Leeds and York Partnership NHS
NHS Foundation Trust

R & I

Innovation

Research and Development Newsletter

Genetics Study Team

in collaboration with Cardiff University

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to read about projects that have recently been completed simply look out for the symbol

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Research Forum 21st November Programme

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Welcome to our new research colleagues

The annual Research Forum is being held on 21st November at Weetwood Hall. We look forward to seeing some of you at this event which will showcase a wide range of projects presented by speakers and in poster format, accompanied by stands of local and national services supporting research.

We are very pleased to have the Trust's new Medical Director, Jim Isherwood, to Chair the event. A full report will feature in the next edition of Innovation. Meantime, the programme is included in this edition.

This edition of Innovation reports the outcomes of seven completed projects that cover a wide range of topics. I am delighted that new research staff introduce themselves to you. They are here to support you and offer you the chance participate in studies that will add to the NHS evidence of what works best, whether you are a member of staff, service user or carer. All but Sinead Audsley, our Research Governance Manager, are funded from sources outside the Trust. Sinead explains some of these funding streams in her article about attributing the costs of health and social care research and development (AcoRD) which is guidance from the Department of Health that came into effect from 1 October 2012.

You are invited to contribute to a project which Is an observational assessment of safety in Seroquel. Dr Nazari says this is: "a good research experience for me and at the same time very easy ... research staff helped with nearly all the data collection." See pages 4 & 5 for further details

There are details of the usual training opportunities offered by our library services and the clinical research network within the National Institute for Health Research.

The completed projects are:

- Enhancing care pathways for Black and Minority Ethnic service users in Leeds mental health provision, commissioned by Yorkshire & Humber Strategic Health Authority and Innov8 NHS.
- Therapists' experiences of therapeutic mistakes – a Doctorate of Clinical Psychology research project
- You may recall mention of the Personal Concerns Inventory (PCI) in a previous issue. This is a goal-based motivational interview to reduce dropouts in a personality disorder treatment service and was conducted at a number of Trusts. Most people in this pilot study found the interview useful and it helped to clarify what they want out of therapy and engage people in therapy. A full-scale evaluation would be worthwhile.
- A collaborative study of the rate of post-psychotic depression in two early intervention services and the service and clinical implications was completed by NHS, Community Links, Universities, Navigo and Social Care CIC. Rates found were 44-48%, demonstrating that this is a significant problem. Recommendations are made.
- A service evaluation of reflective practice groups and staff wellbeing identified key themes of having time, managing feelings, quality assessment and solving problems with a central theme of the benefit of a group setting.
- Validation of British Sign Language (BSL) versions of three mental health assessment tools resulting in a report for the British Society for Mental Health and Deafness and to assist early identification of deaf BSL users' mental health difficulties and promote equality of access to services.
- And finally, a national study on the prevalence of mental illness among victims of homicide.

Alison Thompson

Front cover: The research team working on the genetic susceptibility to cognitive deficits across the schizophrenia / bipolar disorder diagnostic divide

L-R Gerwyn Davies, Clinical Studies Officer Cardiff, Kyla Pennington, LYPFT and Vishal Sharma, LYPFT

Also involved in this study are Dr Alistair Cardno and Dr Tariq Mahmood, both of whom are speakers at the Research Forum.

Completed Research Projects

Therapists' experiences

of therapeutic mistakes

Introduction

In contrast to the extensive literature on related areas such as therapeutic boundaries, alliance and ruptures, little empirical research has been conducted on therapeutic mistakes. Existing research based predominantly on case studies and observations have focused on systems for categorising mistakes. Empirical research on therapeutic mistakes has focused on supervisors' and clients' perspectives. This study is the first to explore therapists' experiences of therapeutic mistakes.

Method

Seven psychological therapists were interviewed using semi-structured interviews on their experience of therapeutic mistakes in therapy sessions. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Initially, individual transcripts were analysed separately, resulting in a number of themes for each participant. A group analysis was conducted across participants, yielding super-ordinate themes and sub-themes, based on their psychological relatedness.

Results

A seven-stage process was identified across participants' accounts (including participants' experiences of before the session, in the session, the emergence of a problem, in the midst of a problem, `The aftermath', making sense and `How I'm left), detailing the experiential themes for participants at each stage. Some of the main themes that emerged were a sense of `something brewing', feeling criticised by their client or self-criticism, relief and recovery, reflecting on roles and responsibility and pre-occupation with the mistake. Four key findings were presented including participants' complex constitution of mistakes, the role of emotion in participants' experiences of mistakes, participants' on-going meaning making process and participants' experience of mistakes as an interpersonal negotiation. The findings also suggested a difference between how participants constituted mistakes in principle (more aligned with the literature on boundary transgressions and categorisations of mistakes) and the mistakes they shared in their accounts (which reflected more ordinary and minor mistakes, e.g. administrative errors or sharing an interpretation that was not well received).

Dr David Aaron email: david.aaron@leedsth.nhs.uk

Completed Research Projects

Validation of British Sign Language

(BSL) versions of mental health assessment tools

Research has established that the mental well-being of d/Deaf people is poorer than that of hearing populations (Hindley et al., Fellinger, 2012); however there is a paucity of valid mental health assessments in British Sign Language (BSL).

The aims of this project were to; (i) translate standard assessment tools used nationally, for example, NHS IAPTs into BSL; and (ii) test their reliability on a population of Deaf BSL users.

Two pilot projects were carried out, one involved the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM) and the other involved the BSL versions of the Patient Health Questionnaire (PGQ9, Generalized Anxiety Disorder 7 (GAD-7) and Work and Social Adjustment Scale (WSAS). The BSL versions of the mental health assessments were produced using a team approach to the back-translation method and were incorporated into an online survey to enable remote data collection. At least 100 Deaf people took part. They were recruited from the general population, as well as, for one project, from primary/secondary mental health services.

Cronbach's alpha was used to measure the internal consistency of the items in the CORE-OM, PHQ9, GAD7 and WSAS. The validity of all assessments has been established by comparing results with those of the BSL version of the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM). Validated BSL assessments had been implemented in primary care; initially through the NHS BSL IAPT project. They will assist early identification of Deaf BSL users' mental health difficulties and promote equality of access to primary/secondary mental health services.

Professor Alys Young & Ms Katie Rogers
Social Research with Deaf People, School of Nursing, Midwifery and Social Work. Room 4.312, Jean MacFarlane Building, University of Manchester, Manchester M13 9PL

OASIS: Observational Assessment of
Safety in Seroquel

OASIS is a nationwide study that has been running in Leeds since 2010. Dr Thomas Hughes is the Principal Investigator and I have recently taken over as the Research Assistant for LYPFT.

