-based evidence. We also aim to illustrate how research and evidence can be used to inform practice by giving an example of how practice-based evidence is routinely used in one large NHS psychological therapies service.

The use of evidence-based practice to improve clinical effectiveness is a significant part of the more systematic approach to quality in health care (Department of Health, 1997, 1998; NHS Modernisation Agency, 2003). The basic model is that research (informed by theory) is carried out to determine best practice and the most effective treatments and service models for particular health problems. When sufficient quality research is available, the evidence is reviewed and treatment recommendations made. Special techniques such as meta-analyses are used for systematically reviewing evidence (see, for example, Sackett, Richardson, Rosenberg & Haynes, 1997). Such analyses attempt to reduce any bias that might be present when combining evidence of different quality and based on different sample sizes. The recommendations from systematic reviews are then disseminated into routine practice, for example through evidence-based guidelines, treatment manuals, protocols and evidence-based training. It is a requirement of health care providers to increase the provision of evidence-based practice and to set up systems to ensure access to information on evidence-based practice and implementation of guidelines. The National Institute for Clinical Excellence (NICE) plays a key role in this process by publishing regular treatment guidance. Recent published guidance in mental health includes those for eating disorders, anxiety and depression.

A parallel development to evidence based practice is the move towards more reflective practice where clinicians are expected to reflect on their work and their role within their service context (Sainsbury Centre for Mental Health, 2001). Within psychological therapies services clinical supervision is well established as the main approach to reflective practice. The assumption is that if clinicians used more evidence-based practice and effectively reflected on their practice, clinical effectiveness would improve. Whilst this process is crucial to improve the quality of services, the dissemination of evidence-based practice into routine practice is a challenge and within psychological therapies it presents particular challenges.

Evidence-based practice in psychological therapies

There is good evidence for the effectiveness of psychotherapies for certain problems and these are summarised in recent evidence-based clinical practice guidelines (Treatment Choice in Psychological Therapies and Counselling, Department of Health, 2001). Among the conclusions from these guidelines are the importance of factors that apply across psychotherapies, such as a good therapeutic relationship. The evidence tends to be clearer with anxiety problems with superior evidence for behaviour therapy for specific phobias; cognitive behavioural therapy (CBT) for panic disorder and generalised anxiety disorders; and behaviour therapy and CBT for obsessive-compulsive disorder. This has made evidence based psychological treatment recommendations for panic (with or without agoraphobia) and generalised anxiety disorder possible in recent NICE guidance. There is also clear evidence for the effectiveness of CBT and Interpersonal Therapy for depression. Some psychotherapies, such as psychodynamic and psychoanalytic psychotherapy, are under-evaluated, making conclusions regarding their effectiveness difficult at this stage. Appropriate brief interventions (eight or fewer sessions) are thought to be appropriate for problems such as specific phobias, uncomplicated panic disorder and adjustment to recent life events whilst more complex problems and poorly motivated clients tend to require more experienced therapists and longer term interventions. The guidelines also make the general point that psychological therapies should be routinely considered as a treatment option when clients with mental health problems are assessed. Improved access to psychological therapies was also highlighted in the National Service Framework for Mental Health (Department of Health, 1999). Improving access implies both reducing waiting times and making psychological therapies available for a wider range of clients and problems.

Despite these recommendations, there are problems with the evidence on which they are based: “...guideline users should be aware that a degree of uncertainty underlies recommendations, because of gaps in scientific evidence, methodological limitations of trials, problems generalising research populations to clinical populations and client heterogeneity” (Department of Health, 2001, page 40). The gaps in the evidence make it difficult to establish clear guidelines on empirically validated psychological therapies.

Evidence-based psychological therapies in routine practice

There is evidence of limited application of evidence-based recommendations to routine practice. In relation to psychotherapy, Barlow (1981, p. 147) stated that, “At present, clinical research has little or no influence on clinical practice”. A recent survey of psychotherapists in the UK showed the relatively low influence of evidence based guidelines and treatment manuals on practice (Lucock, Hall and Nobel, submitted for publication). Factors such as clinical supervision, training, individual case formulations and personal therapy were rated as highly influential. A survey of psychotherapists in the USA (Morrow-Bradley and Elliot, 1986) also found a relatively low utilization of evidence based practice. Hansen, Lambert and Forman (2002) contrast information available from clinical trials with that available from routine services. They report that clinical trials suggest between 57.6% and 67.2% of clients improve within an average of 12.7 sessions, while naturalistic data in routine services suggest that the average number of sessions received in a USA national database of more than 6000 clients was less than five and the rate of improvement was about 20%. This study suggests outcomes would be improved if routine practice would take on board evidence from clinical trials and this is surely the case to some extent.

However, translating research findings and treatment recommendations to routine practice presents a number of difficulties. Poorer outcomes in routine practice may be because clinicians do not follow evidence-based practice guidelines, but they may also be because the clients studied in the trials on which the guidance is based are very different from those treated in routine practice, with multiple problems (co-morbidity) and more complicated problems.

Efficacy and effectiveness research

The distinction between efficacy and effectiveness is crucial to understanding these issues. Efficacy is about demonstrating that a particular set of conditions is responsible for any effects of treatment observed with a particular client group, so efficacy studies require a high degree of scientific control. For this reason, efficacy studies such as randomised controlled trials (RCTs) use carefully selected, homogeneous client groups who are randomly assigned to treatments, and the treatments offered are time-limited and based on the treatment manual. This means one can conclude to a relatively high degree of certainty that differences between outcomes are due to differences between the treatments or between the treatment and control groups. Effectiveness is about demonstrating that treatments work under routine service conditions, so clients are not selected to have only single problems and therapists vary the treatment offered depending on the client's problems. In effectiveness research, it is therefore much more difficult to demonstrate that this particular treatment is what is responsible for any changes in the clients. Efficacy research maximises what is called internal validity to allow clear scientific conclusions to be reached, while effectiveness research maximises so-called external validity, taking account of the complexity of routine practice.

