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The Cumbria Partnership Journal of Research, Practice and Learning

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Editorial

Dave Dagnan

Professor Dave Dagnan, Editor, The Cumbria Partnership Journal of Research, Practice and Learning

This is the fourth issue of the Cumbria Partnership Journal of Research Practice and Learning. This issue has a number of articles that are the product of learning and development of colleagues within the trust. I have previously written that we should work to harness the considerable potential of the training that colleagues undertake and I am very pleased to be able to publish papers from this work. In this issue we have also published abstracts from conference presentations and theses produced by members of the trust. I would like to emphasise that a core aim of the journal is to disseminate work that is relevant to the trust and that we will consider many different formats for publication. Finally I would like to draw attention to a number of articles that are from colleagues in partner organisations, in particular from colleagues at the University of Cumbria. I am very pleased that the journal is considered as a positive outlet for this work.

The first issue of our journal contained a paper on reflective practice (Cavanagh, Masson & McDowell, 2011) that outlined approaches to reflection and described the experience of running reflective practice groups. Since then all issues of the journal have emphasised reflection, both as a specific activity and as part of articles presenting research and evaluation. The current issue has a number of excellent examples of reflective thinking. I believe that the process of reflection is of central importance in safe and compassionate clinical practice. The Francis Report (Francis, 2013) identified numerous examples of care that fell far below what we should regard as ordinary human standards. The report identifies numerous safeguards that may prevent this happening in other organisations. However, as part of my role in the trust is Professional Lead for Psychological Practice I found it particularly powerful that core professional standards of care had not been present in Stafford. For me this resonated with statements from the Kings Fund Publication Preparing for the Francis Report: How to Ensure Quality in the NHS (Dixon, Foot & Harrison, 2012) which suggested that “The first line of defence [of quality] is frontline professionals, both clinical and managerial, who deal directly with patients and carers and are responsible for their own professional conduct and competence and for the quality of the care that they provide”. Reflective practice will of course not be sufficient alone to ensure staff maintain their professional standards and to rectify the failings of Stafford, however staff who engage in reflection with colleagues and who make transparent their assumptions in care will, I believe, be less likely to become tolerant of the dramatically poor standards identified in the Francis Report. We will continue to encourage good examples reflection in the articles we publish in this journal.

References
LETTERS/NEWS/BOOK REVIEWS/REVIEWS

A consideration of Michael Palin Centre Parent Child Interaction Therapy for stammering from the perspective of narrative therapy

Eleanor Convey

Abstract

This paper considers the use of Michael Palin Centre Parent Child Interaction Therapy (MPCPCIT), which is an evidence-based intervention for stammering in children. I will suggest that MPCPCIT draws on similar principles to narrative therapy and has developed as a collaborative approach between the speech and language therapist and the parents of young children (Rustin et al., 1996) from which change can occur that results in the child using more fluent speech. This paper will first explore the development of MPCPCIT, then consider the development of narrative therapy, and finally will discuss the principles of MPCPCIT by drawing on the development of narrative therapy. The aim of the paper is to highlight the development of this model of family therapy and its impact on current professional practice.

MPCPCIT

MPCPCIT has developed as a treatment approach for children by adapting the traditional model of rote訓練. It views stammering within a multi-factorial model identifying predisposing physiological and linguistic factors and their interaction with psychological and environmental factors (Kelman & Nicholas, 2008). Previous therapy for children who stammered had focused on therapists as experts providing parents with lists of ‘dos’ and ‘don’ts’ and identifying unhelpful behaviours. MPCPCIT integrates family therapy and direct therapeutic approaches, whereas direct approaches focus on children making changes to their speech. One of the elements of the MPCPCIT that makes it stand out from other indirect therapy models for children who stammer is that parents are encouraged to select their own strategies based on their knowledge about what helps their child (Kelman & Nicholas, 2008).

Narrative therapy

Family therapy has drawn on influences and theories not only from within family therapy but from those occurring in other fields (Hayes, 1991). The narrative approach to family therapy was developed by White, Epston, and their colleagues (Carr, 2006). The approach has been influenced by the work of Foucault, which emphasises issues of power and subjectivity (White & Epston, 1990). Narrative therapy rejects the idea of universal truth and favours multiple realities and perspectives. Within the model of narrative therapy, human problems are viewed as arising from the stories that dominate the person’s life. A central goal of the therapy is to help people re-author their lives and thus develop therapeutic solutions to problems. The assumption is made that social realities are constructed through language, therefore therapeutic conversation aims to explore multiple constructions of reality. Dallas & Draper (2010) recognise that people have the natural ability to possess, generate, and evolve new culturally shared narratives.

Carr (1998) summarised that the important central practices of narrative therapy include: a collaborative co-authoring position between the client and therapist; Externalising problems; Mapping the influence of the problem; Identifying when clients are not oppressed by their problems thus identifying unique outcomes; Thickening descriptions; Linking to past and extending to future; and Inviting an outsider witness.

MPCPCIT and narrative therapy

Co-authoring

The co-authoring position is central to narrative therapy. It is from this position that many of the other central practices of narrative therapy take place (Walker & Akker, 2004). The approach involves a position of not knowing and the therapist joins the client or family in search of solutions. It is in collaborating to develop alternative stories that a number of different beliefs begin to open up possibilities. The co-authoring position is also central to MPCPCIT. The assessment stage includes a parental interview and a child assessment. The parental interview consists of a series of questions aimed at finding out about the child and his stammer in the context of the family. The child assessment includes a video recording of interaction between the child and each parent, assessment of stammering – including the types of stammering observed and the frequency they occur – speech and language screening, and the child’s perspective. Following the assessment sessions, all of the findings are summarised in a formulation (Kelman & Nicholas, 2008). The language used to construct the summary is based on the language and descriptions the parents use rather than how the therapist would describe the observations. The therapist begins to facilitate conversations to encourage the family to identify some of the knowledge they already possess about their child to develop solutions.

Externalising

White and Epston (1990) describe externalising as an approach that encourages people to objectify or personify the problem they experience. The problem then becomes external to the person or relationship and opens up possibilities to develop an alternative story. Externalising allows the problem to become external to the person or relationship that the person is not the problem; the problem is the problem. Questions are also introduced that encourage people to determine the problem’s influence, thus mapping the influence of the problem (White & Epston, 1990). Although externalising is not central to MPCPCIT, parents will often externalise their child’s stammer and describe it as ‘the stammerer’, e.g., ‘the stammerer is worse’ as opposed to ‘he is stammering more’. It may be of benefit to adopt an externalising questioning style in response to parents externalising in order to confirm the problem. Although White and Epston (1990) discuss how externalising a child’s problem has great appeal for families and often led to a child’s problem being resolved. The use of narrative thinking characterises and externalising has been explored within the field of adults who stammer. Trichon (2010) states that externalising allows both client and clinician the opportunity to gain understanding about their background, self-identity and relationship with stuttering. It also enables the clinician to identify the language the client uses when they discuss their problem. Externalising enables people to separate their narrative from dominant stories, identify previously overlooked experiences, and create an alternative story or ‘unique account’.

The use of externalising in narrative therapy is one of the central principles. This technique has potential benefits – especially with families who already position themselves towards externalising. As discussed, both narrative therapy and MPCPCIT are working towards identifying new outcomes that will result in a change and create a new story. It could be possible to introduce externalising to the parental interview as it would allow parents to begin considering stammering or the problem from a different perspective, and allow the opportunities for the therapist to collaborate with the parents to create some of the goals for therapy.

Unique outcomes

White and Epstein (1990) state that when ‘unique outcomes’ are identified people can be invited to ascribe meaning to them. Sometimes unique outcomes present themselves in a session, often brought to the person’s attention by the therapist’s curiosity in establishing circumstances where problems did not occur but were expected to occur. Language is used to ascribe meaning to the unique outcomes. These unique outcomes are the ‘plot’ of the story and could be incorporated into a story by mapping them (Carr, 1998). MPCPCIT makes use of videoing parent-child interactions and then reviewing them to identify unique outcomes, e.g., noticing when stammering is not a problem within the video clip. Then identifying the type of situation where stammering is not a problem, e.g., when letting the child lead the play. The parents then choose a unique outcome to concentrate on during their therapy tasks between sessions, e.g., providing opportunities in play for the outcome to occur again. Taking the principles of ‘thickening the plot’ from narrative therapy could really enhance this part of MPCPCIT. It is apparent that the Michael Palin Centre is influenced by the ideas of social constructionism through their work with older children who stammer and solution focused brief therapy. It would be possible to invite parents to consider linking the unique outcome they have just identified to events in the past, e.g., ‘Can you recall a time in the past when your child has taken the lead in play and you have noticed stammering is not a problem? White and Epstein (1990) state that imagination plays a significant part in not only externalising the problem but also in identifying unique outcomes. For example, letting a child build with bricks however they choose may not be significant to the therapist but for the parent who wants their child to build a structurally correct house
Most of the reflections are typically generated by therapy, it enables them to identify unique outcomes. As previously discussed, reviewing the notice what is working well to support their child’s interactions each session and inviting the parents to comment on the process and highlight family strengths. Outsider witness groups

Narrative therapy also relies on the use of outsider witness groups where significant members of a client’s social network are invited to witness new self-narratives. The idea of outsider witnessing has been developed in the practice of reflecting teams being utilised in narrative therapy. Reflecting teams were originally developed by Tom Andersen in Norway (Asen et al., 2004). Dallos and Draper (2010) consider the use of reflecting teams to be a significant technique to emerge in narrative therapy. Within this approach the therapist and family observe the reflecting team through a one-way mirror discussing the family interview, during which time the reflecting team comment on the process and highlight family strengths. The family and the therapist can then resume the session and discuss ideas that have come from listening to the reflecting team. Carr (2006) states that the reflections given by the reflecting team must be speculative, use the family’s language, and be relevant to the conversation, and the reflections should not differ too much from the family’s current views. MPPCIT draws on videoing parent-child interactions each session and invites the parents to notice what is working well to support their child’s fluency. As previously discussed, reviewing the videos as part of the session is used as a means of encouraging the parents to identify interactions that are helping their child to be fluent. In terms of narrative therapy, it enables them to identify unique outcomes. Most of the reflections are typically generated by the parents as it has been found more useful for the parents. Although they often identify strategies from ‘dos’ and don’ts’ lists, in terms of stammering, that historically therapists previously used for advice, there are more opportunities to identify them as their own outcomes. The parents are encouraged to identify their own targets as they are likely to result in a change; in a similar way to a therapist drawing a client’s attention to unique outcomes and then building upon these with language to thicken the plot. The use of reflection runs throughout MPPCIT starting with the assessment, where parents are asked to recall the onset of the stammer and how it has changed. At each session, parents are asked to reflect upon any thoughts from the last session with the therapist and upon tasks they have undertaken at home. As this type of therapy will usually be attended by both parents and their child who stammers, each parent has the opportunity to hear the other parent comment upon their interactions. It is more usual for the therapist to make observations only if the parents are finding it particularly difficult to notice any interactions that have been helpful for their child in terms of noticing times when stammering was not a problem. It may be useful to consider the principles of the reflecting team and allow the family to hear what the therapist has observed even if they find it easy to identify strategies. It may also be useful to bring a team into a session in the same way that Asen et al. (2004) suggest that you can bring family members into a consultation without them being present. This would allow the opinions of other colleagues to be used within the consultation. Using this idea it would be possible to allow the family to hear reflections from the therapist and colleagues before the discussion moves on to consider the ideas brought up in reflection.

Conclusions

Considering narrative therapy in the context of MPPCIT highlights several possibilities that would need to be considered in applying a more systemic approach to this type of therapy. The development of the narrative approach to family therapy influenced the work of Michael Foucault and the postmodern movement can be observed in the work of Rustin et al. (1996) in the development of MPPCIT. As this paper has highlighted, there are complementary components of narrative therapy that could lend themselves to the further development of MPPCIT, especially externalising, thickening the plot, and reflective teams. The inclusion of these components within family therapy could facilitate further change for the existing MPPCIT and could result in better outcomes for children who stammer. The benefits of including these components could bring new dimensions to a therapeutic approach which when selected in a thoughtful and culturally aware way.

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References


A critique of the life cycle model used within family therapy: A social work perspective

Caroline Hoyle

Abstract

This paper describes the life cycle model within family therapy. The review will consider the origins, development, criticisms, and ongoing usefulness of the life cycle model in working with children and their families.

Keywords

family therapy; life cycle; children; families; review

Introduction

This paper will explore the model of the family life cycle, a concept central to most schools of family therapy and one which is particularly relevant to my role as a social worker within a child and adolescent mental health team. Social work assessment models seem to share some similarities with the family life cycle model. For example, the National Assessment Framework and the family assessment model (Bentovim & Bingley Miller 2001, p.11), has its focus on the child within a family system and looks in particular at “the tasks and characteristics of family life and relationships which directly relate to how the needs of children can best be met in a family.” I feel, however, that social work assessment models have tended to be a ‘snapshot in time’ and more useful to the worker in gaining information than to the family in gaining understanding of their difficulties. This paper will consider the origins, development, criticisms, and ongoing usefulness of the life cycle model in an attempt to see whether this is a model that remains useful in thinking about and working with children and their families.

