



Innovation

Research and Development Newsletter



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Welcome to the winter edition of Innovation

Our eleventh Annual Research Event, held on Thursday 9 November, was a great opportunity to celebrate projects that have improved the care our service users receive and our understanding of how well our services are working. It was an inspiring day, which was opened by Chair of the Trust Board, Professor Sue Proctor. Thank you to staff from the NHS, third sector and universities, along with service users and carers, who have played a vital part in enabling these projects to happen. You can read more about the event on pages 20 and 21.

A competition for the Forum's best conference poster was won by the team behind the introduction of a LEGO® therapy trial. The Trust was awarded almost £1 million for the trial, which is being led by Professor Barry Wright. Find out more about the trial on page 13 and at www.comic.org.uk/research/lego.

The completed projects featured this quarter cover a broad range of clinical specialties and services, including:

- Development within times of austerity
- The use of harm minimisation approaches within a women's low secure mental health service
- Oxford Specialist Handbook of Medical Psychotherapy
- Amisulpride augmentation in clozapine-unresponsive schizophrenia (AMICUS)
- Evaluation of a group to treat low self esteem
- The physical activity environment and access to food on low secure units in England
- Shared decision-making between people with psychosis and mental health staff
- Mobilising knowledge across health and social care boundaries
- STEPWISE

We're also featuring a clutch of projects from Leeds Autism Diagnostics Service:

- How useful are the Adult Asperger Assessment and AQ-10?
- The association between ADI-R scores and clinical diagnosis of Autism
- No exclusions – developing an autism diagnostic service for adults
- Are we good and are we safe?

In this edition of Innovation, you will also find library training dates and NIHR funding opportunities.

If you have any feedback about Innovation or would like to visit the Research and Development Department and find out more about what we do, please contact:

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Articles about recently completed research projects are marked with this symbol.



Development within times of austerit

The Leeds City Wide Dialectical Behaviour Therapy (DBT) programme is a partnership between the Specialist and Learning Disability Care Group and Leeds Care Group. It began as a pilot from 1 April 2016 in response to clinical commissioners' requests that DBT skills training groups were made more widely available to the people in Leeds. This evaluation aimed to learn how group members have experienced the service and to measure clinical effectiveness.

What is Dialectical Behaviour Therapy (DBT)?

DBT aims to help people to learn new skills to help them cope when they feel suicidal or want to use self-harming or life threatening behaviours to manage distress. DBT recognises that people develop these methods of coping as a result of experiences in their lives that could be described as 'invalidating'. This may include abuse, neglect or other kinds of personal trauma.

Setting up of the pilot / introduction

DBT skills groups have been part of the Personality Disorder Managed Clinical Network (PDMCN) group work programme for eight years. Following the Commissioners requests, a series of meetings were held to establish how to provide more DBT skills training.

An option appraisal document informed discussion regarding model, governance and delivery for DBT skills as a stand-alone treatment. Key to the development of provision was clinical accountability, governance and leadership of the programme. A "hub and spoke" model of delivery was agreed, with a DBT skills training group to be located in each of the three Community Mental Health Teams (CMHTs), all supported by the DBT consultation meeting. No additional funding was defined for this pilot. The team comprises community mental health nurses, a social worker, psychotherapists, an occupational therapist, a service user consultant and an assistant psychologist. Governance and clinical management arrangements are held by the PDMCN.

The DBT groups are mixed gender and service users attend for nine, weekly, two and a half hour groups called modules. Four sets of skills are covered: mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. Each module is required to be completed twice over 14 months, to maximise efficacy.

Evaluation strategy

Clinical outcomes

Three outcome measures are used routinely and service users are asked to complete these at different time points of their engagement in the programme.

1. The Clinical Outcomes in Routine Evaluation

(CORE-OM) – is a 34-item self-report questionnaire used to assess global distress. It is

measured by four domains: wellbeing, symptoms, life functioning and risk to self and others.

2. The World Health Organisation Quality of Life Scale (WHOQOL-BREF) – is a measure of how a client perceives quality of life. It is represented

in four domains: physical, psychological, social relationships and environment.