So although efficacy studies are fundamental to psychotherapy research, a cost of such scientific control is poor external validity – the results do not necessarily generalise to routine service conditions where it is not possible or appropriate to exclude more complex clients, standardise treatments and so on. As more clients are excluded, the external validity of the study is decreased. Thase (1999) reported that as many as 5 to 10 potential participants may be screened for every one included in some efficacy studies because of comorbidity or the disorders being insufficiently severe. In a paper that has caused a great deal of interest in the psychotherapy research, Westen and Morrison (2001) looked at RCTs for panic, generalised anxiety disorder (GAD) and depression and found the majority of clients were excluded from participating in the average study. Inclusion rates were 32% for depression, 36% for panic, and 35% for GAD. Clients were excluded for things such as psychosis and organic disorders, but also such factors as suicidality, comorbid substance misuse and other concurrent problems, such as panic, GAD, personality disorders and significant physical problems. They concluded that exclusion criteria for all three disorders often eliminated more troubled and difficult to treat clients, such as clients with borderline features who are more likely to be suicidal and to have substance misuse problems. In routine services such clients tend not to be excluded on the basis that they are too complex and have multiple problems, although it is possible that more exclusion in routine services would be appropriate. Whether or not some clients should be excluded on the grounds that they will not benefit from therapy is an important issue that has not been adequately addressed in research up to now.

There are also criticisms that efficacy research relies too heavily on the diagnostic system (Persons, 1991) at the expense of considering the client as an individual and individual case formulations. Another problem of the relevance of clinical trials to routine practice is that trials are group comparison studies and do not predict individual responses. Within any group study with a significant group effect there will be those clients who do not respond to the intervention, but clinical trials may not help us understand why this is and how best to ensure therapy is more widely effective. In fact, recently published concerns about the negative side effects of SSRI anti depressants show how some individuals can be adversely affected by a treatment that has been found to be effective based on clinical trials (Whittington, Kendall, Fonagy, Cottrell, Cotgrove, and Boddington, 2004).

If evidence based practice were more widely disseminated, it would be in the form of treatment manuals. In the USA there is a debate over the merits of manualised therapies, which are often based on efficacy research, and what are called empirically validated therapies. Many researchers have called for psychotherapy training and practice to be limited to treatments that have demonstrated efficacy in randomized trials (e.g. Barlow, 1996). These treatments differ significantly from those provided by the majority of therapists. Arguments against the use of manualised treatments include the fact that they are nearly always based on disorders rather than individualised formulations (Eifert, Schulte, Zvolensky et al., 1997), that they fail to inform clinicians about how to treat specific clients effectively because they restrict therapists and clients working together flexibly (Seligman, 1995), and because the evidence from which manuals are developed and evaluated are based on group means and therefore an "average" client. Some of these criticisms may arise from a misunderstanding about the nature of manualised therapies, which in many cases do allow for flexibility to meet the particular needs of clients within a common theory, framework and set of methods. They also underestimate the proven value of conceptualising and developing treatments for particular problems, such as depression, panic disorder, social phobias, post traumatic stress disorder, obsessional compulsive disorder, psychosis and personality disorders, for example in the development of cognitive behaviour therapy. It is, however, important that manualised therapies are not too rigid and prescribed. Persons (1991) advocates a case formulation approach to psychotherapy research enabling more flexible assessment and treatment approaches to be used within a particular psychotherapeutic model and the measurement of individualised outcomes.

Bridging the research practice divide

So the gap between research and practice in psychological therapies is due in part to real differences between the clients in efficacy research and routine practice. There are also differences between the sorts of therapy carried out in efficacy studies and routine practice. One response to this would be to reject the applicability of evidence based practice in psychological therapies (e.g. Marzillier, 2004) but this will lead to persisting with practice that is ineffective or even detrimental and prevents the development of more effective and efficient interventions. For example, critical incident debriefing as a preventative intervention was assumed to be effective but the evidence suggests it could be detrimental to some individuals so it is not recommended in treatment guidelines (Treatment Choice in Psychological Therapies and Counselling, Department of Health, 2001). Instead of a simplistic approach to evidence based practice or a rejection of it, the evidence considered should come from a variety of sources, not just clinical trials, and clinical expertise and flexibility to meet the needs of complex clients should be acknowledged. Sackett, Rosenberg, Gray et al (1996) acknowledge the balance between evidence and clinical expertise: "without clinical expertise, practice risks being tyrannised by evidence, for even excellent external evidence may be inapplicable or inappropriate for an individual client" (page 71). Salkovskis (2002) points out that cognitive behaviour therapy, the most evidence-based of the psychological therapies, has developed as a result of a broader approach to the link between evidence and practice. This approach includes the scientist practitioner model (Barlow, Hayes and Nelson, 1984) and single case methodologies (Hersen and Barlow, 1976). Salkovskis argues that this is best conceptualised as "Empirically Grounded Clinical Interventions" which are supported by a range of evidence. Williams and Garner (2002) argue for consideration of evidence available from other sources such as naturalistic enquiry and case material that helps to understand individual clients.

Important questions are not whether or not we should take account of the evidence, but what sort of evidence we should take account of and how we do so in a way that really does improve effectiveness. We argue that both evidence-based practice from clinical trials and practice-based evidence can inform and improve practice. We will describe an approach to generating and using practice-based evidence in a routine psychological therapies service with the potential to drive effective reflective practice and improve clinical effectiveness.

Practice based evidence in psychological therapies

A complementary approach to the use of evidence-based practice is the generation of good evidence in routine practice – 'practice based evidence' (Margison, Barkham, Evans et al 2000; Barkham and Mellor-Clark, 2000). Barkham, Margison, Leach et al (2001) argue that both paradigms are needed to provide good evidence and to help bridge the gap between research and practice. There are various examples of practice based evidence, some that have been established over many years, such as single case approaches (Turpin, 2001) in which data are collected on the client's progress throughout the intervention. This data, such as number of panic attacks or levels of anxiety and depression, can be fed back to clients and enhance realistic feedback of the progress of therapy. Single case studies have played a significant role in the development of therapies, such as cognitive behaviour therapy for psychosis, which was initially described with a series of single case studies (Chadwick and Birchwood, 1994). Rather than being uncontrolled, single case methodologies allow experimental control and a flexible application to complex individual cases (Hersen and Barlow, 1976). Consistent with this approach is the scientist practitioner approach within clinical psychology (Barlow, Hayes and Nelson, 1984) in which empirical methods of testing predictions and obtaining feedback on progress is gathered, shared with clients and used as a vehicle for therapeutic change. In a broader approach to practice based evidence, Barkham et al (2001) recommend setting up an infrastructure to routinely measure clinical outcome together with other variables that describe the nature of clients and their problems and the interventions (type of therapy, number of sessions, etc.). If such an infrastructure were used widely, large data sets could be generated to look at research questions in routine practice and services could be benchmarked against one another (Barkham et al 2001). There is also evidence that feeding back routinely collected outcome data to clinicians improves outcomes (Lambert, Whipple, Smart et al, 2003). Feeding back results of service audit, research and outcome monitoring are included in the best practice criteria in recent best practice guidance on organising and delivering psychological therapies within the NHS (Department of Health, 2004).