Origins of the family life cycle model

It is important to set the family life cycle model in the context of the time in which it was developed in order to understand its strengths, weaknesses, criticisms, and ultimate survival of the model over time. From the 1950s to the mid-1970s, the origins of family
The functional assumption of the structural approach to family therapy which evolved during this era was that "families have an objective structure" and that "therapy involves a process of assessment and mapping of this structure, followed by clear attempts to alter it where necessary" (Dallas & Draper, 2000, p.41). Embedded within this view are ideas of a "normal" family and "assumptions...about healthy family structures" (Dallas & Draper, 2000, p.48). Bateson introduced the notion that a family could be viewed as a cybernetic system, particularly since by assuming social systems, like physical and mechanical systems, were governed, both the uniformity and variability of human behaviour could be accounted for (Dallas & Draper, 2000, p.18).

The strategic approach to family therapy focuses on the dynamics of family interactions problems seen as existing in circular patterns of interaction. There is an "underlying theme that families are ambivalent about change, usually because family problems serve some important interpersonal function; some family members" (Carr, 2000, p.86). Within this model there is a focus on "exact behavioural definitions...and the sequences of behaviour by the client or others involved which are seen to maintain the system" (Spangler, 1989, p.6).

**Development of the family life cycle model**

It is within this context of the strategic approach that the idea of the family life cycle was initially created by Haley in order "to describe Erickson's work" (Haley, 1986, p.13). Haley describes how Erickson "sees more than any other therapist...has in mind the 'normal' or ordinary processes in the lives of people" and states that Milton's therapy "is most understandable if one takes into account family, all of their interaction processes and the points of crisis that arise when people go from stage to stage through the family life cycle." In essence the family life cycle framework considers the family as a natural system with specific interaction processes and the points of crisis that arise when people go from stage to stage through the family life cycle. The most widely accepted breakdown of life cycle stages is that of the sociologist Duvall (as cited in Carter & McGoldrick, 1989, p.5) "who broke the family life cycle into six stages or key life events that occur in every family over time." In family therapy, the focus on generational patterns and effects of previous family relationships fits with the more postmodern ideas of family scripts and narratives, as well as the "incursion of horizontal family life into our lives, as it has been described as a 'stream' of family life past us, gone by us, and in us. This comprehensive narrative or sequential form has given rise to attempts to make sense of trauma on emotional and brain development.

**Criticals of the family life cycle model**

From a postmodern perspective, however, which "calls into question the assumptions and beliefs foundational to a modernist perspective" (Bevcar, 2003, p.5), it was perceived that the family life cycle model was developed as it was within the more structural and strategic models of family therapy and focused upon the 'norms' of family life, would be re-evaluated. It is within these areas that there exists a single, widely shared commonsense construction of reality, one is likely to encounter inflexibility. The danger is that the framework becomes fixed and prevents family therapy from being seen as a 'normal' family. This could easily mean that those families who do not fit this 'norm' — e.g., single parent families — are treated as "deviant" (Gorell Barnes, 1998, p.44). As Barnes (1998) points out "in practice the theoretical model of the nuclear family — a heterosexual, biologically intact family, headed by a couple where the man brings home the money and the woman keeps the home — is increasingly rare in the UK." As family therapy has shifted into the postmodern era, there has been an "increasing awareness that all views of normality are socially constructed, influenced by our own world view and the larger culture" (Walach, 1993, p.3) and a "narrow and traditional definition of the family is no longer useful" (Walach, 1993 cited in Carr, 2000, p.5).

Family life cycle theorists have recognised the limitations of the model in addressing family systems that are not middle class, white, and heterosexual in format and some attempts have been made to adapt the model. Slater (1995 cited in Carr, 2000) has for example offered a five-stage life cycle model for lesbian couples, and McWhirter and Mattison (1844 cited in Carr, 2001) "developed a six-stage model for describing the themes central to the development of enduring relationships between gay men". Carter and McGoldrick (1989, p.21) "conceptualize the need for family systems to develop in a horizontal plane of development that is cyclical rather than cyclical" and they describe the additional life cycle steps and extra developmental transitions required (p.22, Table 1-2).

Despite this awareness of different family formats, Carter and McGoldrick (1989) were still referring to divorce as a "variation from the norm" or an "interruption or dislocation of the traditional family life cycle". In the third edition of their book (Carter & McGoldrick, 1999, p.10), they raise even more questions on the changing American family structure and they offer this quotation from Gillis (1996, p.240 cited in Carter and McGoldrick 1999, p.15) "if history has a lesson for us, it is that the life cycle model has never been able to satisfy the human need for love, comfort and security...we must keep our families cultures diverse, fluid and unexplored: Despite this assertion, the format of the family life cycle presented in the book and the six transitional stages remain the same as in earlier years. On the one hand, it could be said that the concept of the family life cycle continues to merely map assumptions that people in a given society hold about a particular form of family life" (Carr, 2000, p.54). On the other hand, it is argued that the family life cycle "rents itself on the idea that there is a cycle of stages which describes that the dominant nuclear family as a goal to be striven for" which in our current society may serve "as a form of implicit condemnation for many step families" (Carr, 2000, p.54). As McWhirter and Mattison (1984) point out for others who may not see themselves as fitting the normative pattern of the life cycle model. As Pocock (1995, p.150) points out "classification is such a powerful organiser of thinking" that when a framework exists there is a difficulty in shifting away from it and thinking more flexibly.

The feminist critique of the late 1970s/1980s focused on the lack of attention previously paid to gender related issues both in theory and therapy (Bevcar, 2003, p.11). Hare-Mustin (1986, p.17) states that "the therapeutic models that we have developed for working with families reveal widespread gender prejudice". The focus in strategic models on relationships, behaviour, and communication within families and recurrent themes was criticized as "failing to take into account the "rules, boundaries and hierarchies of society" (Hare-Mustin 1986, p.18). Haley (1986, p.43) recognised that there may be an objection to the family life cycle model, stating that if "the goal of therapy is to help people past a crisis to the next stage of family life" (this) might lead some clinicians to consider it a way of "adjusting" people to their families or to the society that shapes the family. He believed that this view was "naive" and felt it overtook the fact that "the freedom and growth of an individual are determined by how successfully he participates in the new world view that is formed" (Hare-Mustin & McGoldrick, 1999) there is even more focus on the ideological assumption that there is such a thing as a 'normal' family. As Hare-Mustin (1986, p.17) notes, "the ideological assumption that there is such a thing as normal family...is embedded in the hitherto unquestioned terms, such as housewife, chairman" (Dallas & Draper, 2000, p.91). Systems theories received criticism for "the implication that all problems are essentially interpersonal...and unwillingness to contemplate inequalities of power within families" (Dallas & Draper, 2000, p.52). Hare- Mustin and Sue (1995) argue that "if we fail to consider the internal functioning of the families, without concern for the social, economic and political context we are incompitely aware of the need to keep the family unexplored." The lack of focus on ethnic diversity in the family life cycle model has also been criticised. Carter therapy took influence from "general systems theory and cybernetics as a framework for conceptualising family organisation and processes" (Carr, 2000, p.57). Cybernetics, the "brainchild of Robert Weiner...described the activity of feedback cycles not only in machines but in human affairs" (Hoffman, 1993, p.87). A key notion was that "a system was seen as able to maintain its stability through a process of self-regulation by using information about past performance, and specifically how this deviated from the desired or optimal setting to make corrections" (Dallas & Draper, 2000, p.18). In essence the family life cycle framework considers the family as a cybernetic system, particularly since by assuming social systems, like physical and mechanical systems, were governed, both the uniformity and variability of human behaviour could be accounted for (Dallas & Draper, 2000, p.18).
and McGoldrick (1989, p.25) point out that “most descriptions of the typical family life cycle (including ours) fail to convey the considerable effects of ethnicity and religion on all aspects of how, when and in what way a family makes its transitions from phase to phase”. Haley (1986, p.34) points out that Erikson’s approach “ignores differences in class and culture”. Hussain (2003, p.9) questions whether inherent in systems theory and its focus on the interactional aspects of a system and its context there could be a “danger in assuming that all systems theory is universal and that a systemic therapist should be able to apply theory homogenously across culture.” Falicov (1995, p.7) talks specifically about the life cycle transitions and asserts that “even experienced therapists often assume that the blueprints of the life cycle stages and transitions are culture free, perhaps because the cycle has some universal themes such as birth and death, getting married and raising children”. She goes on, however, to look at specific examples of cultural differences, e.g., in “the timings of stages and transitions... the constructions of age appropriate behaviour”.

The family life cycle could also be viewed as a problem-based model in that it focuses on inherent stresses of life cycle transitions and the emergence of problems connected with this. Less is “said about the possible positive effects of external inputs, for example the arrival of a child possibly uniting a couple” (Dallos & Draper, 2000, p.184) suggest that without an awareness of family development “it is difficult for family therapy to move towards offering some ideas regarding prevention and resilience”.

The two-dimensional model described by Carter and McGoldrick could still have relevance in enabling a broadening of clinicians’ understandings of the family, including their family history, current family dynamics, and the wider cultural, social, and political context. If the model is used more broadly and with less focus on normative life cycle stages it can fit well with postmodern developments in family therapy, such as narrative- and attachment-based models.

Conclusion
It is helpful to view the intentions of the life cycle model as positive in helping families to work through specific transitional stresses and get back ‘on track’, whilst recognising that the results are not always as intended. It is maybe our task as social workers to employ the most helpful ideas offered by the model, which I believe could promote resilience and strength in families experiencing difficult times, whilst constantly checking that ‘normative’ and fixed ideas of family life or ‘dysfunction’ are challenged.

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References


A review of the association of medication and falls, and the importance of medicines management in the prevention of falls

Lynn Sutcliffe

Abstract
This literature review examines the significance of medication on falls and the importance of medicines management in secondary prevention assessments and interventions. The conclusion of this review is that there is evidence to suggest an association between medications and falls if one of the risk medications is present. The most significant evidence is related to psychotropic and night sedation medication.

Keywords
falls and medication; polypharmacy; medicines management; medication reviews; reconciliation; psychotropics; sedatives; hypnotics; benzodiazepines

Introduction
This literature review examines the significance of medication on falls and the importance of medicines management in secondary prevention assessments and interventions. The literature review was carried out using a systematic approach to ensure that all the individual pieces of evidence are analysed in context with each other to gain a well-balanced picture. A systematic approach ensures that as significant amount of literature as possible was identified within the constraints of the dissertation upon which this paper is based. The majority of the literature analysed was primary research literature with the addition of some practice and policy literature as categorised by Wallace and Wray (2006). Research-based evidence is considered to lead to stronger evidence than practice-based evidence; however, policy and practice literature are important components within health-related evidence-based clinical practice (Aveyard, 2010).

During the literature search, a hierarchy of evidence (Evans, 2003) was taken into consideration to ensure that the strongest possible evidence was considered. Therefore the literature review consisted of systematic reviews, including Cochrane reviews, meta-analyses, randomised controlled trials, multi-centre studies and cohort/case controlled studies.

Method
The majority of the literature search was carried out electronically and the specific academic search engines

Keywords
falls and medication; polypharmacy; medicines management; medication reviews; reconciliation; psychotropics; sedatives; hypnotics; benzodiazepines
used were Quest, NHS Evidence Guide, Cochrane Review and Cochrane Library, Cumulative Index to Nursing and Allied Health Literature, and Medline. The search engines that were identified are considered to provide the most relevant and recent evidence on evidence-based health information from experts in the field with minimum bias. This is important to ensure that the information analysed is relevant, reliable, accurate, balanced and recent (Cumming, 2010).

The search terms identified relating to the research question initially were ‘falls and medication’; ‘falls and medication reviews’; ‘falls and secondary prevention’; ‘falls and psychotropic and falls and fractures’; and ‘medications and transfer care setting’; and ‘psychotropic medication and ethnicity’.

In order to manage the number of research articles found, only those that had the search terms in the title of the article were considered. The time span used for the search was initially 2005 to 2012 to ensure that the information gathered was current. However, due to the limited amount of information that appeared to be available, a wider range of years was used to include literature collated from research carried out from 1988, which identified risk factors still considered to be relevant in current evidence-based clinical practice.

Inclusion criteria included published articles in the English language. This could add stereotyping to the literature review, however this type of literature is often hard to access. A search was carried out electronically on the System for Information on Grey Literature (Open Grey, 2012) using the search terms listed above; however, this was unsuccessful and is therefore not included. This results in a limitation in the methodology.

From the initial articles, further relevant primary research papers were identified in the reference lists of these articles. The evidence collected was then critiqued/analysed then collated into specific themes.