OASIS featured in Innovation in Summer 2011, but the study is open until March 2013 and we are always looking for new prescribers to be involved. There is minimal effort required on your behalf if you do decide to take part!

"Patients are generally very interested in taking part in research and it has been easy to recruit to the OASIS study. It is an important study but asks very little of the clinician apart from letting the Clinical Studies Officer know a patient has agreed to participate. All data collection is carried out by a Research Assistant."
Dr Tom Hughes

"I have had the opportunity to participate in the OASIS study while working in East North East CMHT. This is a post-marketing safety study of quetiapine. In my view, this was a good research experience and at the same time very easy and simple. I recruited one patient whom I had prescribed quetiapine, and OASIS research staff helped with nearly all the data collection."
Dr Jamshid Nazari

The Study
OASIS is being undertaken by the Drug Safety Research Unit (DSRU); an independent academic unit and registered medical charity, which conducts safety studies, many at the request of the UK medical regulator, the MHRA.

OASIS is a prospective, naturalistic, observational cohort study of patients newly initiated on quetiapine XL / IR (Extended / Immediate Release). This means it follows patients using different doses of quetiapine (brand name Seroquel) in their everyday life (as opposed to during a clinical trial) which enables the systematic collection and reporting of short term safety data.

It aims to:
- Compare rates of events reported for patients taking high dose of both formulations (XL & IR);
- Compare rates of events reported for patients taking low dose with those taking high dose;
- Quantify & explore the pattern of events reported for those taking Seroquel XL over time.

The OASIS study is necessary for AstraZeneca to continue to licence 'Seroquel XL'. Although AstraZeneca funds the study it does not have any say in the running of study or access to patient notes, patient identifiable data nor any individual questionnaires received by the DSRU - they have access to aggregated anonymised data only.

By 31st March 2013 the study aims to recruit around 1500 - the current recruitment total for the country stands at 729, with 213 of these coming from the North of England. There are still 5 months left to recruit patients into the study so I would ask any psychiatrists or prescribers who are about to prescribe quetiapine XL / IR to a patient to consider recruiting them into the OASIS trial - any recently prescribed patients can also be included, up to 12 weeks after treatment initiation.

Who is eligible? The patient must be able to give informed consent and be:
- Diagnosed with schizophrenia or a manic episode associated with Bipolar disorder and newly initiated on quetiapine IR or Seroquel XL;
- Diagnosed with the above conditions and switching from quetiapine IR to XL.
- Those with co-morbidities (e.g. Epilepsy, Cushing's disease) can be accepted.

Who is excluded?
- Those with Bipolar depression.
- Those living in selected institutions i.e. Prisons.
- Those who started Seroquel XL treatment prior to the study start.

What data is collected?
Participants are asked to give consent for us to access their case-notes only - no separate interview or examination of the patient is necessary, as all the required information should be in the case-notes. Two questionnaires need to be completed, which ask about the patient at the time of starting quetiapine (baseline) and at 12 weeks after treatment began. In certain cases the DRSU will request bespoke follow up questionnaires (e.g. for those with a history of self-harm). The questionnaires are a simple tick box format, with closed-ended questions on patient demographics, past medical / drug history, dose titration and any adverse events experienced. They can be completed by the prescriber, another member of the patients care team or I can complete them. As a Research Assistant I am able to answer all questions but one; a Clinical Global Impression Score-Schizophrenia Score which needs to be completed by the prescriber (but this can be done over the phone / email).

How to get involved
If you are a prescriber with potential participants for OASIS you need to register on the OASIS website (www.dsru.org/oasis/healthprofessionals) to receive an Investigator Code. This then allows you to print off questionnaires and other documents for participants. The website is simple to use however I can register prescribers and generate documents if needed.

Benefits of involvement
LYPFT is very keen for prescribers to participate in OASIS and recruits to the study go a long way to securing more funding for R&I involvement on a national and local level. OASIS will also benefit our service users - all studies that have been accepted onto the National Institute for Health Research portfolio are peer reviewed not only for quality, but also for the contribution they make to patient care.

The DSRU pays the Trust for each completed OASIS questionnaires they receive; £200 per baseline, £150 per 12 week follow-up and £50 for any bespoke / event specific questionnaires. LYPFT divides this equally between the R&I department, Pharmacy and the Team of the prescriber. Suggestions on how to spend this remuneration have included paying for attendance at conferences, buying books / journals or organising team building events.

On a personal level, a Certificate of Participation will be sent to the prescriber once both questionnaires have been completed for one recruit. If five participants are recruited prescribers will receive a personalised letter from Professor Joe Reilly (Principle Co-Investigator) acknowledging their achievement - these can be used to show involvement in on-going research for professional points and as evidence of involvement for inclusion in portfolios / appraisals.

Thank you for reading this

I look forward to hearing from anyone about potential participants!

Emma Fleming
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R & I

Innov8
Reframing Diversity Leadership

Completed Research Projects

Black and Minority Ethnic (BME)
Pathways Research

This report presents the results of research carried out within Leeds and York Partnership NHS Foundation Trust (LYPFT) and explores how the BME patient experience can be enhanced from a staff standpoint.

The study included a literature review of the frequency and causes of inequalities in mental health. Interviews through 1-1 focus groups and a survey were carried out with a total of 53 health professionals across the mental health economy in Leeds. This included staff from different specialist areas and a range of levels, both from White and BME backgrounds.

The research highlights cultural competence as a key enabler to more effectively meeting the needs of BME communities and overcoming ethnic inequalities in mental health. It asserts that to be effective, cultural competence needs to be built in at every step of the care pathway, from prevention through to presentation, diagnosis, care and discharge. BME staff were found to have the confidence and capabilities to work effectively across cultures more commonly than White staff. The research concludes that, despite current efforts to improve cultural competence through training, a more focused approach, which draws not only on on-line but more consistently on classroom methods together with a range of experiential learning, such as working with BME community groups and building on the strengths of the BME and White who have gained cultural competence is needed for all staff, leaders and clinical professionals. This could be undertaken as part of the Trust's participation in the Innov8 Charter. Action should be taken to ensure that race equality for patients and staffs is embedded into the Trust's core business process, using clear goals and impact indicators to support leadership and governance on this issue. The Trust could consider undertaking a CQUIN (Commissioning for Quality and Innovation) linked to a metric, such as undertaking BME patient satisfaction surveys or reducing length of stay.