Generating data through practice-based evidence can answer research questions that clinical trials cannot answer. For example, this approach can assess psychotherapy outcomes and processes in routine service settings with a wider range of clients, therapists and therapies. It can also look at why some clients fail to take up therapy, why some drop out during therapy and why some get worse during therapy. We now describe one particular approach to developing a practice based evidence infrastructure and how it can be used to create a culture to facilitate reflective practice using evidence.

The practice-based evidence system

Our service is a multi-professional adult psychological therapies service receiving about 1200 referrals a year (in 2003-2004), serving a population of 320,000 people across the Wakefield Metropolitan District. Therapists include clinical psychologists, a specialist psychotherapy team, counsellors, nurse therapists, cognitive behaviour therapists and an art therapist. A range of therapies has been provided including cognitive behavioural therapy, psychodynamic and psychoanalytic psychotherapies, person-centred approaches and integrative psychotherapies such as cognitive analytical therapy. Initial assessments are carried out to determine suitability for psychological therapy and the most appropriate approach is recommended and provided, including individual, couple and group work.

The service has developed a practice based evidence infrastructure to routinely measure clinical outcome. Clients complete outcome measures at various stages and both clients and therapists rate progress at the end of therapy. The service has used the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Evans, Connell, Barkham, Margison, McGrath, Mellor-Clarke and Audin, 2002) and the Beck Depression Inventory (BDI: Beck et al., 1961) at referral and adds the Inventory of Interpersonal Problems (IIP-32: Barkham, Hardy and Startup, 1996) at assessment, beginning of therapy, discharge and six month follow up. The IIP-32 is a shortened version of the 127-item IIP devised by Horowitz, Rosenberg, Baer, Ureno, and

Villasenor, (1988). These measures are completed by clients and give reliable information about clients' problems in a number of areas. Other measures are used for specific interventions as appropriate, such as group work. This system is integrated into the clinical service by using the data to inform risk assessment and prioritisation. For example, the CORE-OM and BDI both have risk items that can alert the service to clients with particularly urgent problems Recently the BDI was discontinued due to its prohibitive cost and replaced by a transformed score taken from the CORE-OM with which it correlates very highly (Leach, Lucock, Barkham, et al, in press). Therapists receive feedback on clinical outcomes for their clients every year and at other times on request. This information includes data on progress of individual clients as well as data on groups of clients and the whole service. It is fed back in the form of graphs, with clinically and statistically significant cut offs identifying clients who have improved and those who have not benefited. This system is described in more detail in Lucock, Leach, Iveson, et al (2003) and our experience of the outcome measures is reviewed in Leach, Lucock, Iveson & Noble (2004).

Feeding back the evidence - evidence based reflective practice

It is important to justify the time and resources spent on routine service evaluation by attempting to achieve tangible benefits for the quality and effectiveness of the service. This can only be achieved if the evidence generated is fed back into the service in a way that drives service improvements. A key issue in developing such an evaluation and practice based evidence system is getting staff on board, involving them in the process and creating a non-threatening culture of reflective practice. To achieve this, staff should be involved in all aspects of the process, be clear about their role and receive feedback of results (Lucock, Iveson and Leach 1999). Furthermore, this feedback should be meaningful to clinicians and clinically useful. Without this the approach will be seen as an onerous addition to an already busy working schedule. In our service, in addition to annual feedback on their clients' progress and the overall data for the service, the service has also begun discussing findings with clinicians to make clinical sense of the data. This will lead to clinical and service implications and we have called this approach evidence-based reflective practice. For example, interviews were carried out with clinicians about their views on whether or not clients had a sudden improvement during therapy (Tang and DeRubeis, 1999) and what caused the sudden improvement (see Stiles, Leach, Barkham et al, 2003, and Davies, Leach, Lucock et al, in press). Clinicians within the service are interested in reflecting on clients with characteristics derived from the data such as those who score above a certain threshold on measures, those who drop out of therapy, fail to respond to therapy, improve, or those who receive long term therapy. This enables investigations of research questions such as why clients drop out, why they improve and why they deteriorate rather than simply looking at if and by how much they improve. This process of reflecting on evidence to look at clinically meaningful questions also engages clinicians in the process of reflective practice using evidence. Investigating 'why' questions can be done by looking at the available data (for example outcome questionnaire scores, type of problem, type of therapy, number of sessions, alliance measures) and by discussing the issue with clinicians on an individual or group basis. For example, service evaluation projects are planned or have been carried out by trainee clinical psychologists looking at characteristics and outcomes for clients seen for long term therapy, reasons for clients dropping out of therapy and reasons for providing long term therapy, all of which will have implications for improving practice.

Conclusion

The use of evidence-based practice has a crucial role in improving the effectiveness of services and different types of evidence have different purposes. RCTs are required to establish efficacy, while practice based evidence can be used to evaluate the effectiveness of routine services and for benchmarking and audit. Within psychological therapies, limitations with the current evidence restrict the extent to which specific treatments can be recommended for some problems and the complexities of routine practice and individual client needs should be taken account of. Rather than rejecting or resisting evidence based practice, services have a responsibility to audit their services against treatment guidelines, to evaluate their services and provide evidence of their effectiveness. In addition to this top-down approach, generating bottom-up practice-based evidence can help provide evidence of effectiveness of treatment approaches; it can also generate research questions of interest to practitioners such as factors influencing treatment length, treatment failure and drop out from therapy. The process of collecting practice-based evidence can also help engage clinicians in taking account of evidence to reflect on and develop their practice, enhancing existing approaches to reflective practice such as clinical supervision.