### Results

#### Associations of medication and falling

Prior to the falls and bone health audit (Royal College of Physicians, 2007) there was evidence to suggest prescribing psychotropic and night sedation medications for older people could result in falls (e.g., Campbell et al., 1989; Blake et al., 1988). Ray et al. (1987) suggests there was also a twofold risk of a hip fracture with the use of psychotropic medication. However, there were also studies (e.g., Prudham & Evans, 1981) that suggested there was no significant association between hypnotics and an increased risk of falls.

The paper will now describe two recent studies that have systematically explored the relationship between falls and medication, and then describe reviews that have examined this area.

Kragh et al. (2011) carried out a population-based cohort study that analysed medication use six months previous to and following a hip fracture. The research reported that 67.7% of patients received a falls-risk increasing drug prior to their hip fracture and this number increased to 97.7% following their hip fracture. This study also reported that, following the fracture, the use of more than five medications increased by 39.3%; the use of more than 10 medications increased by 59.7%; and the use of more than 15 medications increased by 8.6%. The results were statistically significant for increased use of medications and the research was published in a well-respected Journal making the research very credible.

Berdot et al. (2009) carried out a multi-centre cohort study which suggested that long acting benzodiazepines in occasional and regular users and inappropriate psychotropic medication in regular users was associated with an increased risk of falling. This was a well-designed multi-centre study with a high follow-up rate of 92% at four years which allowed for a substantial timeframe over which to investigate, collect, and analyse the data. Limitations were that falls are multi-factorial in nature and not all of the associated risk factors (e.g., visual acuity) were taken into consideration during the study, which may have impacted on the results. A further limitation was that the information on medication was reported by the individual.

Hartikainen et al. (2007) carried out a systematic review to investigate the association between medication – particularly psychotropic medication – and the increased risk of falls. The study design was appropriate and the studies were relevant to the specific intervention being investigated. However, there were limitations to this study due to the fact that there was a lack of information on the inclusion and exclusion criteria for how the studies included in the research were identified, therefore an element of bias could have affected the results. The results of this study suggested that there appears to be an association between falls and psychotropic medication. There was only one randomised controlled trial within this systematic review therefore the recommendation is, again, that further research is required.

Woolcott et al. (2009) carried out a meta-analysis on the impact of various medications including benzodiazepines, other sedatives, and hypnotics in relation to falls. There were limitations to this study due to the unavailability of randomised controlled trials therefore it is Grade B evidence in accordance with National Institute for Health and Clinical Excellence (NICE) guidance (NICE, 2004). However, the studies reviewed included a large numbers of participants: 79,081 in total. The results were statistically significant for an association with hypnotics and an increased likelihood of falling; however, there was less supporting evidence for sedatives and hypnotics.

### Association of polypharmacy and falling

There appears to be an association between polypharmacy and falls, and several studies have been carried out in an attempt to establish this. Cumming et al. (2009) found that the risk of falling increases with the number of medications that are taken and the relative risk increases from 1.4 with one medication to 2.4 with three or more medications. Studies such as Currie (1999) and Cumming (1998) report similar findings. However, Cumming (1998) also reported that interactions between multiple medications may lead to adverse drug effects and that this may be an additional factor linking to the increased falls risk.

Ziere et al. (2006) carried out a cross-sectional study to identify the effects of polypharmacy and the prevalence of falls. The results suggested that there was an increased risk of falls associated with polypharmacy if at least one fall risk-increasing drug was included in the medication. Lawlor et al. (2003) are in agreement that anxiolytics and hypnotics were associated with an increased risk of falling. However, no evidence was found in this study of polypharmacy being an independent risk of falls. As falls are multifactorial in nature it is very difficult to prove individual risk factors, e.g., medication independent of pathology. The populations in these studies are older people who often have complex multiple pathology and thus take more medication than the younger population. According to Cumming (1991) 85% of older people take more than one medication and 48% take three or more.

### Importance of medication reviews and reconciliation

According to the National Prescribing Centre (2008) medication reviews are an essential component of prescribing practice. A medication review is “structured examination of a patient’s medicines with the objective of reaching an agreement with the patient about the necessity, optimising the impact of medicines, minimising the number of medicine-related problems and reducing waste” (National Prescribing Centre, 2008). Research carried out by the Healthcare Commission (2007) highlighted discrepancies in patient’s medication details resulting in 50% incomplete prescriptions on admission to hospital and only 30% of General Practitioners receiving information on changes made to the patients medication during the acute hospital admission. It is this component of medicine management that ensures the patient receives optimum benefit from the least possible adverse effects from their medications. Medication reviews also encourage patients and carers to understand and take active responsibility for their medication regimes. According to Cumming et al. (2006) there is room for review and improvement of medicines reconciliation in improving the care of the patient at risk of falling.

### Conclusion

The conclusions of this review is that there is evidence to suggest an association between medications and falls if one of the risk medications is present. The most significant evidence is related to psychotropic and night sedation medications. There also appears to be an association between polypharmacy and an increased risk of falls from the evidence analysed. There is a need for further high-quality studies including randomised controlled trials and multi-centre studies in order to gain robust evidence on the effectiveness of medicines reconciliation in improving the care of the patient at risk of falling.

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RESEARCH REPORTS
Depression, physical activity and mental health: An interpretative phenomenological analysis of general practitioners’ experiences of exercise referral schemes in the North West

Rachel L. Ward & Paul K. Miller

Abstract
While there is compelling evidence which demonstrates that physical exercise can have beneficial impacts on mild-to-moderate cases of depression, and strong beneficial impacts on subthreshold depressive symptoms, rates of referral to exercise-based programmes in the UK remains low, particularly when compared to the use of other avenues of treatment. This paper reports findings from an interpretative phenomenological study of semi-structured interviews with a small sample (N=4) of General Practitioners (GPs) in the North West, exploring their experience-based attitudes and assumptions pertaining to the status and value of formal exercise referral schemes.

Keywords
depression; exercise referral; professional attitudes; interpretative phenomenological analysis

Introduction
Depression is, today more than ever, a profoundly serious public health concern in the UK, impacting upon the lives of individuals from all social backgrounds and strata (NICE, 2009; Tylee & Jones, 2005). The national statistics are striking. The percentage of individuals aged 16+ suffering from any form of depression (bar postpartum) in 2009–2010 (see British Medical Association (BMA), 2009, pp.94–100) was an estimated 12.82% in the North West of England, above the national average of 11.19% (NPEHO, 2012a; NPEHO, 2012b), with Cumbria experiencing a rate of 12.67% (NPEHO, 2012a), and Lancashire faring slightly worse at 13.67% (NPEHO, 2012b). Moreover, according to the BMAs Quality and Outcomes Framework “The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.” (BMA, 2009, p.94). Consequently, a number of commentators argue for the more concerted exploration of a variety of prevention, treatment, and rehabilitation strategies to address this widespread and multifaceted problem, at both local and national levels.

Although recent studies suggest that exercise (structured or otherwise) has minimal impact on more severe forms of depression (Chalder et al., 2012), there is a growing body of evidence which indicates that structured physical activity can be effective in the rehabilitation of many individuals with mild-to-moderate depression (Callaghan et al., 2011; Carter et al., 2012) and, more specifically, a benefit for group-based physical activity. Physical activity also has the advantage of bringing other health gains beyond just improvement in depressive symptoms. (NICE, 2009, p.211.)

As a corollary of widened academic interest in the efficacy of exercise for the treatment of a range of health complaints, formal Exercise Referral Schemes (ERSs) have been developed throughout the UK to provide access to tailored programmes of physical activity (Carter et al., 2012): “many of which include depression as a referral criterion” (Lawlor & Hopker, 2001, p.1).

This paper, following the call from Moore et al. (2011) for greater qualitative investigation of the views of healthcare professionals on ERSs, uses interpretative phenomenological analysis (Pringle et al., 2011; Smith et al., 2009) to explore the experiences of a small sample of GPs in the North West of England. It should be noted at this point that the authors do not claim a study of this form can evidence – in anything other than an anecdotal manner – the propositional ‘effectiveness’ of ERS use as a rehabilitative strategy for depression. Rather, through the inductive examination of the experience of four GPs with practical knowledge of the schemes, it is intended to explore concomitant...
issues as they are conceptualised, connected, and rationalised by the participants themselves. This can help add additional dimensions to the understanding of existing concepts, and also sketch new ones for further exploration (Smith et al., 2009; Vachon et al., 2011).

Method

Framework

Interpretative phenomenological analysis (IPA) is a relatively new methodology within the arsenal of qualitative research, providing a structured means of exploring in detail "how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants" (Smith & Osborn, 2008, p.51). IPA has, in recent years, found a broad array of applications in healthcare contexts, predominantly in terms of mapping service users’ experiences of a variety of conditions (Hamill et al., 2010; Todd et al., 2010), including the experience of depression itself (Rhodes & Smith, 2010). There is, however, a growing body of work in the field dedicated to exploring the experiences of healthcare professionals (Arvinen-Barrow et al., 2010; Vachon et al., 2011).

Participants

IPA studies typically use small samples to facilitate higher definition investigation of the particular, with some commentators actually advocating a single-case method (Smith et al., 2009). In this paper, and following procedures in line with institutional ethical guidelines, a small sample (N=4) of GPs was purposively recruited. All participants, at time of writing, were practicing in the North West of England and had practical experience in the use of exercise referral schemes.

Procedure

As recommended by Smith and Osborn (2008) a case study method, and following procedures in line with institutional ethical guidelines, a small sample (N=4) of GPs was purposively recruited. All participants, at time of writing, were practicing in the North West of England and had practical experience in the use of exercise referral schemes.

Data analysis

Analysis proceeded in line with the standard idiographic techniques of IPA, in which an initial free textual analysis is condensed into linked (subordinate) themes, and finally into a smaller number of master (superordinate) themes that hold across the data corpus (see Smith & Osborn, 2008; Smith et al., 2009). Analytic themes were initially developed by the first author, revised by the second, and reviewed by a third academic with strong qualitative analysis experience, in a process of triangular consensus validation (Patton, 1990).

Results and discussion

Analysis revealed 16 subordinate themes, as displayed in Table 1 (below).

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>GPs are not always made aware of ERSs in the area.</td>
</tr>
<tr>
<td>2</td>
<td>GPs have limited information on referral criteria or changes to ERSs themselves.</td>
</tr>
<tr>
<td>3</td>
<td>There is limited feedback on the impacts of referrals, so efficacy is hard to judge.</td>
</tr>
<tr>
<td>4</td>
<td>What feedback is obtained is always positive.</td>
</tr>
<tr>
<td>5</td>
<td>Exercise is often advised but not actually prescribed.</td>
</tr>
<tr>
<td>6</td>
<td>Exercise seems valuable in the short and long term rehabilitation of depression.</td>
</tr>
<tr>
<td>7</td>
<td>Patients with depressive comorbidity struggle to motivate themselves to begin exercise.</td>
</tr>
<tr>
<td>8</td>
<td>Patients can struggle to sustain exercise in the long-term without formal supervision.</td>
</tr>
<tr>
<td>9</td>
<td>Patients with depressive comorbidity are averse to public or group activities.</td>
</tr>
<tr>
<td>10</td>
<td>There are fiscal constraints on many patients that preclude long-term engagement with structured exercise.</td>
</tr>
<tr>
<td>11</td>
<td>Counselling can facilitate a willingness to exercise.</td>
</tr>
<tr>
<td>12</td>
<td>Counselling can be counter-productive as a preparatory step.</td>
</tr>
<tr>
<td>13</td>
<td>Patients may not believe that ERSs work, they need evidence that makes sense to them.</td>
</tr>
<tr>
<td>14</td>
<td>The institutionalised fear of Quick Fix, strategies constrain GPs in prescribing ERSs.</td>
</tr>
<tr>
<td>15</td>
<td>There are time constraints on GPs that can inhibit patient involvement in ERSs.</td>
</tr>
<tr>
<td>16</td>
<td>Exercise is still a ‘fledgling’ therapy for depression.</td>
</tr>
</tbody>
</table>

The overlapping, cross-cutting nature of these subordinate themes gives rise to three superordinate themes, outlined below.

Superordinate theme 1: "I believe that exercise helps treat depression, but better systems of information are needed around the schemes themselves."

Superordinate theme 2: "While exercise referral schemes are likely to be of benefit to patients with depression, the patients themselves experience personal and social obstacles to participation."

Regarding the coronary point (d), meanwhile, it was argued that more compelling, patient-focused research and evidence needed to be produced, ideally "case studies and examples" (GP1) showing successful interventions. This raises the broader issue of difficulties promoting patient engagement with exercise referral schemes. While there is to date very little robust research that investigates issues specifically pertinent to points (a)–(d) above, engagement is a commonly occurring topic throughout the broader literature on ERSs (see Carter et al., 2012; James et al., 2008; Moore et al., 2011; Morgan, 2005), and is further addressed by participating GPs in terms of superordinate theme 2 (below).

Superordinate theme 2: "While exercise referral schemes are likely to be of benefit to patients with depression, the patients themselves experience personal and social obstacles to participation."