3. The Borderline Evaluation of Severity over Time (BEST©) – is a self-report measure developed

to rate the thoughts, emotions and behaviours associated with 'Borderline Personality Disorder' (BPD).

Focus group / Satisfaction survey:

A focus group was initially planned to learn about group members' experiences of engaging in DBT. Whilst group members expressed an interest in this, no one was able to attend the meeting. Barriers to attendance were reported to be anxieties of a formal city centre location and childcare and work commitments. A satisfaction survey was developed to allow the opportunity for service users to share their experiences. The survey included questions in relation to staff support, impact of DBT on life, accessibility of groups, challenges, helpfulness/unhelpfulness of the group and general feedback on the DBT service.

Findings

Clinical Outcomes

Full sets of data for 11 service users were available for the CORE-OM and WHOQOL. The BEST© was introduced in March 2017 and as such, complete data for this measure is not currently available. Statistical analysis on the pre and post scores was performed and revealed a statistically significant improvement in the functioning domain (T-test, $p=.04$) of the CORE. The functioning domain refers to problem solving abilities and interpersonal functioning. Whilst only the functioning domain was statistically significant, mean scores across all domains showed improvements. Additionally six service users showed clinically reliable change on the CORE. The data from the WHOQOL revealed a statistically significant improvement in the psychological domain (T-test, $p=.01$). Mean scores on the physical and environment domains also showed improvements, although these were not statistically significant. The scores on the social domain did not show improvements.

Satisfaction survey:

The survey received a positive response rate of 65% from across the three groups. The quantitative data was analysed using descriptive statistics and content analysis was carried out on the responses to open questions using a six-step method of thematic analysis (Braun & Clarke, 2006). All of the service users who responded said that they would recommend DBT. Positive qualities of staff were described, including understanding and sensitive approach, warmth, positivity and clarity of teaching. Service users stated that they valued peer support and sharing experiences however some stated that being in a group can raise anxiety and make it difficult to open up. Whilst members described that the skills have been helpful, it was noted that these are difficult to put into practice. Key criticisms included uncertainty of level of staff support, limited amount of one-to-one time, lack of broad perspective on BPD and barriers to attending group (childcare and work commitments). A further feedback session took place with each group to discuss the survey findings. Service users found the overall survey process helpful, they felt listened to and that they were not alone in their experiences when compared to other group localities. However it was noted that increased clarity of level of support offered and expectations of the group is needed from the outset. Suggestions for additional training regarding diversity and gender were also made.

Discussion

The evaluation reflects some preliminary positive findings of clinical effectiveness of the group, including evidence of reliable clinical change for half of the participants. Statistically significant improvements were found in the functioning of service users and perceived psychological wellbeing. In addition, both positive experiences and challenges of engaging in the group were revealed across groups, which require consideration within the DBT team.

One of the main aims of the city wide DBT service was to improve access. A change from one to three groups inevitably increases access, however the 9am

to 5pm 'business' working hours continue to be limiting. The team are considering the potential for an evening group within the service and discussions around how this is accomplished are taking place. However this may require significant organisational change which incorporates flexible, accessible and available care-giving systems, to reflect the needs of service users experiencing personality difficulties.

Another criticism identified by service users was the limited amount of one-to-one time, to support application and generalisation of skill learning to personal situations. At present, individual mid-point reviews, end-point reviews and telephone skills support following non-attendance to groups is routinely provided. Whilst the full DBT

programme offers individual sessions, the adapted DBT skills groups do not offer this, however the team recognise this is an ongoing concern. Creative ways to generalise skills to the wider environment is continuously encouraged and explored within groups.

Whilst the above criticisms will inform further service development, the positive clinical findings of the evaluation reflect success of the pilot service. Furthermore in times of austerity and limited resources, effective partnership working between the Specialist and Learning Disabilities Care Group and Leeds Care Group has been

critical to the development of this service.