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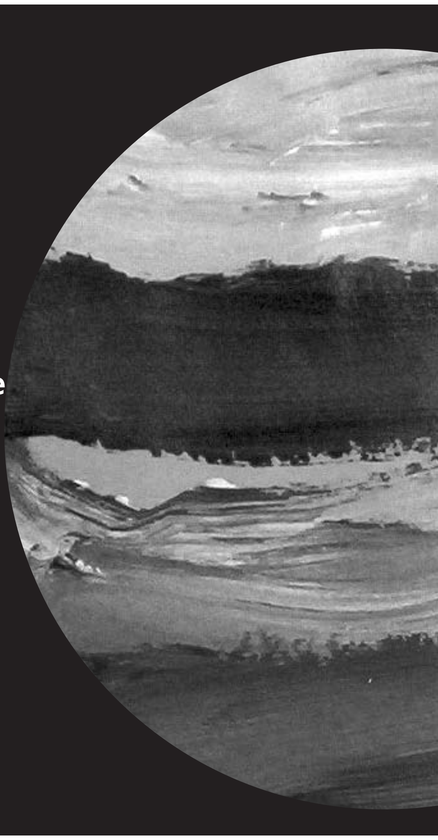
Points of view



‘The most horrendous day of our lives’

John Girdlestone, Daniel Girdlestone, Chris Leach & Virginia Minogue

The fire at Bradford City football stadium occurred 20 years ago. We provide accounts of the trauma of that day from the perspectives of someone who was there and a professional with experience of helping survivors. We also give sources of help

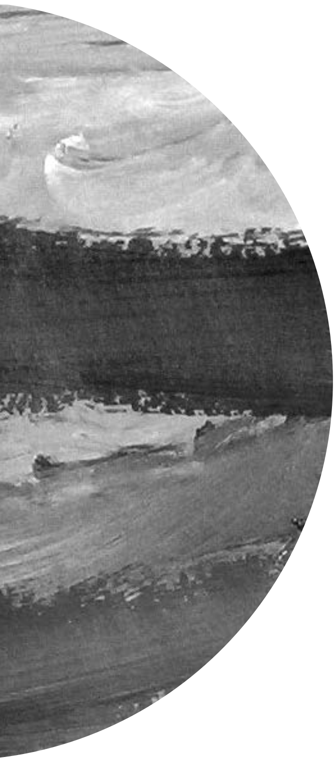
Key words: Post traumatic stress disorder; PTSD; survival; therapy; Bradford City fire

‘The most horrendous day of our lives’

The day of the match

Saturday 11th May 1985. The day itself started well, the weather was warm and just right for football or so I thought. I got on my motorbike and waved my wife and my two year old son goodbye and set off to Cottingley Bar, which is on the outskirts of Bradford, to meet my father. When I arrived dad had made me a lovely lunch. Dad had tried to get us tickets for the main stand; as luck would have it, the seating area was sold out, so we’d have to settle for the paddock, which was situated in front of where the ‘fire’ started. After lunch, dad and I made our way down to Valley Parade.

The occasion



Dad had watched Bradford City all season and they had just been promoted to the second division and won the third division title, which was brilliant for the club and Bradford in general. On our way down towards the turnstiles we could tell it was going to be a good crowd; the official attendance was more than 11,000, which at the time was good. The atmosphere was building and the opponents Lincoln City joined us in celebrating winning the trophy, which was presented to the Bradford team just before kick off.

Lucky to be alive

It was nearing kick off and things weren’t too bad, although something didn’t seem quite right and so it proved. My mind went back to my school days. At that early age I suffered depression on a manic scale. I attended Belle Vue grammar school. My friends and I used to go down to Valley Parade on an afternoon to watch the players as we got in for free. Everyone that sat on those old wooden planks used to remark on all the rubbish that had gathered beneath the stands. There were cigarette packets, crisp bags, old programmes and newspapers. It was a complete dump. It was a very dry day and everyone was in a festive mood. The match started, never to finish.

The fire took just four and a half minutes to burn from one end of the stand to the other, stopping near the dressing rooms. It was a complete disaster. Everybody was just rushing to the exits. As dad and I were in the paddock, we just managed to climb onto the pitch using the dugouts as our get-out clause. A few burly Bradford fans helped dad over the wall onto the safety of the pitch and I followed, very shocked and singed from the heat. Policemen, fire fighters, fans and even the players tried to help but their efforts were in vain. Dear old dad didn’t last much after the fire, which claimed the lives of 56 people and injured more than 250 more.

Worry

My wife at the time was worried about our whereabouts, as she had heard about it on the local news and had no contact with us to see if we were OK. I arrived home OK to the delight of my wife and son. The memories will never leave me and have made me anxious, panicky, depressed and near to suicide. Weeks after the fire I tried to go back to work at the pit but, as I travelled to work one day, I heard someone make some awful remarks regarding the disaster. I couldn’t concentrate on the job and I had to stop working for a few months. I couldn’t sleep; I just kept having nightmares seeing all those people go to their deaths.

Bad dreams

The first year after the Bradford fire was horrific, as one would imagine. Even bonfires in local gardens brought back memories of that horrible day. The felt roofing, the wooden seats and all that rubbish, still the bad dreams never left.

Wakening without much sleep, could only manage cat naps. This deep rooted depression which was bad even before the fire was only to go away slightly over the next two decades. The only thought was to sit about the house, curtains pulled, unshaven and not being able to physically work down the pit. Tablets and medication always close to me, too close!

A few years on

People couldn't believe that I was so poorly, saying I should pull myself together. Even people close to me. Daniel now aged 5 didn't understand what I was going through at that time. Daniel knew a few years on that I was poorly. Five years later I had to sort things out. My marriage had suffered, I needed to go back to work. Daniel's mum and I decided to go into the licensing trade, hoping this would bring things together. I was trained as a manager, so I had a start and the backing of my ex-wife. She was a brilliant landlady, taking care of the money and ordering side of things. Life took on a different perspective. Until I had my second nervous breakdown. I managed to get a bit better, but my marriage ended soon after. Who would live with a person like me?