Despite the generally positive attitude towards ERSs held by the participants, there were some further issues that were conceptualised as likely reasons that patients with depression would themselves resist exercise referral which, in turn, were viewed as obstacles to referral itself.
As noted by Moore et al. (2011) the motivation of many patients, including those with depression, to join a public and/or social activity such as an ERS can be coloured by serious and obstructive anxieties. These can be exacerbated by potentially unfamiliar environments such as gymnasium and leisure centres (Wormold & Ingle, 2004). To similar ends, and conversant with the findings of Carter et al. (2012), James et al. (2008) and Callaghan et al. (2011) participants in the current study spoke extensively of the barriers to motivation that depression itself can erect with regards to such involvement (see sample evidence above).

Strikingly, however, while counselling was seen as a potentially effective strategy in facilitating initial motivation to exercise and socially engage, and for overcoming more general social anxieties, it was also seen as a latent ‘double-edged sword’.

Superordinate theme 3: “Obstacles in the contemporary culture of medicine itself can inhibit my referring patients with depression to exercise schemes.”

Perhaps the most striking of the meta-themes to emerge from the interviews related to the manner in which participants experienced a ‘cultural’ pressure to use particular kinds of strategies in treating depression. Reflecting concerns endemic in medical literature on the topic (see Hyde et al., 2005), this pressure was taken to manifest in two key ways. The first related to the notion of bucking medical trends, i.e., the experienced difficulty in prescribing treatments that are not as yet regarded “mainstream” (which is to say not fully “clinically proven”) when there are more conventional approaches (usually antidepressant medications) available:

Sample Evidence

GP1: “...but then if ...the government want to...you know...manage health better to decrease the health bill in the future, they have to put [money] in these sorts of areas where perhaps you don’t see the immediate benefit.”

Since exercise referral was neither seen as a quick fix, nor as a mainstream approach in the treatment of depression (despite having been in use for over a decade), participants thus felt a particular constraint in using it (despite their own stated positive experiences). These putatively contradictory attitudes, in particular, highlight an issue of circularity stemming from entrenched proof procedures in medical science itself. Across a range of quantitative studies, the efficacy of ERSs for a variety of interventions is deemed largely ambiguous, not due to a lack of evidence per se, but a lack of a very particular type of evidence – that emergent of randomised controlled trials (Lalor & Hopker, 2001, p.6). However, while randomised controlled trials (RCTs) provide evidence par excellence for the monitored assessment of pharmacological treatments, they are rather less appropriate for investigating interventions such as exercise where issues of effect are inextricably bound up with sociological and psychological questions pertaining to uptake, adherence, and interaction. RCTs are, simply, “not designed to answer such questions as they lack the external validity necessary to faithfully replicate practice” (James et al., 2006, p.218). The upholding of RCTs as the singular gold standard of research by medical culture effectively obviates the possibility that a community-oriented treatment for depression – such an ERS – could attain a truly ‘proven’ status within that medical culture. This, in turn, has the potential to cyclically perpetuate (a) the difficulties in referring for individual healthcare professionals described above; (b) the corollary tokenistic funding also described; and (c) ultimately, still fewer robust investigations. As originally recommended by the Department of Health (2001), formal academic evaluation of exercise referral schemes should not confine itself to use of the RCT format; to these ends, a much wider array of research methods should be considered if more three-dimensional understandings of impact in this domain are to be generated (Carter et al., 2012; James et al., 2008; Moore et al., 2011).

Conclusions and recommendations

In the inductive analysis above, participants can be seen to raise a number of issues closely allied to those arising in extant literature, but also some hitherto given limited attention. The primary novelty to emerge relates to the links between research, information, culture, and attitude. At the level of broader academic research, and as discussed above, it has for some time been noted that the use of particular quantitative methods alone may prove something of a blunt instrument for the investigation of ERSs on the grand scale (James et al., 2008). However, the manner in which the participants weave together key matters relating to ERSs and depression rehabilitation both implies and directly calls for attention to the character of research and dissemination at the local level:

1. Formalised systems of structured feedback from patients with depression who have taken part in ERSs – ideally in survey form – would provide GPS...
with more robust and systematic evidence with which to inform their own future treatment decisions, and potentially improve their confidence in local decision-making by making available local (rather than general) data.

2. For cases in which referral to an ERS is deemed suitable by a GP, the production of qualitative case-study data could prove invaluable in allaying patient scepticism and also patient anxiety. ‘Humanising’ the schemes through the dissemination of previous participants’ own stories, giving a voice to others ‘in the same boat’, may help form a valuable bridge between knowing about a scheme and actually feeling ready to take part in it.

Such observations further speak to the production of foundational knowledge bases upon which the grander, multi-method assessments of ERSS called for by the Department of Health (2001) can be constructed.

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References


Associations of Self-harm, Bipolar and Borderline Personality features in a student population

Kirsten Nokling

Abstract
This paper investigates self-harm as symptom of Bipolar Disorder (Axis I) and of Borderline Personality Disorder (Axis II Disorders). The current study assesses 260 adult students in a non-clinical sample, using the Personality Assessment Inventory for Borderline Personality Disorder (PAI-BOR, Morey, 1991), the hypomanic personality scheme from bipolar spectrum as self-harm questions on the PAI-BOR. The self-harming population scored significantly higher on the borderline personality disorder spectrum, and also higher on the hypomanic scale, than their non-self-harming counterparts.

Keywords
bipolar disorder; borderline personality disorder; self-harm; hypomania

Introduction
Borderline personality disorder (BPD) is the mental health disorder most frequently linked to self-harm (Contario & Lader, 1998). This is perhaps unsurprising since self-harm is one of the diagnostic criteria for BPD. Self-harm is neither necessary nor sufficient alone to establish a diagnosis of borderline personality disorder however, the presence of self-harm may be indicative of more severe borderline pathology (Simeon et al., 1992).

Another developmental disorder that also shows strong associations with self-harm is bipolar disorder, which is a Mood and Affective Disorder from Axis I. Previously we have concentrated on the interface between borderline personality disorder and bipolar disorder (Nokling, 2012). However, self-harm features heavily in both disorders, despite their different placements on the Axis system of the Diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000). Hanstock (2007) suggests that self-harm during low mood in female adolescents with bipolar disorder has led to some inpatients being mistakenly diagnosed as having borderline personality disorder traits.

Misdagnosis can cause significant problems, as it delays effective treatment for the young person and creates emotional distress due to the assignment of an incorrect label which carries considerable stigma (Kellerman, 1989).

This paper addresses the question of whether self-harm is simply an overlapping symptom between the two disorders, or whether self-harm can be present without connection to either diagnosis. It has been suggested that self-harm is actually a symptom of underlying factors that these two disorder have in common (Contario & Lader, 1998). These underlying factors, which may be expressed by self-harming behaviours, could include impulse control behaviours or affective difficulties with regard to relationships.

Hypotheses
1. The presence of self-harm in the participants will be associated with higher borderline...
personality disorder scores.

2. The presence of self-harm in the participants will be associated with significantly higher bipolar disorder scores on the hypomanic scale.

Method

Participants

The sample consisted of 260 students (115 males, 138 females, and 7 participants who chose not to disclose their gender), with a mean age of 20.4 years (age range 18–36). The most commonly occurring age was 19 for both gender groups. The majority of the sample had no history of mental illness, with 26 (10%) reporting history of mental health conditions (19 depression, 2 anxiety, 2 depression and anxiety, 1 obsessive compulsive disorder, 1 bipolar, and 1 attention-deficit hyperactivity disorder).

Measures

The PAI-BOR

All participants were tested for positioning on the borderline personality disorder spectrum using the borderline subscale of the PAI-BOR (Morey, 1991). The PAI-BOR consists of 24 items, and participants indicate their level of agreement to each item scored on a 4-point Likert-type scale; 0 for ‘False, not at all true’, 1 for ‘Sometimes true’, 2 for ‘Mainly true’ or 3 for ‘Very true’. Six items in the questionnaire are reverse scored, for example Item 7: ‘My mood is very steady’. The highest score possible is 72, although it is very unlikely for any patient to reach that score. In the literature, Morey explains that a score of about 45 or above would be considered high and may indicate a borderline personality disorder, although Trull’s criteria (1995) for identifying borderline personality disorder using the PAI-BOR assigns participants with a score of greater than 38 into the borderline clinical group. However, alone this subscale has no diagnostic value, as a diagnosis can only be made by clinicians after in-depth interviews with the patient. The self-harm criteria from the PAI-BOR will be used to split the groups to allow investigation of associations with self-harm.

The hypomanic personality scale (HPQ)

The HPQ (known in some literature as the hypomanic personality questionnaire; Eckblad & Chapman, 1986) consists of a 48-item scale in which the participant simply chooses True/False responses. Over half of the HPQ items refer to stable personality characteristics, the rest referring to recurrent experiences, and symptoms of hypomanic episodes. For example, Item 1 states, "There are so many fields I could succeed in that it seems a shame to have to pick one", which is an item indicative of hypomania. Item 5 states, "When I go to a gathering where I don’t know anyone, it usually takes me a while to feel comfortable" which is one of 12 items that are reverse scored.

This scale had already been utilised greatly in the literature in recent years, and Rawlings et al. (1999) in conducting a factor analytic study of the hypomanic personality in non-clinical British, Spanish, and Australian samples had derived from the 48-item scale, a four-factor model. The internal reliability of the HPQ as reported by its authors is .87 and test-retest reliability is .81 (Eckblad & Chapman, 1986). Although no optimal cut-off scores have been reported by the authors of the HPQ, Maryanski and Udachina (2007) note that generally 1.5 standard deviations above mean is accepted as a score strongly indicative of the hypomanic symptoms common to bipolar-II disorder.

Procedure

Participants were all presented with a participant information sheet explaining that the experiment consisted of a series of questions relating to personality characteristics with the aim of placing individuals on the spectrum of personality traits including hypomanic behaviour and impulsivity. Participants were assured that the results were completely confidential and that they had the right to withdraw at any time. Completing the scales lasted no longer than 10 minutes.

Analysis

Pearson’s correlations were used to test associations between the overall PAI-BOR and HPQ scores, and between individual factors for each scale. Means were compared using the t-test, and groups were split by gender and presence of self-harm and partial eta squared values were calculated.

Results

Using Trull’s (1995) criteria, 27 of the participants (10.4%) met above-threshold criteria indicative of the borderline personality; using Morey’s (1991) criteria only 9 did (3.5%). While Trull’s criteria is more generous – as a lower borderline score is required to reach a clinically significant research diagnosis – both of these criteria indicated a higher presence of borderline personality in the population than previous research; e.g., Torgersen et al’s (2001) conclusion indicating that borderline personality disorder affects 1–2% of the population. Perhaps a reason for this is that this sample was derived from student populations, and that borderline personality disorder is more likely to be present among younger populations, with research indicating that the borderline personality has lower impact on people’s lives in middle age (Linehan, 1987).

Self-harm and borderline personality disorder

The self-harm group are all scoring above 20 points on the borderline personality disorder questionnaire, with several in the 50–60 range. However, it must be noted that there are some individuals who do not self-harm who also scored relatively high on the borderline personality disorder spectrum, indicating that the presence of self-harm does not uniquely predict high borderline personality disorder scores.

Self-harm and bipolar disorder

The second hypothesis was that there would be an association between hypomanic scores among populations who reported a history of self-harm (Hanstock, 2007; Clarkin et al., 1993). The self-harm group had a mean hypomania score of 23.8 (SE=1.58), the no self-harm group had a mean self-harm score of 19.2 (SE=0.58), which is a statistically significant difference (F(1, 250) = 12.65, P<.001, n²=0.048). As Figure 1 demonstrates, the self-harm group scored consistently higher scores on the hypomanic scale. However, it must be noted that some individuals from the self-harm group scored within the mean range of hypomanic spectrum scores, indicating that presence of self-harm does not uniquely predict hypomania.

Gender effects were also explored, and while the t-tests revealed that although males scored on average slightly lower than females on the PAI-BOR and slightly higher than females on HPQ, there were no statistically significant gender differences between PAI-BOR mean scores (males 24.02, females 26.02) or for HPQ mean scores (males 21.03, females 19.21).

Discussion

The associations between self-harm, borderline personality, and hypomania scores in a non-clinical sample has implications for the clinical literature; however, in order to generate more clinically useful insights, it would have been necessary to examine information regarding age of onset of the cycle of self-harm and age of cessation, and severity of the self-harm itself alongside the severity of the borderline personality disorder scores. Due to ethical constraints,
the series of questions relating to the onset and severity of the self-harm had to be withdrawn from the current study. These observations have implications for Kellerman’s (1989) description of the “self-harming borderline”, as it has now been demonstrated that high borderline personality disorder scores are present in non-clinical populations among people who do not self-harm. The association of self-harm and higher hypomanic scores in this non-clinical student population also supports findings by Hanstock (2007), who observed that self-harming behaviours in female adolescents with bipolar disorder were frequent and relatively common.