Limitations

There are limitations to this evaluation which should be considered. Whilst the clinical outcome data show positive improvements across the measures, these are based on a small sample of 11 people. A more robust sample with ongoing evaluation will allow for firmer conclusions to be made. In addition, whilst 65% response rate for the survey is promising, this does not reflect all of the service users who are engaging in DBT. Further focus groups are planned to take place in familiar group locations to improve accessibility and enable service user participation in feedback. Additionally those who may not feel comfortable coming to a focus group will be given alternate means to provide feedback (e.g. continued surveys).



Illustration by Tom Bailey



The use of harm minimisation approaches within a women's low secure mental health service

Background:

Traditionally, interventions for the treatment of self-harm have concentrated on preventative approaches or cessation. However these are not suitable or realistic for all people who repeatedly self-harm. In recent years, harm minimisation approaches have become accepted in the field of substance misuse, where they are now mainstream procedures. However, self-harm minimisation approaches are still regarded as marginal practices within inpatient mental health services, and generate anxiety for many practitioners and their organisations.

Aims

This qualitative study aimed to explore and understand staff views and perceptions on the use of harm minimisation approaches in the treatment of self-harm within a woman's low secure mental health service. This will provide a better understanding of the barriers to using these approaches with people where it might be beneficial.

Method

A phenomenological approach was used to guide the study methodology. Multi-professional staff were invited to attend one of two facilitated focus groups, which were audio-taped, and transcribed verbatim. The transcripts were analysed using interpretative phenomenological* analysis (IPA).

Discussion and findings

Through the process of IPA, three super ordinate themes were identified:

- reducing the damage from self-harm
- holistic approach towards self-harm
- barriers to implementation

These are discussed in depth, together with their related subthemes. Based upon the findings and interpretation of the data, a proposed 'Model for Harm Minimisation Approaches in Relation to Dynamic Risk Assessment' is presented along with 'Essential Features for Effective Harm Minimisation Practice'.

Conclusion

It was clear from the analysis that participants held their service users' best interest in mind, welcomed training and support opportunities to enhance the care and treatment they provide, and adopted successful harm minimisation approaches. Although participants' views reflected a growing trend towards advocating safer self-harm, participants emphasised that several systems needed to be in place to support identified approaches and interventions, such as education and training, clear policies and guidelines, and positive organisational values.

* Phenomenological - to understand people's perceptions, perspectives and understandings of a particular situation (or phenomenon).



Oxford Specialist Handbook of Medical Psychotherapy

Listening with medicine in mind

Thirty years ago I qualified as a doctor and in my white coat pocket I carried an Oxford Handbook of Clinical Medicine which I would crib from in the middle of the night when I was on call admitting patients. The book represented a bridge between my lay identity as a medical student and my medical identity – it was a lifeline, a vade mecum. When over twenty years later NHS psychotherapy had become a patient in extremis I was visited by a Commissioning Editor from the Oxford University Press and I had the idea of another lifeline - creating a new Oxford Specialist Handbook for Medical Psychotherapy.

The aim of this book is to offer readers with an interest in a wide range of therapies practised in the NHS a foundation in their theory and clinical applications. It is the first time that nearly all the psychotherapies practised in the NHS have been gathered in a single compendium with cross referencing between the models. The book contextualises psychotherapy, controversially, under the umbrella of Medical Psychotherapy.

My aim in offering the container of medicine from a wide range of models offered by people who are not doctors is to create a bridge between the psychotherapeutic lay identity and the medical identity of practitioners who have much in common in the field of listening to people and the problems of being human.

Alongside my background as a doctor, a psychiatrist and a medical psychotherapist I have another identity as an outsider artist – an amateur with an interest in the links between the arts and psychotherapy and for this reason I made sure the arts therapies were represented in this book – art therapy, music therapy and drama therapy. The bridge between art and science is crucial to the practice of medicine – my own medical school motto was *ars long sed vita brevis* – the art is long but life is short. The

art of medicine lies in bearing the limit of care and cure for the patient and the professional.