Recommendations are also made for the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Education and Training Boards and Health Education England and Local Education and Training Boards.

The full report is available from Tracy Gray

Tracy Grey
Health Improvement Specialist (Advanced)
Email: tracy.grey@nhsleeds.nhs.uk

BHI Black Health Initiative

NHS National Institute for Health Research
Clinical Research Network

Effective Community Engagement Training

West Yorkshire Comprehensive Local Research Network (WYCLRN) are working with Black Health Initiative to provide effective community engagement training for health professionals who work with members of the public from the multicultural and diverse region of West Yorkshire.

Aims

- To progress the delegate from Cultural Awareness to Cultural Competence
- To build confidence within those providing a 'face to face' service with service users
- To build understanding amongst policy makers and strategic planners on deliberate inclusion rather than incidental exclusion

Expected Learning Outcomes

- Explore and understand own Attitudes and Values
- Understand impact of personal Attitudes and Values on others
- Acknowledgement of 'One Size Doesn't Fit All'
- Valuing Diversity as a Cost Effective element of Service Provision
- Exploring Individual and NHS Cultural thought processes

This 1 day course is being held on the following dates:

- **Wednesday 5th December 2012**
- **Wednesday 16th January 2013**
- **Wednesday 6th March 2013**

All dates to be held at the BHI offices, 231-235 Chapeltown Road, Leeds, LS7 3DX. **web: www.blackhealthinitiative.org** To book a place, please contact Nicola Mason at **n.mason@wyclrn.org.uk**

Attributing the costs of
health & social care research & development

A seminar on 'Attributing the costs of health and social care research and development '(AcoRD) was held in Thackray Medical Museum on Monday 8th October.

Trudi Simmons, Senior Manager from the Department of Health Research and Development Directorate opened the seminar with a presentation on the new guidance which was published in May 2012. She started by explaining the reasons for the change to the guidance and provided an update on its implementation in the UK.

AcoRD replaces Attributing revenue costs of externally funded non-commercial research in the NHS (ARCO).The main difference between AcoRD and ARCO is that the Department of Health will meet some research costs for charity-funded research taking place in the NHS, where the research grant funder is a member of the Association of Medical Research Charities (AMRC).

The AcoRD guidance clarifies the distinction between the three categories of costs associated with non-commercial research studies.

They are:

- Research Costs
- NHS Support Costs
- NHS Treatment Costs.

Research Costs are the costs of the R&D itself that stop when the research ends. Research Costs are met by grant funders through the award of a research grant except for PART B costs if funder is an AMRC member. DH will meet PART B costs mainly via Research Capability funding (RCF) and Networks

NHS Support Costs are the additional patient care costs associated with the research, which would end once the R&D activity in question had stopped, even if the patient care involved continued to be provided.

NHS Treatment Costs are the patient care costs which would continue to be incurred if the patient care service in question continued to be provided after the R&D study had stopped.

Excess Treatment Costs are the difference between the cost of usual care and the cost of the treatment provided as part of the study. It is important to remember that sometimes there are treatment savings rather than excess treatment costs.

AcoRD focuses on **why** an activity takes place rather than where or by whom i.e. the focus is on the primary purpose of an activity.
Annex A provides an exemplar set of common activities that have been attributed to the three specific cost categories and Annex B provides a list of Frequently Asked Questions (FAQs). These Annexes will be updated online on a regular basis and users need to ensure that they refer to the latest version when attributing the costs of research.

This was followed by a case study presented by Dr Sue Pavitt, Leeds Institute of Health Sciences, on identifying the different types of cost when developing a grant application. The importance of identifying the costs was illustrated and examples were given from a real-life grant application.

A discussion panel took place for the final part of the afternoon. The panel was made up of R&D managers, CLRN staff and researchers. This session allowed attendees to pose specific questions to the panel which resulted in some interesting debate.

Please note:
AcoRD applies to new grant applications submitted after 1 October 2012

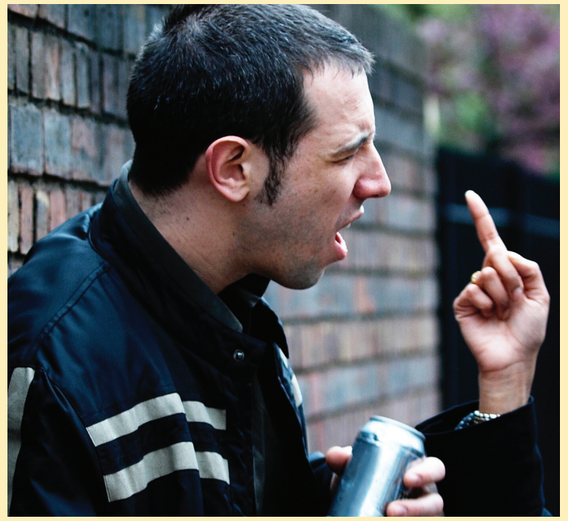
- AcoRD will not be applied retrospectively to studies funded before 1 October 2012

The AcoRD guidance can be accessed from the DH website at the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133882

Mental Illness among Victims of Homicide
Demographic, clinical and criminological characteristics of victims

A study to investigate the prevalence of mental illness among victims of homicide and the demographic, clinical and criminolgoical characteristics of victims

Background
Most research on mental illness and homicide focuses on the perpetrators of the offence. However, studies have shown that people with mental illness are more likely to become the victims of violent crime and crime in general. Relatively little research has been undertaken to examine the characteristics of individuals with mental ill health who die by homicide. Previous research has indicated that the risk of being a victim of homicide is between three and six times higher for people with a mental illness (Dembling et al, 1999; Hiroech et al. 2001; stark et al. 2003) than the general population.



Objectives of the study
The study objectives were to

- Estimate the rate of mental illness among victims of homicide
- Describe the demographic, offence and clinical characteristics of victims of homicide with a history of contact with mental health services (described as patients)
- Establish the proportion of the patients killed by other mental health service users

Methods
Data collection had for stages: (i) the collection of a national sample of homicide offences; (ii) the identification of those victims where a conviction for homicide was recorded; (iii) the identification of the victims with a history of contact with mental health services in the 12 months prior to their death (i.e. were patients); (iv) and within this latter group the collection of clinical data.

Over a 3-year period (January 2003 – December 2005):

- 1,496 victims of homicide were identified
- Clinical data about those victims in contact with mental health services were obtained via questionnaires sent to the clinicians and nursing tams responsible for the victims care
- In all, 58 NHS Trusts in England and Wales, and 2 Regional Secure Units, provided data

The study was successful in achieving its objectives, the response rate from clinicians was high (84%) and the extent to which questionnaires were completed and the quality of this data was good.