Self-harm has been considered a developmental pathology commencing with a cycle of specific cognitive processes up to two years before the actual first self-harm episode takes place, leading to a cycle typically spanning seven years, indicating that for the participants who reported self-harm (n=59), this cycle is likely to have commenced far earlier in the lifespan, possibly during childhood and adolescence (FavaZZa & Conterio, 1988; FavaZZa & Rosenthal, 1990; Strong, 1990; Contario & Lader, 1998).

Conclusions
This research concludes that individuals who self-harm have significantly higher borderline personality disorder and hypomanic scores than those who do not self-harm, demonstrating high importance of prioritisation of research that focuses in on the effects of self-harm. Individuals who self-harm report far more symptoms of borderline personality disorder and hypomania than their counterparts; however, not every individual who engages in self-harm reports higher scores for borderline personality disorder or hypomania.

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References


10% at the initial assessment following the fall. There was a significant reduction in the number of medication reviews carried out at 12-week reviews locally with only 15% of the hip fracture group and 6% of the non-hip fracture group receiving medication reviews.

Conclusion
This analysis demonstrated that there appears to be variations in prescribing practice and medicines reconciliation in both secondary and primary care. The introduction of recent policies both nationally and locally should have an impact on current prescribing practice and may result in different outcomes if the audit (Royal College of Physicians, 2007) were repeated.

Acknowledgements
This research was supported by funding from the Cumbria Partnership NHS Foundation Trust, NHS Cumbria and the Department of Health.

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References

Key publications


Investigation into the impact of enrichment of breakfast to different levels using proprietary and store cupboard products

S. Khweir, S. Wight, E. Bannerman, J. Jones

The abstract below was presented to the British Dietetic Association as a poster at the BDA research Symposium in Birmingham on 30 November 2012. This event included dietitians new to research as well as audits and research carried out in practice.

**Background**
Malnutrition remains prevalent within the UK with older adults at greatest risk (BAPEN, 2011) which can lead to dramatic consequences such as increased risk of infection (Gall et al., 1998). There is evidence that indicates the largest amount of energy (29%) is consumed at breakfast by hospital inpatients (McWhirter & Pennington, 1994). Food enrichment has been shown to be an effective intervention to increase energy intake (Laque et al., 2000) however, the optimal level of enrichment and also which products to use to increase the energy and nutrient content of different foods is unknown. As consumption of the breakfast meal appears to be quite high, this may be a good opportunity to maximise dietary and nutrient intakes.

**Aim**
The aim of this study was to investigate the impact of enriching a scrambled egg breakfast using either proprietary or store-cupboard products on appetite and satiety, hunger, fullness or prospective consumption for the enriched breakfasts at any time point. Enriching the breakfasts caused total energy intake to significantly increase by 472kcal (p<0.05) between the control and level 2 store-cupboard (S2) and by 472kcal between store-cupboard 1 (S1) and S2. The mean (SEM) energy intake were also significantly different by 352kcal between S2 and proprietary 1 (P1). There was no significant difference in estimated protein intakes after the test meals (n=20, p>0.05).

**Results**
Twenty volunteers (mean (SD) age 30.2 (14.8) years, range 18–63 years) consumed the five test meals. There was no significant difference between satiety, hunger, fullness or prospective consumption for the enriched breakfasts at any time point. Enriching the breakfasts caused total energy intake to significantly increase by 472kcal (p<0.05) between the control and level 2 store-cupboard (S2) and by 472kcal between store-cupboard 1 (S1) and S2. The mean (SEM) energy intake were also significantly different by 352kcal between S2 and proprietary 1 (P1). There was no significant difference in estimated protein intakes after the test meals (n=20, p>0.05).

**Conclusion**
This study suggests that incorporating store-cupboard products into a breakfast of up to 840kcal and 30g protein increased total energy intake by 25% (472kcal) but did not alter protein intake. The enriched breakfasts were shown not to hinder satiety or subsequent intake in young subjects. As the level of fortification increased, energy density increased, which is likely to be the most significant factor affecting total energy intake. The above results suggest that store-cupboard materials were more effective in increasing total energy intake than proprietary products when enriching meals.

This indicates that using store-cupboard products may be an effective way to help increase total energy intake without impacting on satiety or subsequent intake later in the day. Further investigation with malnourished older adults who would benefit most from this intervention is required. Whether enriching only one meal in the day, or across all eating occasions is most effective also needs investigation.

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**References**


Khweir, S., Wight, S., Bannerman, E. & Jones, J. (2012). Investigation into the impact of enrichment of a breakfast to different levels using proprietary and store cupboard products. Poster presented to the British Dietetic Association (BDA) at the BDA research Symposium in Birmingham on 30 November 2012.


**EDUCATION AND LEARNING**


The Cumbria Partnership NHS Foundation Trust and the Centre for Disability Research, Lancaster organised the 12th Seattle Club Conference for researchers in intellectual and developmental disabilities in the UK and Republic of Ireland. This is a research-based intellectual disability conference that has the following core principles:

- Participation is restricted to authors and co-authors of accepted oral and poster presentations together with researchers at the beginning of their research careers, who have applied for and been awarded Seattle Club Studentships.
- A focus on data-based presentations reporting findings gained by appropriate application of quantitative and qualitative methods.
- Oral posters and posters are equally weighted in terms of worth, rigour and status.
- The selection of contributions for oral and poster presentation is designed to achieve a mixture of more established and early career researchers.

Seventy-seven researchers participated in the two-day conference held in Kendal. There were 18 oral papers and 45 posters presented at the conference; abstracts of all of the presentations and posters can be found on the Seattle Club website (Seattle Club, 2013). There were five posters presented involving staff from the Cumbria Partnership NHS Foundation Trust; the abstracts from these posters are reproduced here.

**References**

1. Training Improving Access to Psychological Therapies (IAPT) therapists to work with people with learning disabilities

Dave Dagnan, Richard Thwaites, Chris Hatten, John Masson, & Amy Cavagin
Background
National drivers (e.g., No Health Without Mental Health and CQC/Monitor standards) suggest the importance of mainstreaming for mental health services for people with intellectual disabilities. This paper reports the outcomes of training for Improving Access to Psychological Therapies (IAPT) therapists in adaptation of cognitive behaviour therapy (CBT) for people with intellectual disabilities.

Methods
A modularised training curriculum was delivered to 32 Primary Wellbeing Practitioners (PWP) and 36 High Intensity Practitioners (HIP) within one IAPT service. A therapy confidence scale, a measure of general therapy self-efficacy, and a measure of attitudes to the treatment of people with learning disabilities in mainstream services were delivered pre-training, immediately post-training, and three months post-training. A qualitative interview focused on how participants had used the training was also carried out with six PWPs and six HIPs at three months post-training.

Results
All measures showed significant change pre- to post-training which was maintained at three months follow-up. Qualitative data demonstrated the effective use of the training in clinical cases and thinking. It was interesting that PWPs were consistently more confident and saw themselves as more efficacious throughout the training and follow-up.

Conclusions
A relatively short modularised training approach focused on CBT for people with learning disabilities has had a positive effect on therapist confidence and attitude to people with learning disabilities.

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2. The experiences of people with learning disabilities in using the internet and social network sites
Peter Fairlamb, Janet Robertson, Chris Hatton, & Sara Mallinson

Background
The aim of the study was to explore the experiences of adults with learning disabilities in their use of the internet and social network sites.

Methods
The study employs a qualitative methodology and involves the use of qualitative/semi-structured interviews, including the use of a topic guide. A purposive sample was identified and interviews were conducted with nine participants, all of whom have learning disabilities to varying degrees.

Results
The data was analysed using thematic analysis and seven themes were identified: motivation issues, barriers, skill development and access issues, support, usage, risk issues, and training.

Conclusions
The results revealed that adults with learning disabilities can and do access computers, the internet, and social network sites. Despite there being barriers to people with learning disabilities becoming part of digital society, the participants in this study were motivated to use computers and the internet. However, due to limited IT skills and training, there is a reliance on support, including family members and paid carers/ staff, to maintain safety and mitigate risk. In mitigating risk both the participants and their support may take a cautious approach resulting in restricted use.

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3. Access to IAPT services by people with learning disabilities using First Step in Cumbria
Chris Hatton, Dave Dagnan, Richard Thwaites, Amy Cavagn, & John Masson

Background
There are concerns about the accessibility of IAPT services to people with learning disabilities (LD).

Methods
As part of a bigger Health Innovation and Education Cluster project, we cross-referenced IAPT data with NHS and Social Services databases to identify people with LD using First Step IAPT services in Cumbria.

Results
Of 27,064 First Step clients identified in the database, 72 (0.27%) were people with LD known to LD services. Clients with LD were on average younger than those without LD (mean 34 vs 40 years) and evenly split between females and males; most clients without LD were female (63.9%).

Both for people with and without LD, the most common referral source was a General Practitioner (81.9% LD; 85.3% non-LD), followed by self-referrals (6.9% LD; 8.3% non-LD) and community practice nurses (6.3% LD; 3.2% non-LD).

For clients with LD, 36.1% had a primary diagnosis recorded. The most common diagnoses were: F32 – Depressive episode (9.7% LD; 13.0% non-LD); F41.2 – Mild intellectual disability and regressive disorder (5.6% LD; 6.9% non-LD); F41.1 – Generalised anxiety disorder (4.2% LD; 7.0% non-LD); and F99 – Mental disorder not otherwise specified (4.2% LD; 2.9% non-LD).

In terms of process, the three most common codes for clients with LD were: END-DIS (therapy completed discharge – 31.3%), REF-FTE (referral – failure to engage – 25.0%) and END-SPE (signpost elsewhere – 15.6%). Three clients (4.7%) were referred to the LD service. For clients without LD, the most common codes were END-DIS (39.7%) and REF-FTE (31.4%).

Conclusions
Clients with LD are accessing IAPT services in Cumbria; the next step is to examine service effectiveness.

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4. Staff responses to challenging behaviour: A preliminary investigation into their development over the course of an interaction
Tony Levitan, Dave Dagnan, Peter Baker & Celia Heneage

Background
This study was carried out in collaboration with Cumbria People First Independent Advocacy Services’ project Voices of the Voiceless. The project’s aim was to extend advocacy services to people who were unable to verbally communicate. Whilst working alongside individuals living in residential settings, an observation was made by the advocate that people with lower communication abilities appeared to be less active compared to other residents. This study set out to explore the activity levels of people with intellectual disabilities comparing people with higher and lower communication abilities.

Methods
Participants included 35 men and 19 women (aged 20 to 80) with intellectual disabilities living in a variety of domestic settings. Depending on ability, either the individual or a carer recorded activities for one week along with the number of activities occurring inside the individual’s home and outside their home. Adapting the Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) items, ratings were made for ‘communication level’, ‘mobility level’, and evaluating their interventions. Cognitive responses varied over the course of challenging interactions. However, there was less variation in emotion over time. Tentative relationships were found between interactional negative emotions and staff verbal responses, and between mixed emotions and staff nonverbal responses.

Conclusions
Staff members made causal attributions of service user behaviour during challenging interactions, which may have contributed to their behavioural responses. Rather than being a stable attribute of the staff member, attributions seem to vary across the course of an interaction, suggesting a lack of consistency in understanding challenging interactions.

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5. Not heard and not seen: The level of activities outside of their home of people with intellectual disabilities and low communication abilities
Kathryn McDowell, Dave Dagnan & Lorna Smith

Background
This study aimed to use video elicitation methodology to address these issues and explore variation in responses over the course of an interaction.

Results
Staff recalled making causal attributions about service user behaviour, as well as having a number of other cognitions such as anticipating challenging behaviour and evaluating their interventions. Cognitive responses varied over the course of challenging interactions. However, there was less variation in emotion over time. Tentative relationships were found between interactional negative emotions and staff verbal responses, and between mixed emotions and staff nonverbal responses.

Conclusions
Staff members made causal attributions of service user behaviour during challenging interactions, which may have contributed to their behavioural responses. Rather than being a stable attribute of the staff member, attributions seem to vary across the course of an interaction, suggesting a lack of consistency in understanding challenging interactions.

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5. Not heard and not seen: The level of activities outside of their home of people with intellectual disabilities and low communication abilities
Kathryn McDowell, Dave Dagnan & Lorna Smith
QUALITY/ORGANISATIONAL CHANGE

The uptake of the NHS Bowel Cancer Screening Programme in people with intellectual disabilities in Cumbria

Graham Bickerstaff

Abstract

Bowel cancer is the third most common cancer in the UK and accounts for one in eight new cancer cases. It is the second most common cause of cancer death in the UK claiming around 44 lives each day (Cancer Research UK, 2008). It is the second most common cause of cancer death in the UK claiming around 44 lives each day (Cancer Research UK, 2008). The facts

Keywords

intellectual disabilities; learning disabilities; bowel cancer; screening; health promotion

Introduction

Bowel cancer is the third most common cancer in the UK and accounts for one in eight new cancer cases. It is the second most common cause of cancer death in the UK claiming around 44 lives each day (Cancer Research UK, 2008). If detected at an early stage can be successfully treated. Because of this, the NHS Bowel Cancer Screening Programme was introduced to everyone aged 60–75. This paper reports on a small scale scoping project that investigates if people with intellectual disabilities in Cumbria are being included in the project and what their experiences are.