The spirit of the book is to offer an ideal for NHS psychotherapies which are in reality still in extremis, only available in the NHS in piecemeal and eroded forms. One review of the book said as much – this book describes an illusion and the reviewer felt like throwing it at the wall. In contrast the foreword of the book describes it in idealised terms as a phoenix from the ashes – but between the denigration and the idealisation of this small book lies a more humble truth which is that it is an attempt to hold in sight the value of high quality therapeutic work which is limited and is undermined in the NHS.

Listening with medicine in mind is to recognise that limits and loss are the leitmotif of life. Limits in the NHS are mainly spoken of in monetary terms. This book turns from finance to the finite resource that has become an embattled psychotherapy.

Life is long but psychotherapy is short.



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Amisulpride augmentation in clozapine-unresponsive schizophrenia (AMICUS)

When schizophrenia has not improved with standard antipsychotic medication, (clozapine) can sometimes work. If the response to treatment with clozapine on its own is insufficient, a second antipsychotic is sometimes added. However, despite several research studies addressing such combination treatment, it is still uncertain whether or not it is worthwhile trying in clinical practice.

We carried out a trial comparing the effects of adding either an antipsychotic (amisulpride) or a dummy tablet (placebo) for 12 weeks in people with schizophrenia who had not been helped much by their clozapine treatment. We chose amisulpride because the way this medicine works may be complementary to that of clozapine, and it is less likely than some other antipsychotics to add to some of the characteristic side effects of clozapine, such as sedation, weight gain and changes in the levels of blood sugar and fats. The study was opened in NHS multidisciplinary teams in adult psychiatry including at Leeds and York Partnership NHS Foundation Trust.

To avoid bias towards either amisulpride or placebo, no one knew which of these two medications any person was prescribed. The people who had been prescribed amisulpride proved to be a little more likely than those given placebo to have a 20% improvement in their symptoms by the end of the 12-week trial, although we did not manage to enrol enough people in our trial to be confident about this finding. More side effects, including heart symptoms, were reported by the people who had been given the amisulpride and clozapine combination, which suggests that this treatment should be carefully monitored for safety and tolerability in both clinical and research settings.



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Evaluation of a group to treat low self esteem

It has long been understood that having a poor view of oneself is a maintaining factor in many service users' distress, regardless of their diagnostic label. There is now growing evidence that targeting this factor can help to reduce distress and promote recovery toward better mental health.

As human beings we operate within the context of relationships and within groups. Group therapy has a long history and many advantages:

- a 'ready-made' audience for practicing skills learnt
- feelings of being similar and not different
- helping and supporting others can boost self-worth and provide a sense of purpose
- a sense of belonging
- feeling seen and understood by peers

The self-esteem group is a trans-diagnostic intervention that sits within a recovery focused model of clinical practice. The group uses a Cognitive Behavioural Therapy formulation for low self-esteem but also draws from other theoretical perspectives, including compassionate mind theory.

Five out of eight service users agreed to participate. Using self-rated outcome measures four out of five found that their self-esteem improved (Rosenberg Self Esteem Scale) and all group members saw an improvement in their overall mental wellbeing scores (Clinical Outcomes in Routine Evaluation).

Feedback that service users gave included:

- 'I thought I was the only one who felt like this'
- 'The group has made me feel normal again'
- 'I wish it could have been longer'
- 'It's been hard but I think doing this is really going to help change my life for the better, thank you.'

The study allowed us to more fully explore the mechanisms of change within the group and the content has been adjusted accordingly. The group continues to run within the Leeds Care Group.



Rachel Dobbing, LYPFT, rachel.dobbing@nhs.net



Physical activity, environment and a

At the time of data collection, 752 service users were in 39 low secure wards. Broken down by gender, 77% of wards were male-only wards, 19% were female wards and 4% had both male and female service users. Eleven per cent of respondents worked for an independent organisation while 89% worked for the NHS.