Main Findings
The main findings of the study summarised below:

- Six percent of victims of homicide (90/1496) were identified as having had contact with mental health services in the 12 months prior to their death (i.e. were patients)
- These patients were two and a half times more likely to die by homicide than the general population
- The majority of patients were male (56, 62%) with a median age of 36 (14,91). Over half (40,51%) were killed by an acquaintance
- Similar proportions of patients had diagnosis of schizophrenia (17,19%, affective disorder (17,19%), and drug dependence (17,19%). A quarter (22,25%) had dual diagnosis (severe mental illness and alcohol and/or drug misuse and/or dependence)
- Over half (48, 53%) had previously been admitted to in-patient care
- A third (29, 32%) of patients were killed by another mental health service user. In half (13, 50%) of these cases the patient was killed by a spouse, partner or family member.

Conclusions
Approximately 30 patients of mental health services die by homicide per year. The study's findings suggest there should be more awareness of the vulnerability of mentally ill patients, especially if they are known to associate, be in a relationship, or have a family member with mental illness.

Professor Jenny Shaw
C/O Alyson Williams email: Alyson.williams@manchester.ac.uk

Welcome
to our new research staff

Aishia Perkis

I am Aishia Perkis, a new Research Assistant with the Research and Innovation Team. I am part of a team across the North of England working on the Electro-convulsive Therapy (ECT) and Ketamine Study, which is looking to improve outcomes for those with Major Depressive Disorder.

I have worked in Mental Health for the last four years, and I graduated from the University of Leeds last year with an MSc in Memory and its Disorders. My dissertation was an experiment that looked in to sex differences in cognitive functions. I have worked in a variety of roles with adults with severe and enduring mental health problems in Calderdale. I have also just finished working as an Intern in the Neuropsychology section of the Health and Clinical Psychology Department at St James' Hospital. It was here that I looked at the outcome measures used in psychotherapy for people with neurological conditions.

Aishia Perkis:
0113 2952433 Email: aishiaperkis@nhs.net

Vishal Sharma

I am Vishal Sharma, a new Research Assistant within the Research and Innovation Team. As part of my role I will be contributing to a number of studies, such as studies looking into the role of environmental and genetic factors in the development of schizophrenia and bipolar disorder. Additionally I hope to promote further research into mental health and increase participant recruitment across existing studies.

I initially graduated from the University of Nottingham with a BSc in Computer Science and Management Studies. After a few years in industry I realised I wanted to develop my interest in psychology and mental health, and worked towards an MSc in Psychology from Sheffield Hallam University, where my dissertation focused on the social and environmental contributors to the increasing numbers of overweight and obese individuals. I have taken forward knowledge from my MSc and personal interest in health and exercise to lead a team exercise initiative to promote health and wellbeing as well as encouraging the team to take regular breaks.

Vishal Sharma
Tel: 0113 295 4544 E-mail: vsharma2@nhs.net

Kyla Pennington

My background is academic neuroscience research where I spent 7 years investigating the pathophysiology of psychiatric and neurological disorders. Having graduated in Neuroscience at Glasgow University in 2001 my dissertation evaluating the evidence base for the efficacy of Gingko biloba in the treatment of Alzheimer's disease inspired me to continue further in research. I successfully completed a PhD in 2006 graduating from the Institute of Psychiatry after investigating the neuropathology and biochemistry of schizophrenia. Although this and subsequent post-doctoral work was incredibly rewarding I decided I wanted to place my neuroscience knowledge in the context of the whole person and wider society. Consequently, I returned to education and completed a Psychology diploma at York St John University. My dissertation investigated issues associated with the stigma of mental illness and more specifically how familiarity with schizophrenia influences certain beliefs about its causation.

I worked as a voluntary assistant psychologist in a neuropsychology department and chronic pain clinic in York from September 2011 and carried out an internship project at Parkside Lodge in LYPFT. Since January 2012 I have worked as a research assistant on the START (Systemic Therapy for At Risk Teens) trial where I conducted follow-up interviews with families and managed the Leeds site. More recently, I have begun working on the schizophrenia cognition and genetics study and will be involved in screening caseloads, recruiting participants and conducting interviews. I am looking forward to this new role and the opportunity it will provide to learn more about psychiatric disorders in this clinical research context.

Kyla Pennington
email: kyla.pennington@nhs.net

Emma Fleming

I had a degree in Philosophy and Theology but developed an interest in Psychology and began to study with the Open University. I graduated with a BSc in Psychology in 2005 and worked as a Support Worker in a low secure hospital for women, which gave me practical insight into the challenges faced by those with chronic mental health issues and motivated me to pursue a career in Psychology. In 2008 I completed a Masters in Psychological Research (MRes) at York University and joined the Trust as an Assistant Psychologist in the Learning Disabilities service, based as St. Mary's Hospital and Parkside Lodge. This showed me the varied and challenging work that NHS psychologists are involved with and the pressures on the NHS in general. I then worked as an Assistant for a private Educational Psychologist for 6 months before returning to LYPFT in 2011 to work as a Data Quality Officer at Trust HQ, which gave me some insight into the more 'corporate' workings of the NHS.

I joined the Research team in May 2012 and a large part of my job is to try to increase staff and service user involvement in studies. I am mainly working on the OASIS (Observational Assessment of Safety in Seroquel see pages 12 and 13), AMICUS (Amisulpride augmentation in clozapine-unresponsive schizophrenia) and ASC (The association between autism spectrum conditions (ASCs) and psychosis: investigating the importance of chromosome 15 at q11-13) studies, each of which are showing me a different aspect of research; from staff engagement and recruitment to screening caseloads and interviewing participants.

Emma Fleming
e.fleming2@nhs.net

Jules Beresford-Dent

I am Jules Beresford-Dent and I work as part of the Research and Innovation team as Evaluation Project Manager (Transformation). My post is funded by Leeds York and Bradford CLAHRC (Collaboration for Leadership in Applied Health Research and Care).

I have worked in the NHS since 2001 in a variety of business planning and project management roles primarily in mental health and substance misuse services.

My academic background is in Sociology and Social Policy and I graduated from The University of Leeds with BA (Hons) in Sociology and Social Policy and from the University of York with a MA in Social Policy. I am currently working towards a MSc in Health Research.