Methods

A questionnaire was developed and sent to all organisations included in this survey. The survey was carried out in December 2009 and January 2010. Of those eligible for screening, 63% had received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits. It is interesting to note that three of the seven respondents who had not received the kits.

Results

There are a number of methodological shortcomings within this project. The main one being that the survey was of organisations and homes, but not of individuals within the homes. However, it is likely that by using this approach the majority of people eligible will have been captured within this project, as it is likely that the majority of people with intellectual disabilities in the screened age group would be receiving some sort of residential support rather than living with parents or living alone.

Of those eligible for screening, 63% had received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits. It is interesting to note that three of the seven respondents that originally claimed that they had not received the kits.

Discussion

There were no significant differences found between groups based on gender and mobility level.

Conclusion

The results suggest that people with lower communication abilities had significantly fewer activities outside their home compared to age; no significant differences were found between groups based on gender and mobility level.

References


A survey of the information needs of NHS students and staff

Pippa Orr & Sheila Marsh

Abstract
NHS Library and Knowledge Services continually review and reassess how to deliver services to meet the needs of staff. A variety of techniques are used to engage with staff so that we can support them across a large geographical area, including delivering services on an outreach basis. Surveys are used to measure the impact of services and help plan for development. This article outlines the first joint information needs survey undertaken by the North Cumbria and Morecambe Bay Library and Knowledge Services.

Keywords
information access; information needs; survey; user engagement; impact; service improvement; library services

Introduction
Darzi (2008) identified challenges presented by the ‘information society’ in which we live and work. He stated “the internet has transformed our relationship with information” and highlighted the need for healthcare staff, patients, and the public to have access to “authoritative clinical and non-clinical evidence and best practice” to ensure high-quality care. “Easy and convenient access to knowledge is an essential part of a modern and effective workplace.” The importance of information and the knowledge base in healthcare continues to be highlighted in more recent white papers and reports (Department of Health, 2012).

The aim of NHS library services is to support and contribute to:
• improving patient care;
• ensuring that decisions are evidence based;
• ensuring that all NHS staff have access to resources for life-long learning;
• ensuring that research and development outputs are turned into practice.

Indeed, previous library surveys have demonstrated the high regard held by staff for the resources and services provided by the library services. However, with the increasing importance of the internet and other electronic information, it was also clear how users and non-users of the service felt about the relevance of these information sources and the need for information to support professional updating, education, and the provision of evidence-based healthcare.

Background
NHS staff and healthcare students across Cumbria and North Lancashire are supported by the two Library and Knowledge Services of North Cumbria and Morecambe Bay (Library and Knowledge Services, 2013). In 2011, we carried out a survey (Orr, 2012) as part of a wider Information Needs Project, to help us improve user experience and satisfaction with our services and to enable us to redesign and update services to better fit our users’ needs. To achieve this we needed to establish the types of information and evidence NHS staff and healthcare students needed and used to help with their work, and how and where they looked for information. We could then identify how to improve access to information for existing users and engage new users.

Method
From our own experience and drawing on lessons learned by partner services within the NHS Library and Information Health Network North West (LIHNN, 2013) we asked the questions, grouping them under the main themes we wanted to explore, which were:
1. Why information was needed and the nature of their information-seeking behaviour.
2. Barriers to finding and using information at work.
3. How staff preferred to share and receive information.
4. Information skills training needs of staff.

We used the web tool Survey Monkey (2013) as it allowed flexible and qualitative questions and provided an analysis of the results.

The survey targeted current and potential users of the services across the health and social care community in Cumbria. The web link to the survey was publicised widely via email and in Trust newsletters. Printed copies were also available in all the libraries and learning spaces. The Survey Monkey link was open for five weeks during May and June 2011.

Response
Responses were received from all of the main healthcare organisations, including students on university healthcare programmes and a small number of social care staff working with NHS teams (Figure 1). The total number of survey responses was 632 (68.8%) completed the entire survey. The largest group of responders and roles within clerical and administration (14%) were the second largest group (Figure 2). Note that the ‘clerical and administration’ (Clerical/Admin) staff category includes managers. A possible explanation for ‘Other’ forming a significantly large group is that respondents had found it difficult to identify their appropriate staff group.

Figure 1
Who is your employer or if you are a student, where are you studying?

Figure 2
Who is your employer or if you are a student, where are you studying?
Summary of key findings
Four main themes were investigated in the survey.

Why information was needed and where people look for it
Table 1 identifies ‘keeping up to date’ (487: 68%), ‘education or training course’ (463: 65%), for ‘personal interest’ (469: 57%) and ‘preparing a presentation or teaching session’ (369: 52%) as some of the most common reasons staff gave for needing information. This suggests that the traditional role of the library in supporting personal development and educational needs of staff is still necessary. These results were almost identical to those of other surveys of information needs of NHS staff, with the exception of ‘research’, which did not feature as high on the list (Thornton, 2010). Use of information for audit (272: 38%), ‘clinical support’ (264: 37%), ‘patient or carer information’ (250: 35%) and ‘developing a guideline or policy’ (246: 34%) had lower response rates; however, it nevertheless showed that staff were making use of the evidence available to them.

Table 1: For what reason might you try to find information relating to your work?

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Response %</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>38.0%</td>
<td>272</td>
</tr>
<tr>
<td>Care pathway</td>
<td>27.2%</td>
<td>195</td>
</tr>
<tr>
<td>Clinical support</td>
<td>36.9%</td>
<td>264</td>
</tr>
<tr>
<td>Demonstrate providing value for money/cost effective service</td>
<td>18.2%</td>
<td>130</td>
</tr>
<tr>
<td>Patient or carer information</td>
<td>34.9%</td>
<td>250</td>
</tr>
<tr>
<td>Protocol development</td>
<td>20.3%</td>
<td>145</td>
</tr>
<tr>
<td>Publication</td>
<td>11.3%</td>
<td>81</td>
</tr>
<tr>
<td>Risk management</td>
<td>16.1%</td>
<td>115</td>
</tr>
<tr>
<td>Service planning and decision making</td>
<td>20.0%</td>
<td>143</td>
</tr>
<tr>
<td>Support QIPP Plans (Quality, Innovation, Productivity and Prevention)</td>
<td>7.7%</td>
<td>55</td>
</tr>
<tr>
<td>Systematic review</td>
<td>12.2%</td>
<td>87</td>
</tr>
<tr>
<td>To answer a query about patient/service user care</td>
<td>26.3%</td>
<td>188</td>
</tr>
<tr>
<td>Preparing a report</td>
<td>31.0%</td>
<td>222</td>
</tr>
<tr>
<td>For a job interview</td>
<td>15.1%</td>
<td>108</td>
</tr>
<tr>
<td>Research</td>
<td>29.1%</td>
<td>208</td>
</tr>
<tr>
<td>Developing a guideline or policy</td>
<td>34.4%</td>
<td>246</td>
</tr>
<tr>
<td>Keeping up to date</td>
<td>68.0%</td>
<td>487</td>
</tr>
<tr>
<td>Preparing a presentation or teaching session</td>
<td>51.5%</td>
<td>369</td>
</tr>
<tr>
<td>Personal interest</td>
<td>57.1%</td>
<td>409</td>
</tr>
<tr>
<td>Education or training course</td>
<td>64.7%</td>
<td>463</td>
</tr>
<tr>
<td>Legal/ethical issues</td>
<td>26.5%</td>
<td>190</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>7.6%</td>
<td>56</td>
</tr>
</tbody>
</table>

Information-seeking behaviour
One of the purposes of the survey was to try to identify where staff generally start when they need to find work-related information and also to establish what type of information resources staff were using. The internet was a source which was cited frequently in responses to questioning about the information search habits of staff and is also reflected in comments such as “When not on a Uni course Google scholar but when attending uni use the uni web site” (Nurse); and “I would probably do an online search and then look within the books held in our department. I would search Google books but if I was unable to get hold of a book online I would try the library service” (Psychologist).

While library services were not necessarily the first choice, the information sources they chose were in some cases provided by the library, (i.e., journals, electronic databases). While previous research had shown information from colleagues was preferred over published and electronic sources – in the case of a study of nurses (McCaughan, 2005) – our survey showed that while ‘human sources’ (i.e., ‘ask a colleague’), still featured strongly, the internet and other electronic sources of information had become more popular.

It is clear from the results and comments, such as those above, that respondents wished to find information quickly and easily, many preferring to do so themselves, even if this meant using the internet, over more specific and reliable resources, such as available peer-reviewed research papers and journals. This information search behaviour has already been identified by universities (Hyams, 2012).

Barriers to finding and using information at work
“Time is always an issue but so is funding and it puts one off applying for really good courses because you just think – it’s too expensive. A shame because good courses keep me aware, up to date and make me more enthusiastic about what I do” (Allied Health Professional).

“ While I was on courses last year but I haven’t felt I was able to keep on learning. If I can’t find time to read, I just don’t” (Occupational Therapist).

“ While I make use of the internet and often find my answers there I always go back to the library for something more specific” (Allied Health Professional).

“Information is available online but can be time consuming. I would prefer more specific information” (Medical Professional).

While information was available in some form or another, many found it too time-consuming, or too expensive, to make use of it. Many respondents felt that they did not have enough time to do this, and that this prevented them from taking advantage of the resources available. In some cases, respondents felt that the cost of accessing the information was too high (Time is always an issue but so is funding and it puts one off applying for really good courses because you just think – it’s too expensive. A shame because good courses keep me aware, up to date and make me more enthusiastic about what I do” (Allied Health Professional)."

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“While I make use of the internet and often find my answers there I always go back to the library for something more specific” (Allied Health Professional).

“Information is available online but can be time consuming. I would prefer more specific information” (Medical Professional).

While information was available in some form or another, many found it too time-consuming, or too expensive, to make use of it. Many respondents felt that they did not have enough time to do this, and that this prevented them from taking advantage of the resources available. In some cases, respondents felt that the cost of accessing the information was too high (Time is always an issue but so is funding and it puts one off applying for really good courses because you just think – it’s too expensive. A shame because good courses keep me aware, up to date and make me more enthusiastic about what I do” (Allied Health Professional)."

Table 2

NHS Libraries Information Needs Survey

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Always</th>
<th>Often</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask a colleague</td>
<td>131</td>
<td>346</td>
<td>177</td>
<td>4</td>
</tr>
<tr>
<td>NHS Library Service</td>
<td>88</td>
<td>163</td>
<td>212</td>
<td>137</td>
</tr>
<tr>
<td>Course or training material</td>
<td>81</td>
<td>272</td>
<td>226</td>
<td>24</td>
</tr>
<tr>
<td>E-mail</td>
<td>49</td>
<td>186</td>
<td>210</td>
<td>92</td>
</tr>
<tr>
<td>Internet</td>
<td>118</td>
<td>246</td>
<td>192</td>
<td>60</td>
</tr>
<tr>
<td>Internet</td>
<td>359</td>
<td>258</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Journals</td>
<td>158</td>
<td>252</td>
<td>195</td>
<td>49</td>
</tr>
<tr>
<td>Electronic databases</td>
<td>172</td>
<td>282</td>
<td>128</td>
<td>31</td>
</tr>
<tr>
<td>Other care organisation or network</td>
<td>19</td>
<td>91</td>
<td>211</td>
<td>177</td>
</tr>
<tr>
<td>Public library</td>
<td>19</td>
<td>43</td>
<td>141</td>
<td>325</td>
</tr>
<tr>
<td>University library</td>
<td>75</td>
<td>96</td>
<td>135</td>
<td>218</td>
</tr>
<tr>
<td>British Library</td>
<td>7</td>
<td>58</td>
<td>140</td>
<td>311</td>
</tr>
</tbody>
</table>

While library services were not necessarily the first choice, the information sources they chose were in some cases provided by the library, (i.e., journals, electronic databases). While previous research had shown information from colleagues was preferred over published and electronic sources – in the case of a study of nurses (McCaughan, 2005) – our survey showed that while ‘human sources’ (i.e., ‘ask a colleague’), still featured strongly, the internet and other electronic sources of information had become more popular.

It is clear from the results and comments, such as those above, that respondents wished to find information quickly and easily, many preferring to do so themselves, even if this meant using the internet, over more specific and reliable resources, such as available peer-reviewed research papers and journals. This information search behaviour has already been identified by universities (Hyams, 2012).

Barriers to finding and using information at work
“Time is always an issue but so is funding and it puts one off applying for really good courses because you just think – it’s too expensive. A shame because good courses keep me aware, up to date and make me more enthusiastic about what I do” (Allied Health Professional)."

“While I was on courses last year but I haven’t felt I was able to keep on learning. If I can’t find time to read, I just don’t” (Occupational Therapist).