No help

Everything was at a standstill; I had no wife for help. Daniel was at school in Featherstone, but I only saw him three days a week. He had become a strong character, not letting my condition interfere with his education. Daniel, my eldest son John and daughter Victoria were all brilliant at their respective schools and they all have good jobs, which makes me proud.

Life today

Well, here we are nearly 20 years after the disaster. I am stronger and able to write this piece of work, whereas 10 years ago I couldn't have managed it. I have had some first class training at Baghill House and Fieldhead Hospital[1], which has proved very therapeutic. My son, who is now 21 and ironically a Bradford City fan, realises what his granddad and I went through and has helped me complete this work. The main stand at Valley Parade has now been replaced by a brilliant structure which incorporates a memorial with the names of those who lost their lives. Daniel helped me return to Valley Parade to watch football and overcome many obstacles and has been a big help to me. My thanks go to him and his mother, also Virginia, Chris and everybody at Fieldhead Hospital.

Thanks,
From John & Daniel Girdlestone

1. Baghill House and Fieldhead Hospital are located within South West Yorkshire Mental Health NHS Trust. Baghill House is the base for a community mental health team. Fieldhead Hospital is the location for a range of in-patient, out-patient, and other Trust services.

Reflections on the Bradford Fire and Post Traumatic Stress

''Time doesn't heal, processes do'' (James Thompson)

I came to Leeds to train as a clinical psychologist three years after the Bradford Fire. In one of our training sessions, we were shown photographs of the stadium in the four minutes it took for the fire to take hold and devastate so many lives. I had known about post traumatic stress before then, having edited the British Psychological Society's statement on the psychological effects of nuclear war (Thompson, 1988). That book had included a review of the known impacts of disasters, from Hiroshima and Nagasaki to natural disasters like floods, so I was familiar with how people reacted to major catastrophes. One interesting thing was that it had taken about 17 years before anyone studied the impact of Hiroshima/Nagasaki seriously, so great was the effect. This is a good example of denial, one of the known post traumatic stress reactions, this time at a public level. If you don't think about it, it will go away - but it doesn't.

The photos of Bradford, though, had a different sort of impact. Difficult to get them out of your head - close in time and close to where I was living and immediate emotional impact, not like the academic words I'd been reading and writing. Some time after that session, I decided to do my dissertation on the impact of the fire on the police who had been involved. The accounts I heard made it clear how much police and other service personnel had been affected. The dissertation compared how much sick leave they had taken in the two years before the fire with the years after the fire, but most interesting were the things some of the police said. How unfair it was that it was their home ground. How difficult it was seeing people, who the previous week they might have thought of arresting, dying in the fire while trying to save others. How many thought things like “If only I'd gone back into the stand, I could have saved that person”, when the reality was they would have died themselves in the attempt.

Since that time, I've heard many first-hand accounts from people who have survived major disasters, some of them friends, some strangers, and some clients. One that stays with me is listening to Eva Hart talk about her life to an audience of clinical psychologists. Eva was one of the last survivors of the Titanic. She was 7 when the Titanic sank. Her father drowned, but she and her mother were rescued. She reported having nightmares for years, which her mother helped her through. She said going on another cruise liner as a young adult helped her. At 85, when I saw her, she came across as a strong, powerful woman, who had somehow gained strength by going through that awful experience. She said she had lived through the Blitz in London without being badly affected by thinking “I've survived worse things than this”. And Eva had never received any professional help.

The key factor in healing is captured in the quote from James Thompson above. Reactions to a traumatic event are often automatic, giving you thoughts, images and feelings you have never had before. Trauma can also shatter previous beliefs about yourself (e.g., “I can always cope”) or about the world (e.g., as a safe place). These impacts can lead to you feeling totally out of control and you certainly cannot “pull yourself together”. What gets you through is being able to make some sense of what’s happened and integrate it with your understanding of the world. Some people, like Eva, manage to do this on their own, with help from family and friends. Others benefit from professional help, which can be offered in different ways, from talking to your general practice doctor to having individual therapy with a specialised therapist or making use of self-help material provided by specialist services such as Elaine Burleigh’s 1997 leaflet – see our list of sources of help given after this article.

When something completely out of your experience happens, be it a major disaster like the Bradford fire, or the devastation caused by the tsunamis following the earthquake in Indonesia in December 2004, or a personal tragedy like an unexpected violent attack, most people get three sorts of reactions. The first is a preoccupation with what happened. We talk about it all the time, re-experience it in the form of flashbacks and nightmares, and can’t get it out of our heads. This is our attempt to make sense of or process what has happened. In many cases, this is just too difficult to do, so the second reaction comes in, which is denial. This is a protection process, which stops us being overloaded by the enormity of the event. For some people, preoccupation takes over and they get overwhelmed. For others, denial takes over and their feelings get totally buried. For others, the two processes go on at the same time and people alternate between feeling overwhelmed and trying to avoid thinking about what has happened. The third reaction is that we become hyper-aroused to signs of danger, a sensible reaction if the danger is still there, but not very helpful if the danger has gone.

What heals is being able to talk or think through what has happened in a safe environment, which might be around sympathetic family, friends or a therapist. Feeling safe is a key requirement; otherwise hyper-arousal or denial will take over. What helps is starting to think through or re-experience the event in imagination, so that the first reaction, the preoccupation, can run its course without totally overwhelming us. Getting back on the horse after you’ve been thrown really does help, but not if you’re absolutely terrified and the horse is too out of control to

mount. This re-experiencing in a safe environment is what's captured in treatment guidelines for posttraumatic stress (Foa, Keane & Friedman, 2000, or the recent guidance from NICE: National Institute for Clinical Excellence, 2005).
The guidelines recommend treatment like cognitive behaviour therapy (CBT) or eye movement desensitisation and reprocessing (EMDR), the key components of which are safe re-experiencing of the traumatic event. Medication, such as one of the Selective Serotonin Re-uptake Inhibitors (SSRIs), can be effective in reducing some of the symptoms of posttraumatic stress, but will not deal with the underlying problems.