This study has found high rates of obesity amongst males and females in low secure settings, 54% and 73% respectively. Forty six per cent of service users were reported to be obese, 12% as morbidly obese and 28% as overweight. Twenty five per cent of females were morbidly obese, almost three times greater than the prevalence of morbid obesity amongst men in low secure units (9%). The rates of obesity among service users in low secure was found to be highest in wards in London (57%) with morbid obesity prevalence highest amongst wards in the East (20%).

Twenty seven per cent of service users in low secure units were reported to be hypertensive with 18% on anti-hypertensive medication.

On average, 14% of service users were reported to have a diagnosis of Type 2 diabetes and 21% were classed as pre-diabetic. The current prevalence of diabetes in low secure settings is one and a half times the projected national average (9.7%) for 2035 (Public Health England, 2016). This highlights the extent of the problem in a low secure setting as service users have surpassed this projection 18 years early.

Trained Professionals

Ninety four per cent of wards have access to dieticians and exercise professionals yet the hours they are available varied greatly. Ninety one per cent of low secure units have access to a dietician less than one day a week, with 34% having access to physical activity (PA) professionals less than one day a week. Less than one third (28%) of service users engage in the recommended 150 minutes of moderate intensity exercise a week, with 26% of units reporting that none of their service users met this target.

Access to facilities

To the author's knowledge this is the first study that has explored the facilities that promote engagement in physical activity in low secure units in England. Twenty eight per cent of low secure units do not have any access to outdoor areas on the ward. The findings show that 60% have no gym on their ward, 55% have access to gym equipment on their ward and 76% have no access to free weights on the ward. Given that many service users will not have leave from the ward for an extended period of time, there is clear a need for more sites to have better access to facilities that promote physical activity.

Access to Food

Findings from this study indicate that 78% of staff believe that service users should have reduced access to certain foods in order to improve their physical health. The way in which access is reduced remains unclear, although individual sites should initially look at food provision from the hospital including meals provided, unhealthy snacks used to entice service users to take part in groups and foods prepared in cooking activities. By reducing the amount of desserts provided to service users daily and twice daily, 76% of service users would reduce their intake of sugar, fat and high calorie food.

On 70% of wards service users are allowed to have a takeaway on the ward once or twice a week, with 22% allowing service users to have a takeaway on the ward less than weekly. Four per cent of wards allow service users to have a takeaway seven days a week. Eighty nine per cent of wards do not allow service users access to energy drinks on the ward.

Access to food on low secure units

Policies

More than half (58%) of low secure wards do not have a written policy on physical activity with 48% not having a policy that incorporates nutrition, yet staff in low secure units agree and strongly agree that the ward culture supports service users to engage in physical activity (94%) and to eat healthily (84%). This indicates that low secure wards do not require local policies to provide a supportive environment for physical and nutrition and national standards may be enough. Forty two per cent of participants agreed that service users should have reduced access to certain foods in order for them to live a healthier lifestyle with over a third (36%) strongly agreeing. Just over one fifth of respondents (22%) disagreed and strongly disagreed.

Recommendations for Practice

National

- work with the Ministry of Justice to reduce waiting time for prescribed leave
- physical activity and nutrition should be prioritised more in the standards for low secure units
- there are many areas of good practice within low secure units already. Services should be encouraged and supported to share good practice with other units.
- national review bodies should support services attempting to prevent physical health problems from developing



Local

- dedicated exercise and nutrition professionals who can work with both staff and service users to improve the physical health of service users
- better access to facilities, physical activity and nutrition professionals outside of 9am to 5pm weekday hours
- if fitness facilities are available, allow staff to use them to act as role models to service users
- review how Section 17 leave is prescribed at site level to incorporate leave for physical activity at the earliest opportunity
- review fitness equipment and access to physical activity on wards for service users without Section 17 leave
- consider reducing the amount of desserts service users have in a week
- consider using money saved on desserts to increase fruit and vegetables availability, increase healthy snack provision or improve the quality of main meals
- when reviewing access to certain foods and drinks service users should be part of the discussion and take into account money management and reflecting life in the community as well as the physical health and operational management
- reduce the number of times staff purchase food items for service users with Section 17 leave and encourage them to purchase it themselves in order to promote independence



Shared decision-making between pe

Existing literature suggests that although ideas about collaboration in decision making are prominent in policy and guidance, it can be hard to implement these principles in mental health settings. The aim of this study was to examine naturally occurring conversations involving decisions between professionals and service users with complex needs to explore shared decision making (SDM) in action.