“While I make use of the internet and often find my answers there I always go back to the library for something more specific” (Allied Health Professional).

“Information is available online but can be time consuming. I would prefer more specific information” (Medical Professional).

While information was available in some form or another, many found it too time-consuming, or too expensive, to make use of it. Many respondents felt that they did not have enough time to do this, and that this prevented them from taking advantage of the resources available. In some cases, respondents felt that the cost of accessing the information was too high (Time is always an issue but so is funding and it puts one off applying for really good courses because you just think – it’s too expensive. A shame because good courses keep me aware, up to date and make me more enthusiastic about what I do” (Allied Health Professional)."

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“While I make use of the internet and often find my answers there I always go back to the library for something more specific” (Allied Health Professional).

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Sharing and receiving information

“Sharing information is difficult because we are often too busy to pass on information at work” (unidentified).

“Depends on the type and urgency of communication. Generally, I prefer electronic communication to printed” (unidentified).

The importance of accessing relevant information at work is reflected in the many of the responses in our survey (Figure 5). However, increasing the importance of information sharing and ‘know how’ is being recognised, and the devastating impact when this does not happen has long been reported in the press (e.g., the case of Victoria Climbie, Bristol and North Staffordshire Hospital).

Email (82%) then electronic bulletins (57%) were the most cited preferred option for both sharing and receiving information; however, informal meetings or conversations (48%) and regular meetings (52%) were close behind. This response is somewhat surprising as staff often tell us they receive too many emails and suffer from information overload. The more face-to-face methods of sharing information, however, often provide opportunities to share more ‘tacit knowledge’ and ‘know how’ (Nonaka & Takeuchi, 1995). Indeed, some organisations are now actively supporting more informal knowledge-sharing activities. There are examples where the library service is involved in these activities, for example the Learning Lessons programme at University Hospitals of Morecambe Bay NHS Foundation Trust.

Training needs

It is recognised that healthcare staff are not always aware of the evidence-based information available to them and it is the library services’ responsibility to provide access to and skills in information literacy (i.e., information search, critical appraisal, and evaluation):

“I think training would have to be made mandatory to be useful / allowed in our context” (Other).

“Library service is vital to good practice and CPD - as clinicians in the community I don’t think we get enough time to use the service as much as we might do” (Psychologist).

“Hardly ever use Library. I have bought my own books that are appropriate for me and the rest I access through the internet or find a specialist to consult” (unidentified).

Table 3 shows the number of respondents who had received training. Just over half of respondents (325) said they had received library training in searching and 187 wanted to know how to access electronic books and journals. This can be explained and demonstrated to staff at their workplace or over the telephone and PC.
Table 3: Have you ever received or would you like to receive training in any of the following?

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Yes</th>
<th>No</th>
<th>Would like training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic internet searching</td>
<td>329</td>
<td>297</td>
<td>62</td>
</tr>
<tr>
<td>Searching Google effectively</td>
<td>206</td>
<td>348</td>
<td>99</td>
</tr>
<tr>
<td>How to use the library</td>
<td>308</td>
<td>248</td>
<td>107</td>
</tr>
<tr>
<td>How to access electronic books and journals</td>
<td>321</td>
<td>213</td>
<td>187</td>
</tr>
<tr>
<td>Literature searching (e.g., Medline, CINAHL, Social Care Online)</td>
<td>325</td>
<td>199</td>
<td>169</td>
</tr>
<tr>
<td>Critical appraisal</td>
<td>236</td>
<td>266</td>
<td>155</td>
</tr>
<tr>
<td>Using Wikis and blogs</td>
<td>85</td>
<td>405</td>
<td>131</td>
</tr>
</tbody>
</table>

Responses also indicated that some staff still felt that they lacked the right skills to search for information (20%) or were unsure where to find the information they needed (30%). This still compares favourably with a survey by the Royal College of Nursing (Bertulis & Cheeseborough, 2008) which found 44% stated they lacked search skills, but is higher than a similar survey in another local NHS Trust (Thornton, 2010) where the ratio was 16% and 13% respectively.

Conclusion and recommendations

From the results of this survey it can be seen that access to and effective use of information is extremely important to the day-to-day working practice and continuing personal and professional education and development of staff. It also showed that electronic access to information has become increasingly important, but that sharing and learning with colleagues is also still valued and needs to be supported. While many respondents had received some information skills training, there was an interest amongst staff for refreshing these skills, especially in how to access electronic journals, as well as developing new skills using new tools such as blogs and Wikis.

According to survey respondents, however, the biggest barrier to finding information was a lack of time. While many used a wide range of information, including the library service, some were unsure how to access the service, or were aware of how it could save them time. These responses highlight the need to communicate to all staff some key messages about library services. These messages include:

- You usually do not need to visit the library to use our services.
- Library staff can save you time by searching for information for you.
- Journal contents pages can be delivered direct to your PC.
- You can access full text journals from your PC.
- Our services are for all NHS staff.
- Library staff can help with assignment support and referencing skills.
- Most library services are available electronically using a computer.

- All staff who join the library as members are eligible for out-of-hours access.
- Library staff can help staff get more out of the internet and Google.

The themes which emerged highlighted key areas in which the library needs to improve staff experience and satisfaction:

1. Continue to promote and improve remote access to all library services.
2. Identify and promote new and existing time saving services.
3. Continue to improve desktop access to library services.
4. Increase awareness of library services.
5. Develop a wider range of support materials.
6. Continue to develop and improve the range of electronic resources.
7. Build on the insights from the survey by establishing focus groups to gather further feedback and test new approaches and services.

It was encouraging that 194 respondents gave us their contact information to be involved in follow-up focus group work or interviews. The focus group work has been taken forward as a separate project and we have started to implement the survey recommendations. Look in the ‘news’ section on the library website homepage (Library and Knowledge Services, 2013), where information is posted about resource trials, new ways of accessing healthcare information (e.g., apps, blogs, and Wikis available), service developments, support materials, new publications, and much more.

Library services need to continue to improve and promote their services in this rapidly changing information and digital age, as they play a key role in supporting the development of staff that value and recognise the importance of embedded evidence-based practice and the systematic use of knowledge in their everyday work. They cannot do this alone, or in isolation, but in conjunction with a supportive senior management who recognise the need for them to be part of a much wider programme that develops a strong learning culture across all NHS organisations.

Service improvement: Reducing physiotherapy outpatient waiting times

Helen McGahon

Abstract

This paper describes a project that reduced waiting times for outpatient physiotherapy in the Eden locality of Cumbria from six weeks to a maximum wait of two weeks whilst maintaining high-quality service outcomes.

Keywords

waiting times; musculoskeletal physiotherapy; efficiency

Background

Historically patients referred to the locality Physiotherapy Department by their General Practitioner (GP) for a musculoskeletal physiotherapy appointment waited a minimum of six weeks for an appointment. The physiotherapy staff found this frustrating as patients’ conditions often became more chronic during the wait and they often needed to take prolonged periods off work. Physiotherapists felt that in order to provide a better quality service they should see the patients sooner. Local GPs had approached the Physiotherapy Department informally to enquire if improvement in patient waiting times could be made. Two patient user group engagement meetings were carried out to obtain views on how patients would like to access physiotherapy. These meetings highlighted that the users of the service wanted fast access to a physiotherapist within a maximum one- or two-week waiting period.

Rationale for the project


Northwest, 2013). Specifically:

- Evidence from a pilot project at the locality Physiotherapy Department that gave patients access to physiotherapy with a two-week maximum wait demonstrated that when patients are seen when they initially seek help they are more engaged in their treatment, require fewer visits to a therapist, and have an improved patient experience.
- Faster access to treatment reduces the impact of illness on people's quality of life and will reduce lifestyle-related illness.
- Faster access will see quicker resolution of conditions reducing days lost at work.
- The Cochrane Library's February 2012 issue special collection covering exercise for musculoskeletal conditions (Cochrane Library, 2012) supports increasing the volume of group work as this gives best outcomes thus increasing capacity and capability of physiotherapy departments.

**Objectives for the project**

The project had the following objectives:

1. To change how first appointments are delivered. In order to achieve this dedicated 'new patient sessions' were introduced which led to an increase in efficiency and productivity. To assess the impact of working with new patient sessions the orthopaedic consultant waiting list was managed by two physiotherapy staff providing dedicated new patient referrals. During this time, a patient satisfaction survey was administered to assess the effect the change in referral appointment capacity could lead to a large increase in referrals (demand) from outside the locality leading to lack of perceived benefits for local commissioners/patients. The commissioners therefore agreed to limit the Choose and Book service for Eden Physiotherapy to Eden-based referrers only in order to properly understand the effect the proposal had on waiting times. GPs outside the Eden locality (Cumbria) could still access the service if they sent referrals by letter.

2. To change the follow-up (F/U) treatment regime. In order to achieve this the department carried out a pilot study assessing patients who accessed the service in a maximum wait of two weeks and demonstrated that when conditions were treated in this timescale they resolved more quickly and patients took more ownership of their own treatment and exercise.

3. To ensure that the patient’s condition resolves in fewer contacts and therefore less time. In order to achieve this the department carried out a pilot study assessing patients who accessed the service in a maximum wait of two weeks and demonstrated that when conditions were treated in this timescale they resolved more quickly and patients took more ownership of their own treatment and exercise.

4. To consider how the Choose and Book service affected productivity. GP referrals to the locality physiotherapy service are 100% by Choose and Book. The service believed that an expansion in referral appointment capacity could lead to a large increase in referrals (demand) from outwith the locality leading to lack of perceived benefits for local commissioners/patients. The commissioners therefore agreed to limit the Choose and Book service for Eden Physiotherapy to Eden-based referrers only in order to properly understand the effect the proposal had on waiting times. GPs outside the Eden locality (Cumbria) could still access the service if they sent referrals by letter. This ensured patients who needed the treatment in the Eden area could still access the service.

**Service change**

From 14 May 2012, all staff commenced new patient sessions of Choose and Book referrals and orthopaedic referrals. From 14 May 2012, all staff commenced new patient sessions of Choose and Book referrals and orthopaedic referrals. During this time, a patient satisfaction survey was administered to assess the effect the change in referral appointment capacity could lead to a large increase in referrals (demand) from outside the locality leading to lack of perceived benefits for local commissioners/patients. The commissioners therefore agreed to limit the Choose and Book service for Eden Physiotherapy to Eden-based referrers only in order to properly understand the effect the proposal had on waiting times. GPs outside the Eden locality (Cumbria) could still access the service if they sent referrals by letter.

The results indicate a significant increase in productivity for the service, it is important to demonstrate that this was not achieved at the expense of a positive patient experience. In order to demonstrate this, data are presented here from the patient satisfaction survey. The patient satisfaction survey was designed to establish if the new way of working had an impact on the patient experience. Figures 1, 2 and 3 show the results from the specific questions in the satisfaction survey. Figure 4 shows the results of a ‘wordle’ (Feinberg, 2011). A ‘wordle’ is a ‘word cloud’ created to give greater prominence to words that appear more frequently in the source text; in this case, the words used by patients to describe the service. This can be seen as a graphical representation of features of the service valued by patients.

The patient satisfaction questionnaire also used a ‘friends and family’ question. This question has since been introduced to the NHS and identifies whether patients would recommend a particular NHS service to their friends and family. In the wider NHS, the results of the test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback. In this evaluation, 100% of patients said they would recommend the service to friends and family.

**Figure 1: Results from the patient satisfaction questionnaire**

![Image of patient satisfaction questionnaire results]

**Table 1**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2011</th>
<th>2012</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new patients seen</td>
<td>737</td>
<td>927</td>
<td>Increase 26%</td>
</tr>
<tr>
<td>Number of patients seen once</td>
<td>320</td>
<td>428</td>
<td>Increase 33%</td>
</tr>
<tr>
<td>Number of patients assessed and given advice with option to self-refer back (SOS)</td>
<td>70</td>
<td>114</td>
<td>Increase 62%</td>
</tr>
<tr>
<td>Number of new patient DNAs</td>
<td>79</td>
<td>60</td>
<td>Decrease 24%</td>
</tr>
<tr>
<td>Total contacts</td>
<td>3048</td>
<td>3571</td>
<td>Increase 17%</td>
</tr>
<tr>
<td>Average number of contacts</td>
<td>3.13</td>
<td>2.92</td>
<td>Minimal change</td>
</tr>
</tbody>
</table>
Figure 3: Results from the patient satisfaction questionnaire

Figure 4 is a wordle showing the words that patients used to describe what they ‘liked best about the physiotherapy department’. Words that are larger are words that were used more frequently.

Figure 4: What do you like best about our Physiotherapy Department?