From the perspective of the therapist, the healing power of just listening cannot be underemphasised, but it can be extremely difficult to listen when someone is telling you awful things. What helps the therapist are good supervision and a good knowledge of the process of healing, as well as not being totally involved with the person recounting their experiences, which is what sometimes makes it difficult for family members or friends to help someone through – they might get overwhelmed themselves. How difficult it must have been for Eva Hart's mother to have helped her through her nightmares, when she had experienced the same horrific event herself, but it might have helped her heal too.

Twenty years on, the Bradford fire is still with me, although not in the immediate way it must be for John Girdlestone and his family, who experienced it directly and whose account is in this issue of the journal. Such major disasters affect many people and, although rare, occur frequently enough to remind us all we are not invulnerable. Samuel Pepys writes about the impact on him of the Great Fire of London in 1666. Whilst writing my dissertation in 1989, I was listening to the news and heard of a terrible tragedy unfolding at Hillsborough. Whilst writing this article in December 2004, I heard the news of the Indonesian earthquake…

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Chris Leach

What is Post Traumatic Stress Disorder or PTSD?

People who have lived through a very traumatic event, usually one that is quite outside everyday experience, may experience post traumatic stress or PTSD. The event is usually one that is life threatening or likely to cause serious injury to oneself or others. Not everyone will experience PTSD in similar circumstances. Those who do experience PTSD usually have a group of three types of symptoms:

A. Persistent experiencing or re-experiencing of the event, including things like:

- Distressing recollections of the event
- Distressing dreams of the event
- Acting or feeling as if the trauma were recurring
- Intense distress at exposure to things that resemble of remind them of the event

B. Persistent avoidance of things associated with the trauma, including things like:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places or people that remind you of the trauma
- Inability to recall an important aspect of the trauma
- Loss of interest in things or activities that used to interest them
- Feeling detached or estranged from others
- Unable to feel things as before
- Sense of a foreshortened future

C. Persistent increased arousal, including things like:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper vigilance
- Exaggerated startle response

After a frightening event, it is normal to feel shocked or anxious but if these feelings continue and stop a person living their normal life then they may be suffering from PTSD. To be labelled PTSD, such symptoms as those listed above should continue for more than a month after the event and should have a major impact on social or work life. If you have experienced a traumatic event and don't have the symptoms in sufficient intensity for your problems to be labelled PTSD, this doesn't mean that you haven't been affected by the trauma. People react to traumatic events in many different ways. Many cope with traumas with minimal help from others; those whose symptoms are sufficient to count as PTSD may need professional help.

Useful sources of help and advice on Post Traumatic Stress Disorder

The first source of advice and help is likely to be a person's General Practitioner (GP). The GP may then make a referral to either psychiatric or psychological services for a further assessment and possible treatment or support from someone who is a specialist in Post Traumatic Stress Disorder (PTSD). Treatment may take the form of trauma focused therapy sessions such as cognitive behavioural therapy (CBT) or eye movement de-sensitisation and re-processing (EMDR). Self-help material is also becoming available; this can give a good understanding of likely reactions and ways to overcome them. Some people may benefit from taking anti-depressants for a time.

Many people find it helpful to have sources of information that offer practical advice in the immediate aftermath of a traumatic experience or the opportunity to talk to someone about their experience. Some sources of information and advice are listed below:

General sources of advice and support

NHS Direct Online
www.nhsdirect.nhs.uk

The NHS Direct site links to another site:
www.besttreatments.co.uk/btuk/conditions/post_traumatic_stress

MIND
National MIND can be contacted at:
15 – 19 Broadway
London E15 4BQ
MINDinfoLine: 0845 766 0163

Details of local MIND offices can be found on the information line or via the website:
www.mind.org.uk

MIND also has a series of helpful booklets including 'Understanding post-traumatic stress disorder'.
www.mind.org.uk/Information/Booklets/

Victim Support
National Office
Cranmer House
39 Brixton Road
London SW9 6DZ Telephone: 020 7735 9166
Local offices exist in each area and details can be found on:
http://www.victimsupport.org.uk

Alternatively contact the support line 'Victim Supportline' which offers free and confidential support: 0845 30 30 900

Social Services Departments
Details of local social services offices can be found in telephone directories or from Town Halls.

The Samaritans
Helpline: 08457 90 90 90 (24 hours)
Website: www.samaritans.org.uk

More general support and advice

ASSIST (Assistance Support and Self Help in Surviving Trauma)
11 Albert Street
Warwickshire CV21 2QE
Helpline: 01788 560 800
assist@traumatic-stress.freeserve.co.uk

British Association for Behavioural and Cognitive Psychotherapies (BABCP)
Globe Centre
PO Box 9
Accrington BB5 2GD
E-mail: babcp@babcp.com
Website: www.babcp.org.uk
The leading body for cognitive-behavioural therapy in the UK. The website has a search facility to find an accredited therapist and gives information on how the therapy works.

British Association for Counselling and Psychotherapy (BACP)
35-37 Albert Street
Rugby CV21 2SG
Tel: 0870 443 5252 (Mon-Fri 8.45am-5pm)
E-mail: bac@bac.co.uk
Website: www.bacp.co.uk
BACP can provide you with a list of private counsellors in your area, plus information on counselling and choosing a counsellor. Please telephone or send an SAE to the above address. Alternatively, you can search for a counsellor at the website which, along with an online directory of counsellors, contains details about membership, training and an extensive publications list.

Specific support and advice

Cruse Bereavement Care
Cruse House, 126 Sheen Rd
Richmond
Surrey TW9 1UR
Runs a helpline and offers counselling, advice, information and support to anyone who has been bereaved.
Helpline: 0870 167 1677 or 0808 808 1677 (for 12 to 18 year olds)
www.crusebereavementcare.org.uk

Ex-Services Mental Welfare Society (Combat stress)
Tyrwhitt House, Oaklawn Road
Leatherhead KT22 0BX
01372 841 600
www.combatstress.com

Lifeline
Help for victims of violence in the home, sexual abuse, and incest.
Telephone: 01262 469085

Refuge
2-8 Maltravers Street
London WC2R 3EE
Helpline: 0808 2000 247 (24 hours)
E-mail: info@refuge.org.uk
Website: www.refuge.org.uk
Provide counselling, support and welfare rights for women and children escaping domestic violence as well as accommodation and refuge.