As Evaluation Project Manager for Transformation, I will be working closely with colleagues in the Trust and academic colleagues from the University of York and the University of Leeds to co-ordinate all aspects of the Evaluation and I look forward to working with staff, service users and carers in the course of my work over the next 18 months

Jules Beresford-Dent
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R & I

Leeds and York Partnership NHS
NHS Foundation Trust

Research forum

Weetwood Hall, Wednesday 21 November 2012
Commencing at 9.00 am until 4.30 pm

PROGRAMME

09.00 Welcome Coffee and registration
09.30 Opening Remarks Jim Isherwood, Consultant Forensic Psychiatrist & Medical Director
09.40 CAMHS Lime Trees Barry Wright, Consultant Child Psychiatrist
10.25 University of Leeds Alistair Cardno, Senior Lecturer in Psychiatry
11.10 *Morning coffee*
11.30 Leeds Addictions Unit Sarah Thurgood
11.50 Yorkshire Centre for Eating Disorders Saeideh Saeidi
12.10 NSCAP Elisabeth Edginton
12.30 *Lunch*
13.30 Cutting Edge Genetics Research Tariq Mahmood, Consultant Psychiatrist Consanguinity Multiplex and Schizophrenia – The Royal Road to Genes of Major Effect
14.15 Community treatment orders and psychiatric hospitalisation Lackson Mzizi
14.30 Staff Well Being & Reflective Practice Groups Pauline McAvoy
14.45 *Afternoon tea*
15.00 NIHR Portfolio Research Tom Hughes, Consultant Psychiatrist
15.45 NIHR Research Design Service for Yorkshire and the Humber Maureen Twiddy, Research Fellow: Applied Health Research
16.00 Patient and Public Involvement Isla Dowd, Patient and Public Involvement Development Officer
16.15 Closing Remarks and Prizes Jim Isherwood

NHS National Institute for Health Research
Clinical Research Network

Leeds and York Partnership NHS
NHS Foundation Trust

Clinical Research Network
Training & Events

Good Clinical Practice (GCP) Training

Introduction to GCP
Monday 10th December 2012
Huddersfield Royal Infirmary

GCP Refresher Course
Tuesday 4 December 2012, 9:30-12.30
Annex, 34 Hyde Terrace, Leeds, LS2 9LN

Wednesday 12 December 2012
Bradford Royal Infirmary

Essential Project Management Skills in Clinical Research
This is a one day course aimed at research nurses and allied health professionals who are working proficiently in clinical trials and want to develop their skills in project management.

Monday 5th November 2012
The Eurich Room, Bradford Royal Infirmary

Monday 4th February 2013
The Eurich Room, Bradford Royal Infirmary

See back cover for details of how to book on these and other NIHR funding training course

Commercial Research: A Masterclass
An interactive workshop designed to help researchers improve collaboration with pharma companies, identify strategies to acheive successful site selection and improve delivery of commercial research.

Thursday 31 January 2013, 9:00 - 13:00,
Fairburn House, Leeds

Wednesday 20 February 2013, 9:00 - 13:00,
Fairburn House, Leeds

Monday 25 March 2013, 9:00 - 13:00,
Fairburn House, Leeds
Please contact e.k.giddings@wyclrn.org.uk to book a place.

Informed Consent Workshop
A course for those currently working on, or with experience of, clinical trials who will be obtaining informed consent from study participants.

Thursday 7 March 2013,
Garland Gallery, Leeds General Infirmary

Monday 29 July 2013,
The Eurich Room, Bradford Royal Infirmary

Monday 2 September 2013,
Garland Gallery, Leeds General Infirmary

To book a place please email l.pryer@wyclrn.org.uk

Adverse Event Reporting
This course defines the responsibilities of the investigator and sponsor with reference to UK regulations.

Monday 17 December 2012, Huddersfield Royal Infirmary
To book a place please contact sarah.clayton@leedsth.nhs.uk

Essential Documents
This course will allow delegates to develop a greater awareness of the scope and variety of essential documents.

Monday 17 December 2012, Huddersfield Royal Infirmary
To book a place please contact sarah.clayton@leedsth.nhs.uk

CLAHRC Events
The NIHR CLAHRC for Leeds, York and Bradford is now offering a series of outstanding, free, research training opportunities to all NHS staff (clinicians and managers) in Y&H and supported by the SHA and NIHR. Details are at; www.clahrc-lyb.nihr.ac.uk/events All are encouraged to review these outstanding training programmes and register.

Completed Research Projects

The PCI Study

Personal Concerns Inventory (the PCI)

A pilot study of a goal-based motivational interview called the Personal Concerns Inventory (the PCI) to reduce dropouts in a personality disorder treatment service

Main Findings

- **Recruitment to the study was below target**
- **Assessments were conducted on fewer people than we aimed for**
- **Most people found the motivational interview to be useful**
- **The motivational interview appears to help people to clarify what they want out of therapy**
- **The motivational interview appears to help people to engage in therapy**
- **A full-scale evaluation would be worthwhile**

Background

Non-completion of treatment is an important problem in personality disorder (PD) treatment services, with, on average, 37% of those starting therapies not completing their treatment. Non-completion of treatment is associated with poorer clinical outcomes, such as being hospitalised more frequently and spending more days in hospital. Efforts, therefore, need to be made to engage people with PD in therapy.

One promising approach is based upon goal theory. An individual's personal goals are what give purpose, structure and meaning to a person's life. Clarification of a person's valued goals, identification of the obstacles standing in the way of goal attainment, and drawing attention to how therapy might help overcome those obstacles may motivate people to engage with therapies.

Aim

We used an interview called the Personal Concerns Inventory (PCI) to improve treatment engagement. To prepare for evaluation in a randomized controlled trial, we conducted a pilot study in a PD treatment service to see how well we could recruit people to the study and collect follow-up information.

Participants and Recruitment

The research was conducted in Nottinghamshire Healthcare NHS Trust's Personality Disorder (PD) Network, an outpatient service for people with PD. We aimed to recruit 100 participants over 1½ years. People who were accepted for psychological treatment and who agreed to participate were randomised to receive either the PCI interview plus treatment as usual or treatment as usual only.

Targets

Our target sample size was 100. We set criteria by which we would consider a full randomised controlled evaluation to be feasible. These were: (1) a recruitment rate of 54% of all referrals, (2) 80% of clients finding the intervention useful, and (3) 80% of assessments completed. We collected information on the clarity of individuals' therapy goals pre-treatment, attendance at therapy sessions, and engagement during treatment. The views of clients were collected using semi-structured interviews.