Conclusion
Changing to a system of specific new patient sessions has increased the capacity of the locality physiotherapy service. Providing a wider range of treatment options i.e., group work and technical instructor treatment packages frees up physiotherapist time to be able to see more new patients for assessment. By increasing capacity in this way, patients’ waiting time to access the service is significantly reduced. As a result, the number of patients needing only one appointment to provide assessment and advice to manage their condition increased. Physiotherapists were concerned patients seen only once may need to return for follow-up appointments. To ensure patients had this opportunity to access physiotherapy without having to visit their GP for a second referral, patients were given details to directly access the service should they need to. This study has not measured the number of patients who took up the opportunity to return to the service but it is evident that offering this facility has not impacted on waiting times.

This way of working has reduced the number of did-not-attends thereby improving service efficiency. The new way of working has become embedded in the department with waits remaining less than two weeks. The staff feel they give excellent evidence-based treatments when patients are presenting for treatment. They feel that because patients are engaged early in treatment they get more involved and take greater ownership of their recovery. Following the introduction of this system, the average number of contacts per patient has not changed significantly. Physiotherapists report that they do not compromise their clinical decision-making and they have the capacity to offer treatment they feel is appropriate to the patient and their condition. The patients report satisfaction with the service they receive, with 100% stating they would recommend the service to family and friends.

This report has demonstrated that it is possible to improve the efficiency and effectiveness of a service without a detrimental effect on the patients’ experience.

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References


Implication pitfalls for Targeted Mental Health in Schools: Evidence from a qualitative evaluation of the Cumbrian programme

Paul K. Miller, Nicki Wilson, Alyson Dickson, & Joanne C. Gaffney

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Abstract
This paper reports findings from a qualitative evaluation of the Targeted Mental Health in Schools (TaMHS) programme in Cumbria. Focusing on the two most widely documented problems in TaMHS implication at the national level – the style/content of basic training provided to school staff, and a restrictively short lead-in period – the analysis explores their impact as perceived by participants in the programme, and makes recommendations for future practice grounded in these.

Keywords
intervention; learning; mental health; teaching; schools; youth

Introduction
The national TaMHS programme was initiated in 2008 by the Department of Children, Families and Schools as a major component in a drive *to transform the way that mental health support is delivered to children aged 5 to 13, to improve their mental wellbeing*
and tackle problems more quickly”. (DCFS, 2008, p.ii). The programme, aimed specifically at enabling schools to deliver a holistic, whole-school approach to the promotion of children’s mental wellbeing, was implemented in three phases. In Phase 1 (2008–2009), 25 ‘pathfinder’ children’s trusts were funded for three years to develop and deliver a flexible, responsive, and effective early intervention model of mental health services for young people. The early evaluation outputs of these interventions would, moreover, inform a phased national implementation from year two of the programme (2009–2010) onwards. In Phase 2 of TaMHS (initiated April 2009), 55 Local Authorities joined the programme, receiving funding for two years. In Phase 3 (initiated April 2010), 72 further Local Authorities, including Cumbria itself, joined the programme, receiving funding for one year.

TaMHS in Cumbria

In Cumbria, the 12-month TaMHS project concluded at the end of March 2011. Formal work in schools began in September 2010, supported by a steering group including senior managers from Children’s Services and the NHS. Eighteen schools, in three clusters across the county itself, were supported. These clusters each included a secondary school and partner primary schools, plus one Pupil Referral Unit (PRU) in the Workington cluster. A number of specialists from tier three Child and Adolescent Mental Health Services (CAMHS) and Specialist Higher Level Teaching Assistants from Local Authority, Children’s Services, Educational Psychology and Behaviour Support Teams were selected and covered each cluster of schools (working part time). These workers were mandated with the provision of staff training, support for parents, group interventions, and direct work with young people. Through the TaMHS project all involved schools accessed cluster meetings, support from a Primary Mental Health Worker, Specialist Higher Level Teaching Assistants (HLTAs) providing small group Social and Emotional Aspects of Learning (SEAL) and Family SEAL, mental health training, and a mental health toolkit, including a mental health and emotional wellbeing policy and information on mental health and emotional wellbeing for students. Additionally, some schools accessed parenting workshops, counselling for staff, outdoor activities for young people, ‘Stardom’ projects or after-school craft activities, and/or a whole-school health day.

Two common ‘glitches’

In terms of the national picture, and particularly with respect to Phase 3 TaMHS initiatives, two problems in implication are reported more commonly in published evaluations than any others. These are: (a) that basic training provided to school staff was seen as either too basic or too generic; and (b) that the allocated lead-in period between the beginning of any initiative proper and its actual delivery in schools was insufficient for full preparation, and that, therefore, even minor delays could result in major difficulties. In Trafford, for example, Jeyasingham (2011, p.15) reports that there was “some uncertainty about remit and referral criteria at the start of the project which can be explained by [initial] delays” that further shortened the available preparation period while, in Derbyshire, lead-in time was constrained by difficulties in initially filling Primary Mental Health Worker posts (Barrow, 2011, pp.20–21) and, also, some school staff found the early training to be of ‘starter’ level (p.9). As evidenced in the Results section (below), these apparently systemic problems also manifested in the Cumbrian TaMHS. The nuances of the data further demonstrate, however, a range of more complex ways in which they impacted at the level of participant experience.

Research design

With pertinent ethical approval and informed consent, data were collected through a programme of semi-structured interviews, conducted and recorded via telephone over a period of two weeks immediately following the closure of the TaMHS initiative itself.

Participant selection

Participants (N=30) were purposively selected from the three categories of professionals involved in TaMHS in order to provide the most multifaceted overview possible: (a) School TaMHS Leads (STLs, N=13), (b) staff members at participating schools (SSMs, N=11), and (c) Dedicated TaMHS workers (DTWs, N=6).

Research materials

Three different, but strongly interrelated, interview schedules were developed (available from Dr Paul K. Miller – see below for contact details), one for each category of respondent with a view to elucidating all priority issues in a manner sensitive to the roles of each respondent. In this way a three-dimensional, but fully interlocking, sense of the overall picture (and any discrepancies in it) could be formed. Interviews were organised around a series of central broad and open questions, with subsidiary topical ‘prompts’, rather than a rigid set of predefined inquiries, permitting participants to voice a greater range and depth of opinions than is often permissible within more structured data collection frameworks (Fielding & Thomas, 2008; Silverman, 2010). Interviews were on average 20 minutes in length, and questions in all three schedules were tailored to explore the impact and success of the TaMHS programme in terms of the set of central aims stipulated in Cumbria County Council’s original participation documentation (see Cumbria County Council, 2010, pp.6–8).

Data analysis

Data were explored for patterns and themes in line with the core principles of Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998), in order to generate robust and defensible, practice-oriented findings from a systematic and rigorous qualitative analysis of the corpus (Silverman, 2006). This process was conducted using Scientific Software’s ATLAS.Ti qualitative analysis package, which is optimally suited to this mode of inquiry (Lewins & Silver, 2007).

Results

The Cumbrian TaMHS was, on the whole, very well received. All issues voiced by participants in terms of

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Table 1: Issues in early training

<table>
<thead>
<tr>
<th>Early training was...</th>
<th>Participants</th>
<th>Sample Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>...too simplistic.</td>
<td>STL, N=3; SSM, N=4.</td>
<td>We attended two sessions...to deal with mental health and sort of recognising mental health within...children and, and young adults. Both of those I found were not as helpful [as later sessions]...they did say it was very basic but it really was very, very basic, and...think with early years in key stage one certainly...we’re very heightened to lots of aspects of this social emotional development anyway, because of the early years development profile.</td>
</tr>
<tr>
<td>...focused on typical ‘mental health’ concerns, without providing specific and tailored links to educational practice.</td>
<td>STL, N=2; SSM, N=2.</td>
<td>I think a lot of it came from the health side right at the beginning about mental health in...children and adolescents, but I think if [things may have been clearer], if right at the beginning they’d said ‘If you’ve got children in your school who this, and this, and this, that actually would be classed as a mental health problem’...</td>
</tr>
<tr>
<td>...not designed to take account of different demographic compositions within and between schools.</td>
<td>STL, N=1; SSM, N=3.</td>
<td>I felt actually that...some of it’s it’s not differentiated enough...because everyone has problem children from whether you live in a £600,000 house or a ‘sink’ estate...people from all walks of life have problems with children and I feel that the [training] was aimed at more the Sure Start end of the market.</td>
</tr>
</tbody>
</table>
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Global theme 2: Lead-in period

This theme also manifested in three key subthemes, with very distinct implications for the interaction between the involved professionals in health and education:...
Table 2: Consequences of short lead-in period

<table>
<thead>
<tr>
<th>Short lead-in period resulted in...</th>
<th>Participants.</th>
<th>Sample Evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>...difficulties in organising activities around schools’ pre-existing activities at short notice.</td>
<td>DTW, N=2; STL, N=2; SSM, N=1.</td>
<td>[It is important that] the planning’s done a little bit before we start the project, [that] schools are given more notice, because what we found was schools were quite booked up, their timetables were booked up, a lot of the training slots were booked up,...</td>
</tr>
<tr>
<td>...confusion over the exact roles of the DTWs in schools.</td>
<td>DTW, N=1; STL, N=3; SSM, N=2.</td>
<td>I think there was a little bit of confusion at the start about how the primary mental health workers would actually work in schools, and I think we were under the impression in schools that they would be working one-to-one with a lot of young people and there was quite a lot of confusion about that...</td>
</tr>
<tr>
<td>...a lack of awareness among school staff in terms of what TaMHS was ‘really about’.</td>
<td>STL, N=3; SSM, N=2.</td>
<td>I am glad we’ve taken part now, but they need to give schools bigger lead-in time to get their heads round things like this...</td>
</tr>
</tbody>
</table>

Thematic integration

It is highly noteworthy that a majority of participants themselves made very explicit connections between the various themes identified above, with a dominant assertion that the issues around Global theme 1 were largely outputs of those embedded in Global theme 2, i.e., that many of the problems in the early training were because of the short lead-in period itself. For example, one STL participant maintained that the DTWs did not seem to have been adequately prepared to deliver to an audience of professional educators not in terms of content, but in terms of style. An SSM, meanwhile, reported that time constraints had even resulted in training and practice being ‘chronologically inverted’: “I actually worked on a small group SEAL programme first of all and we [then] went and we had one or two training sessions...So I just felt that was bit back to front.”

Figure 1 schematises the full range of ways in which the themes discussed above were linked by participants themselves [Note: one should be mindful that this schematisation is one of the relationships between issues that were raised, not quantification thereof].

Discussion

Participants in the evaluation identified two central ‘problem’ issues with respect to the implementation of TaMHS in Cumbria, a set of perceived outcomes of these problems, and the connections between them. However, the mode of evidence collected in the evaluation – with a specific focus on how problems manifest at the level of participant experience – facilitates an understanding of ways in which the initiative might have been buffered against some of the objective and subjective impacts of systemic obstacles. These have clear implications for the successful execution of future health interventions of comparable character, in a range of types of institution.

With respect to interventions involving the provision of training to professionals outside the domain of health itself:

1. The one-size-fits-all model of training was not universally well received. Although adaptations to audience made during the training proved very fruitful, the earliest sessions often left a lasting impression and informed the manner in which school staff viewed the whole initiative.

2. An evidence base was required pertaining to the specific demographics and perceived training requirements of staff at involved institutions in terms of both style and content of delivery.

3. Baseline demographic data are generally freely available; simple surveys to assess prior knowledge and preferred modes of delivery are: a) relatively cheap, quick and easy to conduct as soon as participating schools had been identified and prior to the formal rollout of training itself; b) likely to result in training programmes that engage staff from the outset; and c) likely to provide staff with a sense of being involved in the learning process itself, rather than simply being its ‘audience’.

The development of such an evidence base would also have impacted on other central matters. For example:

1. The prior assessment of school staff expectations in terms of the roles that visiting health professionals would play may well have assisted the TaMHS staff themselves in providing clarity from the outset.

2. Input into the form of the initiative at their own schools would have invariably impacted positively upon staff members’ awareness of the initiative itself, with corollary benefits in terms of their own attitudes towards it.

Conclusion

The evidence presented herein makes a clear case for future health interventions in schools or similar bodies in the region to embed not only post-hoc evaluation, but also a priori investigation (even if relatively cursory) of the sometimes eclectic characters, needs, and expectations of client bodies. Such research could stimulate a more uniformly positive reception of an initiative from the outset in terms of actual improved experience of delivery due to more effective tailoring to audiences; the direct involvement of clients in the specific structure of the initiative at any given site; and the perception of shared responsibility inherent therein. With respect to educational institutions in particular, and much as it is axiomatic that medical professionals are prone to exercise a heightened critical eye on their own healthcare, it might well be anticipated that teachers/lecturers would take particular account of what and how they are being taught by others. The reality and the perception of shared involvement are, thus, critical to fostering affirmative attitudes towards health-related training provision for this group.

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References


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It’s ok to ask!

Free health research roadshow

Cumbria Partnership NHS Foundation Trust will be coming to a number of towns in Cumbria in August 2013 to:

- answer questions about NHS research
- provide information about available research opportunities and how to get involved
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Remember ‘it’s ok to ask!’

Contact Barbara Bishop for more information on 01228 602170

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