Refugee Support Centre
47 South Lambeth Rd
London SW8 1RH
Rsctherapy47@hotmail.com

The Compassionate Friends
53 North Street
Bristol BS3 1EN
For bereaved parents and their families.
Helpline: www.tcf.org.uk

Traumatic Stress Centre (Wales)
Aims to assist the healing process by offering a confidential service providing free help and advice. Run a 24-hour helpline, backed by an emergency 24-hour mobile number, and a range of courses relating to PTSD.
Advice Line 01792 521063
www.trauma999.co.uk

Traumatic Stress Clinic
73 Charlotte Street
London W1T 4PL
020 7530 3666
www.traumatic-stress-clinic.org.uk

Traumatic Stress Service
Maudsley Hospital
99 Denmark Hill
London SE5 8AZ
0207 919 2969
Referral through Community Mental Health Teams.

Other Websites

Helping Children and Adolescents Cope with Violence and Disasters
www.nimh.nih.gov/publicat/violence.cfm
This site is run by the US National Institute of Mental Health to help children and adolescents cope with violence and disasters. It identifies post traumatic stress disorder and the way in which children and adolescents react to it. It also offers sources of advice and treatment.

Psychology in Daily Life
www.helping.apa.org/daily/traumaticstress.html
This site is produced by the American Physiological Association and has articles and resources on managing traumatic stress and information on coping with the aftermath of a disaster. It also has guidelines for children coping with trauma.

The International Society for Traumatic Stress Studies
www.istss.org
This site is for both health professionals and the general public. It contains fact sheets and useful resources and links.

The National Center for Post Traumatic Stress Disorder
www.ncptsd.org
This US-based organisation was set up to address the needs of veterans with military-related PTSD. The website is an educational resource concerning PTSD and other enduring consequences of traumatic stress. It has extensive information, fact sheets, links, FAQs and suggested reading.

Trauma Information Pages

www.trauma-pages.com

This site focuses on emotional trauma and traumatic stress, including PTSD, whether following individual traumatic experience(s) or a large-scale disaster. Aimed primarily at clinicians, researchers and students in the traumatic-stress field. It is American-based.

UK Trauma Group

www.uktrauma.org.uk

This website contains information on PTSD and features details of local specialist centres providing diagnosis and treatment for sufferers. It also has links to other

With all of us in mind

South West Yorkshire NHS
Mental Health NHS Trust

Modernising Mental Health & Learning Disability Service Delivery & Organisation

Annual Research Conference

Thursday 5th May 2005
10.00am - 3.00pm
Education Centre, Fieldhead, Wakefield

The programme includes:

An update on the research programme

Keynote speech - Roger Paxton (RDC/NIMHE North East)

Stream sessions

- Ageing and mental health
- Learning disabilities
- Psychological research in service settings
- Pathways and packages of care
- User involvement in research

Poster presentations

If you would like to book a place please fill in a form or contact:
Alison Holmes
School of Human and Health Sciences
University of Huddersfield
Tel: 01484 473646 or e-mail: a.holmes@hud.ac.uk

Calderdale and Huddersfield NHS
NHS Trust

Research and Development
TRAINING 2005 – 2006

Research in Health & Social Care
A Practical Introduction

A comprehensive introduction to all aspects of health and social care research, now accredited at undergraduate and masters level by the University of Huddersfield. It will enable participants to become better able to access, evaluate, and apply research evidence to practice, develop or participate in local research projects, understand the place of research and evidence in modern health and social care.

ST LUKES HOSPITAL	***Starts Monday 5th September 2005***
CALDERDALE ROYAL HOSPITAL	***Starts Tuesday 7th March 2006***

"From Bright Ideas to Funded Proposal"

A one-day training course designed to enable participants to turn an idea for research into a viable question, introduces the principles of research and how to get that necessary funding for your project.

FIELDHEAD HOSPITAL, WAKEFIELD	***Tuesday 6th September 2005***
CALDERDALE ROYAL HOSPITAL	***Spring 2006***

Involving Consumers in Health Research and Evaluation
(Involving service users/patients in research in a meaningful way)

Aimed at any healthcare professional involved in research or evaluating a service, this one day seminar involves researchers, managers and service users/patients themselves in exploring meaningful and valid alternatives.

CALDERDALE ROYAL HOSPITAL	***Friday 21st October 2005***
FIELDHEAD HOSPITAL, WAKEFIELD	***Friday 28th April 2006***

Critical Appraisal Skills
A half-day workshop

Critical Appraisal skills enable you to systematically assess the trustworthiness, relevance and results of published papers. By the end of the session, participants will have the necessary skills critically appraise research evidence about effectiveness in order to promote evidence-based practice.

HUDDERSFIELD ROYAL INFIRMARY	***Friday 16th September 2005***
FIELDHEAD HOSPITAL, WAKEFIELD	***Wednesday 6th April 2006***

Advanced Critical Appraisal Course

A course on critical appraisal, held over five half days is being offered here in Calderdale and Huddersfield NHS Trust. This course is led by the Critical Appraisal Team and will give you practical, individual assistance to enable you to complete your systematic review.

HUDDERSFIELD ROYAL INFIRMARY	***Starts Tuesday 6th September 2005***

Clinical Trials Co-Ordination

A full day programme looking at all the background requirements that underpin a Clinical Trial within a NHS setting. By the end of the session participants will have an introduction to ICH/GCP, role of monitor/sponsor/ research nurse. We will also be looking at the principles of EU directives and the role they play into running a Clinical Trial.

HUDDERSFIELD ROYAL INFIRMARY	***Thursday 27th October 2005***

To book a place on any of the courses please contact Lesley Argyle, R&D Secretary.
Telephone: 01484 347007. Email: Lesley.Argyle@cht.nhs.uk

For further information on any of the courses please contact the R&D Department.
Telephone:01484 347007. Email: R&D@cht.nhs.uk

Certificate in Professional Studies

Learning Disabilities

Two new courses for those working with people who have a learning disability or people with a learning disability and additional forensic needs. The courses enable you to consolidate and update your current knowledge. Both routes are available part-time and last one year.