Intervention

The PCI interview lasts approximately 1½ hours and asks participants to identify their goals in life areas such as relationships, work, home, and health. Participants were then asked to identify obstacles to goal attainment and consider the possibility that therapy could help them overcome these obstacles. This was intended to enhance participants' motivation to engage in therapy.

Assessments

1 - A Pre-Intervention Interview was conducted prior to the start of therapy. The purpose was to assess the goals that they expected therapy to help them achieve.

2 - Attendance records were kept for group therapy sessions.

3 - The Treatment Engagement Rating Scale was completed by therapists for each participant at the end of group therapy. This scale focuses on participation, openness, and efforts to change.

4 - A Post-Intervention Interview was conducted with participants in the PCI group asking for their views on the acceptability and usefulness of the PCI.

Results

1 - Recruitment

We recruited 28% of referrals, which is below the 54% we hoped to recruit. Of the 76 recruits, 38 were randomised to receive the PCI interview and 38 to treatment as usual.

2 - Acceptability to Service Users

We hoped that 80% of clients would find the intervention useful. Of the 38 who did the PCI, we analysed 12 interviews and found that 8 (67%) were positive about the PCI. This falls somewhat short of the 80% target that we set. Eleven participants were asked to rate the usefulness of the interview on a scale of 0 (not at all useful) to 10 (very useful indeed), and the average score was 8 out of 10.

3- Pre-Intervention Goals.

Pre-intervention interviews were conducted with 23 (61%) of the PCI group and 28 (74%) of the treatment-as-usual group. Again, this falls short of our target of 80%. The treatment goals generated by participants were rated for clarity on a scale of 0 (not at all clear) to 10 (clear and specific). The PCI group got a better score than the treatment-as-usual group (an average of 7 for the PCI group and 3 for the treatment-as-usual group). This difference suggests that the PCI interview was helpful in clarifying treatment goals.

4 - Session Attendance

Over 12 weeks, the PCI group attended 73% of sessions offered, whereas the treatment-as-usual group attended 60%. This difference suggests that the PCI interview was helpful in improving treatment engagement.

5 - Treatment Engagement Rating Scale.

Of eligible participants at follow-up, 40 of 59 (68%) completed the TER — 19 of 29 (66%) in the PCI group and 21 of 30 (70%) in the treatment-as-usual group. This again falls short of the target of 80%. However, the mean TER score for the PCI group was higher than that for the treatment-as-usual group (3.35 compared with 2.83). Again, this difference suggests that the PCI interview was helpful in improving treatment engagement.

6 - Costs of Treatment

The PCI took an average of 1½ hours to complete. A face-to-face assessment by a member of a specialist outpatient team costs £145.

7 - Views of Service Users

The views of 13 service users were collected using semi-structured interviews. Four themes were identified.

- **The PCI Had Specific Benefits.** Participants reported that the PCI interview 'got them thinking'. Specifically, it helped clarify goals. For example, one person said: "It was quite informative actually because I hadn't thought about setting myself any goals before it."

- **The PCI had General Benefits.** The interview also had a more general beneficial effect of preparing people for therapy. It was seen as helpful for familiarising individuals with the location where therapy would take place. For example, one person said: "Just coming into the centre beforehand helped as familiar with the centre then and met members of staff." The individual interview was also appreciated as raising confidence for participation in subsequent group work. For example, one person said: It was nice to have that one-to-one time. It was a chance to get everything out of my mind before starting. It felt like a safe place as not in a group situation. It gave me more confidence to come into the group and talk about things I've never discussed before."

- **Interviewer Characteristics.** Many participants expressed appreciation of the interviewer's interpersonal style and skills. For example, one person said: " [The interviewer] was really positive. She wasn't forceful but managed to get over what she wanted me to do. She was very supportive to me and had a lovely tone. [She] talked to me properly …not like a child like most people do…. I wish other people in mental health field were more like her then we might all be better."

- **Other Problems or Concerns.** In some cases, other problems or other concerns were more pressing and the PCI was either seen negatively or not remembered. For example, one person said: "I did find it very useful but my health got in the way of me going so I had to drop out."

Discussion

Overall, the study fell short of its targets for recruitment and follow-up measures. Reasons for the shortfall were mainly uncontrollable changes to the service in which recruitment took place. Over the 32 months of this project, there were changes to the treatments provided; a freeze on staff recruitment; withdrawal of services in some localities; a freeze on referrals to the service; long waiting times for service users to get into group treatment; and withdrawal of clinicians' time to conduct the PCI. The research was conducted in a turbulent service and this no doubt had an impact on recruitment. Nonetheless, most service users who were in a position to report their experiences found the PCI to be useful. Opinions revealed that the PCI benefited engagement both by helping people to clarify important personal goals that therapy could help them attain, and through more general processes, such as familiarising people with the venue and people providing therapy services. Importantly, there was suggestion of a positive impact of the PCI on improving the clarity of therapy goals, treatment attendance, and treatment engagement. At a cost of only £145 per session, a full-scale evaluation of the PCI as pre-therapy preparation seems well worth pursuing. The study was funded by the National Institute of Health Research, Research for Patient Benefit Programme. All aspects of the study were subject to ethical approval.

The research team: Professor Mary McMurran, Professor Miles Cox, Diane Whitham, Lucy Hedges

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The rate of Post Psychotic depression in two Early Intervention Services: Service and clinical implications

Authors: Gupta, A[1]., Morton, A[2]., Wood, S[3]., Floris, J[4]., Iqbal, Z[5]

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South Essex Partnership University NHS Foundation Trust[2] (SEPT)
University of Leeds[3]
University of Essex[4]
Navigo Health[5] and Social Care CIC

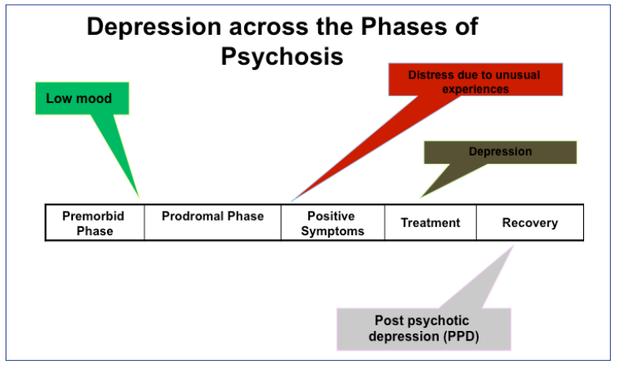
Introduction

Depression is common in individuals experiencing psychosis and can occur at any phase: premorbid, prodromal or acute phase (Upthegrove et al., 2009). Depression occurring after the acute phase, when positive signs have abated, has been associated with poorer outcomes, increased relapse rates, loss of functioning, loss of roles in life and increased risk of suicide (Bartels & Drake, 1988, Rooke & Birchwood, 1998, Birchwood et al., 2000, Iqbal et al., 2000, 2004, Addington et al., 1998). The experience of depression in the recovery phase is known as secondary or post psychotic depression (PPD) (McGlashan & Carpenter, 1976, Iqbal et al. 2000, 2004). Figure 1 depicts the experience of depression across the phases of psychosis