Three routine clinical meetings were filmed. These involved five clinicians, three service users (with diagnoses of psychosis, schizophrenia or schizoaffective disorder) and a carer. The meetings captured a total of seven decisions about different aspects of care and treatment. Participants were also invited to participate in a follow up interview to watch the recording and reflect on their experience of the meetings. All recordings were transcribed and analysed using Discourse Analysis.

Results and discussion

The decisions in these meetings were generally about different physical health settings. Clinicians were helping service users to make 'life decisions', involving housing, work and occupational activities alongside any 'medical decisions', involving medication. It seems clinicians in mental health teams face different expectations in terms of their role and a challenge in determining, 'should I be involved in this decision, and if so, to what extent?'

Clinicians experienced significant challenges enacting principles of collaboration in practice. They sought to practice in line with the principles of empowerment and patient-centred care as outlined in policy and guidance, but faced difficulties reconciling these ideas with a sense of professional responsibility in terms of risk and treatment outcomes. Staff described this as being like a 'tightrope', balancing the need to do one's duty as a mental health professional, with trying to secure service-user involvement and promote autonomy. This

seemed to be especially challenging at times when staff had a sense of what change might be helpful for a service user, but where the service user did not necessarily agree.

Service users seemed to expect strong guidance and advice. They spoke of their sense that mental health professionals are 'experts' and therefore underestimated the value of their own contributions. This seemed to make it difficult for decision making to be collaborative, and sometimes contributed to impasse because staff were keen not to be prescriptive, whilst service users expected a paternalistic approach.

Another prominent feature of the talk in this meeting related to the challenge of making time to explore issues that service users were keen to discuss whilst also being aware of other role demands. This included an expectation that certain areas will be discussed, which meant staff felt pulled at times to redirect the conversation to specified topics (e.g. mental state, risk).

“
Staff described this as being like a 'tightrope', balancing the need to do one's duty as a mental health professional, with trying to secure service user involvement and promote autonomy
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Reflections

In thinking about how we try to 'do' SDM and collaboration in spite of these challenges, it seems there might be a role for increased discussion of the competing aims and dilemmas faced by staff. This could include deliberate and conscious identification of the amount of influence clinicians could and should hold across different types of decisions. It might also be helpful to reflect on whether a different model of SDM is more appropriate for mental health service settings.

People with psychosis and staff

The timing of SDM conversations may be important to consider, especially as staff described feeling pressure to achieve specific outcomes. It might be helpful to recognise that conversations involving decisions may need longer when making decisions with a service user who experiences psychosis, because of the impact of intrusive experiences and changes to cognitive processes.

There is also an important question about how we explore change with service users in light of the apparent discrepancy between what staff and service users saw as helpful in relation to wellbeing. Motivational interviewing might offer a framework to explore readiness to change and the potential costs or benefits of making a change, and mitigate clinicians' sense of trying to persuade service users to reach a specific decision.

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I-SOCIALISE

Investigating Social Competence and Isolation in children with Autism taking part in LEGO®-based therapy clubs In School Environments (I-SOCIALISE)

Leeds and York Partnership NHS Trust, alongside the University of Sheffield and University of York, is running a research trial to test the effectiveness of LEGO®-based therapy for children with autism spectrum disorder (ASD).

Previous pilot work has shown that many children with ASD engage with LEGO®. Not only do they enjoy the sensory aspects of LEGO®, the geometric patterns and the engineering involved in building models, but they also enjoy the process of construction.