Holistic Care

Forensic Care

Holistic Care consists of

- **Holistic Health and Individuals with a Learning Disability**

30 Credits The concept, definitions, attitudes, constructs and experience of holistic health will be examined as applied to people with a learning disability

- **Person Centred Approaches to Meeting Holistic Care Needs of People with a Learning Disability**

30 Credits Examines person centred planning in its application to the person with a learning disability

Forensic Care consists of

- **The Nature of People with Learning Disability and Forensic Needs**

30 Credits Outlines the nature of the person with a learning disability and forensic needs. The nature of intellectual disability and offending, risk and dangerousness will be explored.

- **Approaches & Interventions for People with Learning Disability & Forensic Needs**

30 Credits Considers assessment issues, tools and approaches that could be used for helping a person with learning disabilities with forensic needs.

These modules can be taken at intermediate and honours levels, with a possibility of master's level credits being available soon. You may study an individual module, complete the one year stand-alone Certificate or use the credits towards various qualifications including the BSc (Hons) Professional Studies.

Fees
FREE to students funded by the West Yorkshire Workforce Development Confederation who have their manager's approval, otherwise fees may apply.

University of
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For further information

Lorraine Croft, Admissions Assistant
☎ 01484 473868 ✉ l.croft @hud.ac.uk

or

The CPD Enquiry Centre
☎ 08701 202295

Mental Health and Learning Disabilities Research and Practice

Types of manuscript

Articles, Short Papers, or Reviews, are welcomed from practitioners, managers, researchers, and academics, working or involved in any aspect of mental health and learning disabilities, and service users or service user groups. All articles and papers are peer reviewed by at least 2 referees.
Articles - Articles will be reports of mental health and learning disability research, reports of service evaluation, practice development, or audit and should be between 3,000 and 5,000 words.
Short papers and reviews - Short papers of up to 3,000 words are welcomed on issues of practice or research.
Educational and Service Developments - The 'Developments' section of the journal will provide evaluation, review or critical appraisal of a recent development in policy, practice, education and research in mental health and learning disability.

Submission of manuscripts

Contributors are asked to submit 3 copies of their paper or one copy by e-mail attachment, together with a separate sheet providing brief biographical details and details of their full postal and email address, telephone and fax numbers. Manuscripts should be submitted using A4 size paper, in double line spacing with wide margins.
Authors should submit 3 copies of their manuscript, including any tables or illustrations, to The Editor or by e mail to: a.holmes@hud.ac.uk. Authors are advised to retain a copy of their paper.

Presentation of manuscripts
Articles

Articles should be between 3,000 and 5,000 words.
Abstract - an abstract of the paper, of up to 200 words, should accompany the article together with up to 6 key words suitable for indexing, abstracting, and on-line search purposes. The abstract should provide a concise summary of the whole paper.
Author details - a brief biographical note about the author should be submitted on a separate sheet. Details should include the author's full postal and email addresses, telephone and fax numbers.
Abbreviations – all abbreviations should be preceded on the first occasion they appear, by the full name. Full stops should be used after abbreviations such as e.g., i.e., etc., and where the end of a word is cut as in p. (page), or ed., but are not necessary in acronyms such as HMSO, HMIP, UK.
Notes should be kept to a minimum and placed at the end of the article before the references. Footnotes should not be included.
Quotations – use single quotation marks for material quoted in the text. Double quotation marks can be used for quotes within quotes. Long quotations (40 words or more) should be displayed indented. Shorter quotes may be retained within the text.
Tables, figures, and diagrams should be kept to a minimum and, where included, should be submitted on separate sheets attached to the article with a short title. In the text the position of a table, figure, or diagram should be shown by typing on a separate line 'take in Table 1(Figure 1/Diagram 1)'. Tables, figures, and diagrams should be in black and white, clear and well drawn.
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References – references should appear at the end of the article. The Harvard reference system is preferred in this journal. Within the text, the name of the author and date of publication should be cited (e.g. Smith 2001), and, following quoted material, the page reference (e.g. Smith 2001, p. 90). A full alphabetically ordered list of references (headed References) should appear at the end of the article after any notes. The reference list must include every work cited in the text with dates, spellings and titles being consistent. Two or more works by an author in the same year should be distinguished by using 2000a, 2000b, etc. Where there is more than one author of a text or article, each author's name should be spelt out in full in the reference list. It is not permissible to use et al. The date of publication cited must be the date of the source that is being referred to.
References in the Reference list should conform to the following style:
Robson, C. 1997. Real World Research. Oxford, Blackwell Publishers Ltd.
Phillips, C., Palfrey, C., & Thomas, P. 1994. Evaluating Health and Social Care. London, Macmillan Press Ltd
Minto, C., & Morrow, M. 2000. Clinical supervision for nurses in a learning disability forensic service. In Mercer, D., Mason, T., McKeown, M., & McCann, G. Forensic Mental Health Care. London, Churchill Livingstone.
Faulkner, A., & Thomas, P. 2002. User-led research and evidence based medicine. British Journal of Psychiatry 180: 1 – 3.

Additional points on style to assist contributors

• It is expected that language used in articles will be non-sexist, non-racist, and non-discriminatory. • Single spaces should be used after full stops, commas, colons and semicolons, quotation marks etc. • Dates should be written in the form 1 January 2004.

Short papers and reviews

Short papers should be up to 3,000 words. Authors should follow the same guidelines as for the submission of longer articles.

Educational and service developments

Contributions should not normally exceed 1000 words. Authors should follow the guidance for submission of articles in their use of references and abbreviations. Generally, authors should try and avoid the inclusion of tables, figures and notes.

Publication

Once accepted for publication authors will be asked to submit electronic versions of their articles or short papers. Authors will be asked to send an electronic copy of the final version of their article by e-mail attachment or on disk (3.5" version in Word). Authors should ensure that the final hard copy of their typescript is an exact version of what is on disk. Authors will be sent proofs of their article for checking and are expected to correct any typesetting errors quickly. These should be marked in red on the proof and returned to the editor within 3 days. Authors are asked not to make any alterations to the original text unless absolutely essential. Authors will receive a complimentary copy of the journal and off prints of their article.

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