PPD can remain unidentified perhaps because it can be masked by side effects of medication or by negative symptoms (Iqbal et al, 2000). There is no agreed consensus on the definition of PPD and reported prevalence rates vary from 13.3% to 50% (Baynes et al., 2000; Birchwood et al, 2000, Lancon et al, 2001)

It has been suggested that PPD is an emotional reaction to the experience of psychosis (Birchwood, 2003): demoralisation resulting from an uncontrollable life event (Jackson & Iqbal, 2000). Once an individual reconnects to an external reality, after recovery, a re evaluation of life and goals occurs which may result in negative appraisals of the experience of psychosis leading to loss, humiliation and entrapment, low self - esteem and perceived loss of status (Iqbal et al, 2000, Birchwood et al, 2005). Individuals who find it difficult to integrate the experience of psychosis and, therefore, struggle with the negative impact on their social identity or who have poor personal resilience may be more likely to develop negative appraisals about psychosis, to "seal over" to protect themselves from negative self - beliefs and, therefore, be more vulnerable to developing PPD (Tait et al, 2004).

Alternatively, individuals may experience an increase in self - esteem in the acute phase, perhaps due to unusual experiences like voice hearing, which recedes during the recovery phase (Iqbal et al, in draft) resulting in depression. Psychological interventions that address negative appraisals of psychosis and support an integrative recovery style by developing personal resilience may be effective in treating PPD, improving outcomes and reducing the risk of relapse



Aim of audit

- To determine the prevalence PPD in two EI services.
- To provide a population specific estimation of the proportion of service users who could be expected to experience PPD.

In addition to the above aims aspire also explored the relationship between recovery style, PPD and insight, while South Essex EI service looked at gender differences in PPD.

Service descriptions

aspire is a specialist city wide EI service consisting of 4 teams covering a multi - cultural and urban area. The service is managed by a third sector organisation: Community Links and is the only EI service, nationally that has been directly commissioned from a voluntary organisation.

South Essex EI is a specialist community service within a NHS statutory service consisting of 3 teams covering the areas of Bedfordshire, Essex and Luton.

In this study PPD was defined as "at least moderate depression" occurring in the recovery phase of psychosis (Birchwood et al, 2005).

Ethical approval was given by Leeds East NHS Ethics, LYPFT research governance committee, SEPT Research governance steering group and University of Essex Ethics committee.

Measures

- Calgary Depression Scale for Schizophrenia (CDSS) – Addington et al, 1993
- Beck Depression Inventory - Second edition (BDI-II) – Beck et al, 1996 aspire site only:
- Service users' recovery style (Clinician rated) – McGlashan, 1987
- Insight Scale - Birchwood at al, 1994

Inclusion criteria:

- Age group – 14 – 35 (In South Essex EI criteria was for over 18 years old)
- To be on caseload as experiencing a first episode of psychosis
- To be in stable recovery for a minimum of 4 – 6 months (to ensure

Depression was identified by a score of 20 or more on the BDI-II and 7 or more on the CDSS.

Results

1. Participants

Table 1 shows the number of participants meeting inclusion criteria who consented to take part in the study.

Service	Total number of participants	Percentage of total caseload	Percentage of those meeting inclusion criteria
aspire	25	10.5%	17.1%
South Essex	23	15.1%	29%

Table 1 (above): Number of participants in study and percentage of service caseload

Table 2 (below): presents gender and age characteristics for samples

		aspire participants	South Essex participants
Gender	Female : male ratio	1 : 2.1	1:2.5
Age (mean)		23.7	26.4
Standard deviation		4.7	6.8
Range		15 - 37	19 - 45

2. Prevalence rates of PPD

Similar prevalence rates of 44% (aspire) and 47.8% (South Essex) for PPD were found in the sample population, which matches current literature, using BDI-II. The confidence intervals around the aspire proportion are 0.27 and 0.63, indicating that on the basis of these findings, one would expect the true rate of PPD to fall between 27 and 63%.
Gender differences were found using BDI-II indicating a significant difference, with men reporting more depression than women ($\chi 2 = 7.99$, $p < 0.01$). No relationship was found between PPD, recovery style and insight.

Discussion

Prevalence rates of 44% and 47.8% were found in aspire and South Essex EI, respectively, with an expectation that the rate of PPD would fall between 27 and 63%.

These findings suggest that PPD is a significant problem for a large proportion of service users after a first episode of psychosis (FEP) with implications for low mood, suicide risk, overall recovery and the need for PPD specific psychological interventions. PPD emerges in the recovery phase which may be the time that services may be otherwise reducing contact with service users. The successful identification of PPD will enable clinicians to offer appropriate treatments to these individuals.

The BDI-II (but not the CDSS) identifies significant gender differences with men reporting more depression, though women were more likely to be already taking anti - depressant medication.

Recommendations

Based upon the outcome of this study the following recommendations are made:

- To raise awareness of the psychological understanding and implications of PPD
- To routinely screen for PPD for service users emerging from the acute phase of a FEP, especially men
- All staff to be trained in the administration of the CDSS and BDI-II
- To provide appropriate psychological treatment focussing on the specific appraisals and psychological consequences of psychosis that may underlie this phase of depression.

Selected References

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Leeds and York Partnership NHS
NHS Foundation Trust

A Service Evaluation
of Reflective Practice Groups and Staff Wellbeing

Rationale

Reflective Practice Groups (RPG) have been running on the acute in-patient wards within Leeds PFT for over five years. Although there is a lot of descriptive literature about reflective practice and it is widely encouraged in policy (e.g. DoH 2002) there has been little evaluation of the outcomes of groups for staff. This summaries the findings of a Service Evaluation Project Commissioned by Dr James Johnson, and undertaken by Pauline McAvoy as part of the Doctorate in Clinical Psychology.