Research shows that children with ASD are not asocial and do not wish to completely avoid social interaction. Instead, children with ASD are 'differently' social, preferring to engage socially with others in much smaller groups and are much more likely to engage in interactions and conversations that are factually, practically or technologically based,

rather than conversations about feelings or social relationships. LEGO®-based therapy can help children with ASD develop cooperative and interactive skills around mutually enjoyable play.

LEGO®-based therapy has been used to help children with ASD develop their social and emotional skills but there is no real evidence to show whether it is effective in doing so. The research will include 240 children aged between seven and 15 who have been recruited through mainstream schools in York, Leeds, and Sheffield over two years. To be eligible for the trial, the children must have a clinical diagnosis of autism. The trial started recruiting children in October 2017.

For more information, visit: www.comic.org.uk/research/lego or contact the author.

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How useful are the Adult Asperger's Assessment and AQ-10?

Purpose

The Adult Asperger Assessment (AAA) was designed to be a screening tool to identify adults with Asperger syndrome and/or high-functioning autism. The AAA includes three questionnaires; the Autism Quotient (AQ), the Empathy Quotient (EQ) and the Relatives Questionnaire (RQ). The Autism Quotient-10 (AQ-10) was designed to be a "red flag" for healthcare professionals considering referral for Autism Spectrum Disorder (ASD) assessment. The purpose of this paper is to determine the usefulness of the AAA and AQ-10 as part of an adult autism diagnostic pathway that includes patients of all intellectual ability.

Design/methodology/approach

Results were obtained for all patients who had received a clinical decision at Leeds Autism Diagnostic Service, which is a service that assesses patients of all intellectual ability, during 2015, n=214. Of these 132 were included in the analysis, 77 patients were excluded for not completing the AAA and five were excluded for not receiving a clinical decision.

Findings

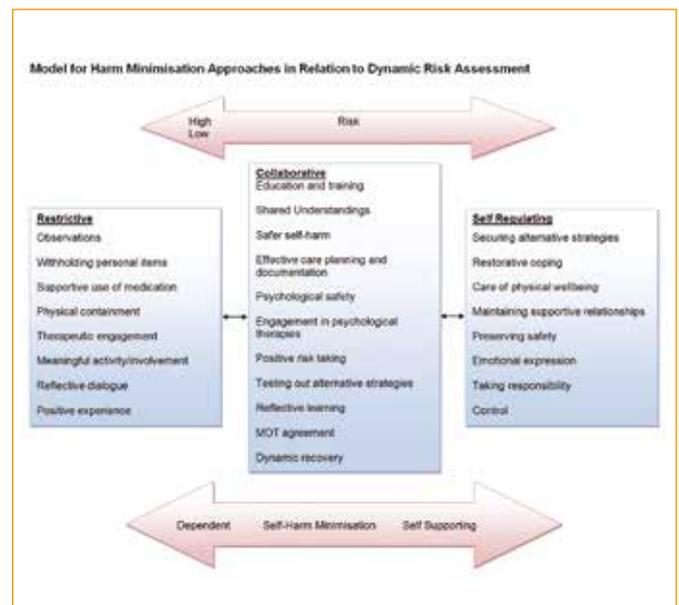
Results suggest that patients diagnosed with ASD without intellectual disabilities score on average 35 on the AQ, 17 on the EQ and 20 on the RQ. Those not diagnosed with ASD score on average 33 on the AQ, 22 on the EQ and 15 on the RQ. For patients with intellectual disabilities, scores are lower on the AQ, and higher on the EQ and RQ than those without intellectual disabilities. These results are the same regardless of diagnosis of ASD. The RQ is the only questionnaire to result in a significant difference between those diagnosed and not diagnosed. Results suggest that the AQ-10 is not useful in this clinical population.

Research limitations and implications

This study was undertaken as part of a service development improvement process. The specific demographics of this clinical population may have influenced the findings. The process will need to be repeated to ensure that the results are consistent across time and increased sample size. The population of patients with an intellectual disability is small, and further studies into the use of the AAA or the design of other intellectual disability specific screening tools should be pursued. It is of note that the AAA was never intended for use within an intellectual disability population.