Methodology

One-hundred and fifty staff from the acute adult inpatient wards were issued with standardised measures of well being and burn out (GHQ-28, Goldberg & Hillier, 1978, <BI-HSS, Maslach & Jackson, 1986) and a survey about their experiences of reflective practice groups. 37% of the surveys were returned. 90% of respondents had attended at least one group and ward managers felt this was representative of the staff group.

Key Findings

The study was not able to draw conclusions about impact of reflective practice groups on staff well-being as measured by the GHQ-28 and the MBI-HSS. The levels of stress and burnout in this sample are similar to those found by previous studies using the same measures with ward based mental health professionals. There was a trend in this sample towards lower depersonalisation of clients.

While there were high levels of agreement that attending groups increased awareness of emotions raised at work, both for participants and for colleagues, respondents were least likely to say that they were better able to manage their stress as a result of attending groups. This may reflect the multi-dimensional nature of stressors encountered by staff which extends beyond issues discussed within reflective practice groups. For the most part, respondents placed high value on reflective practice groups. The staff who responded enjoyed the opportunity to have time out and think together as a team. Identified benefits such as Managing Feelings, Solving Problems and Quality Assessment are similar to functional models of clinical supervision (e.g. Hawkins & Shohet, 2006).

Further Information

For further information contact Pauline McAvoy at umpm@leeds.ac.uk. A copy of the full report is available from the Research and Innovation Department of Leeds and York Partnership NHS Foundation Trust or via the University of Leeds Doctorate in Clinical Psychology site.

Our new Research Governance Manager
Sinead Audsley

Sinead Audsley joined the team as Research Governance Manager at the beginning of September, having previously worked for two years as a Research Ethics Co-ordinator for the National Research Ethics Service. She moved to Leeds from Ireland in September 2001 to study for a Masters in Applied Translation at the University of Leeds having completed her degree in Spanish and Greek & Roman Civilisation at University College Dublin.

Sinead worked for the Department of Health from 2003 to 2008; during this time she co-ordinated the National Institute of Health Research Physical Environment Research Programme which funded studies into the built environment and its effect on patient care. She took a career break in 2008 and went travelling for 12 months, the majority of which was spent in South America. She has also worked in other areas of the NHS including the Yorkshire and Humber Strategic Health Authority and the NHS Information Centre for Health and Social Care.

Sinead's aim is to be a source of important support to all those undertaking research activity within the Trust and to ensure that the sometimes complex process of gaining approval is as smooth as possible.

Sinead Audsley email: Sinead.audsley@nhs.net

Calderdale and Huddersfield NHS
NHS Foundation Trust

Developing Research Proposals for Funding – One Day Workshop

Date: Monday 14th January 2013
Time: 9.45am - 4.30pm
Venue: Conference Room, Bradford District Care Trust, New Mill, Victoria Road, Saltaire BD18 3LD

A one day training course designed to enable participants to turn an idea for research into a viable question. It introduces the principles of research and guidance on what makes a successful bid for funding. It will also give information on the funding streams available within the new National Institute of Health Research. With emphasis on group work and guided learning, participants will have the opportunity to work on their own research ideas, and by the end of the day they will have an introduction to resources available to turn into a funded proposal.

Course Overview:

- **Introduce participants in how to formulate proposals through critical thinking and design a valid research question**
- **Introduce aspects of research design, resourcing and management for a research proposal**
- **Look at how to prepare a proposal for funding**
- **Identify available resources and funding streams**
- **Introduce key principles of ethics and research governance.**

For more information please contact the course leader Asifa Ali or Leslie Argyle on **01484 347007** To reserve a place contact Leslie Argyle at **lesley.argyle@cht.nhs.uk**

Attendance is free to all staff within Yorkshire & the Humber SHA organisations.

Leeds and York Partnership NHS
NHS Foundation Trust

Finding the Evidence Training Dates

Courses free to Leeds NHS staff

Please contact the LGI library on 0113 3926445 for more information. Full details and booking forms can be found on the training calendar at: http://www.libraries.leeds.nhs.uk/Training

November				
05/11/2012	Monday	9.30-11.30	Cochrane Library	Bexley IT Suite
14/11/2012	Wednesday	9.30-12.00	Healthcare Databases	LGI
15/11/2012	Thursday	10.00-11.30	Google	Bexley IT Suite
22/11/2012	Thursday	14.00-16.00	Critical Appraisal	Mtg Rm1, LYPFT Trust HQ
22/11/2012	Thursday	9.30-12.00	Healthcare Databases	St Mary's Hospital, RIO Training Room
22/11/2012	Thursday	13.00-15.00	Cochrane Library	St Mary's Hospital, RIO Training Room
27/11/2012	Tuesday	9.30-10.30	E-journals	IT Suite, Mount Annexe
27/11/2012	Tuesday	9.30-10.30	E-journals	IT Suite, Mount Annexe
December				
03/12/12	Monday	9.30-12.00	Healthcare Databases	St Mary's Hospital, RIO Training Room
03/12/12	Monday	13.00-15.00	Cochrane Library	St Mary's Hospital, RIO Training Room
07/12/12	Friday	10.00-12.00	Critical Appraisal	Seminar Room, Mount Annexe
11/12/12	Tuesday	9.30-12.00	Healthcare Databases	IT Suite, Mount Annexe
12/12/12	Wednesday	13.00-14.30	Current Awareness	Bexley IT Suite
12/12/12	Wednesday	10.00-11.00	E-journals	North West House
13/12/12	Thursday	9.30-10.30	Introduction to Athens	IT Suite, Mount Annexe
14/12/12	Friday	10.00-12.00	Cochrane Library	LGI Library
18/12/12	Tuesday	14.00-15.00	E-journals	Mtg Rm1, LYPFT Trust HQ

Cochrane Library Training - This course focuses on the skills required to search the Cochrane Library effectively to retrieve high quality evidence to support work and study.

Critical Appraisal - This course focuses on why it is important to appraise journal articles, how to go about doing this, and how to obtain further help.

Current Awareness - Aimed at all Leeds NHS staff who wish to set up and use email and RSS alerts and feeds to support their practice or professional development.

E-Journals & E-books - Aimed at all Leeds NHS staff who wish to use e-journals and e-books to support their practice or professional development.

Google Training - Aimed at all Leeds NHS staff who wish to gain skills in searching Google for information to support their work,practice or professional development.

Healthcare Databases - This course focuses on searching healthcare databases

Contact us
Research and Innovation

Innovation is a newsletter for sharing and learning about research. This includes information about projects being carried out in your area. As such we welcome any articles or suggestions for future editions.

For more information please contact:

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