Originality/value

This is an original paper as it will be the first to consider the usefulness of each of the aspects of the AAA collectively. It will be the first to assess the AQ-10 alongside the AAA, the usefulness of the AAA regardless of intellectual ability and the usefulness of the AAA within a clinical population by using the diagnostic outcome as the benchmark of the usefulness of the AAA scores. This paper only discusses the scores generated by the AAA, and the correlation of these scores with a diagnosis.



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Supervised by: Dr Alison Jane Stansfield, LYPFT.



Are we good and are we safe?

Leeds autism diagnostic service is an adult autism diagnostic service for people of any intellectual ability that also offers consultancy to service users, carers or professionals, as well as a wide range of autism training. The purpose of this paper is to describe the approach taken to measure the quality of the service the authors provide and accurately assess risk in adults with autism.

Since LADS was launched as a pilot service in 2011, we have sought to embed outcome measurement in our care pathway. Tools used are:

- Referral data – we routinely collect data on referrals and waiting times. Our referral numbers have tripled over the last six years – to the current rate of approx. 40 referrals per week. Despite this, we still broadly meet our waiting time target of 12 weeks.
- LADS service evaluation questionnaire – patient and carer reported.
- Mental health measures – we routinely collect data on PHQ-9 (depression), GAD-7 (anxiety) and SWEMWBS (well-being).
- Clinical audit – a clinical audit in 2014/15 found very high compliance with NICE guidelines for adult autism assessment. We are currently re-auditing our assessment pathway.

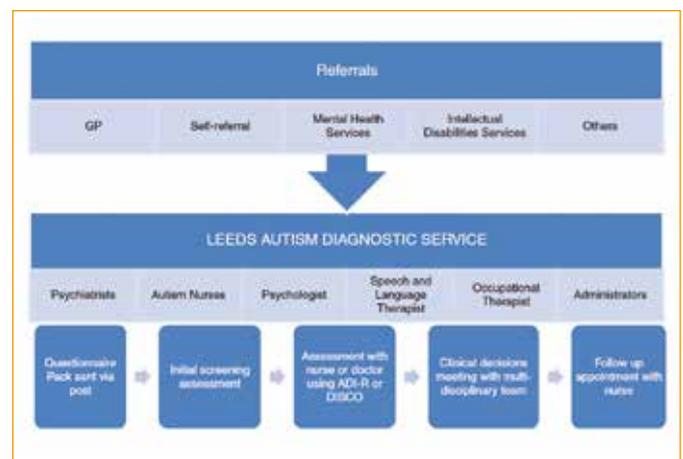
For a period we collected TOMS (therapy outcomes measure) data in an attempt to measure change in level of functioning following autism diagnosis. Despite having co-developed a bespoke data set for adult autism, our experience of using the TOMS has been mixed. The LADS clinicians found it quite difficult to administer in a consistent fashion. Analysis of results found that the average TOMS scores for our patients changed very little between appointments. This may reflect that it takes a longer time following diagnosis for improvements in activity, engagement and well-being to bed in.

In 2014 we conducted a larger scale patient survey of 164 patients. This found that satisfaction with the service was generally high (70%+ of patients), but tended to be lower if the patient was not diagnosed with autism. Another interesting finding was that when asked, “Has having a diagnosis of autism made your life

better?”, only 44 per cent said “yes” (33 per cent said “not sure”; 23 per cent said “no”). This might reflect the relative lack of autism-specific follow-up available in the UK after diagnosis.

In the absence of any appropriate autism-specific risk assessment tools, we have developed our own bespoke tool – the Leeds Autism Risk Assessment (aLARM). This seeks to measure risks seen more commonly in autism (such as fire-setting, computer hacking, and vulnerability to exploitation) and also take into account autism-specific risk factors (such as abnormally intense special interests and resistance to change). The aLARM has proved particularly useful in the consultancy setting.

Going forwards, the service is trying hard to de-medicalise autism and empower people with autism to embrace their specific skills and integrate into the neurotypical world. We are incredibly grateful to all our service users who have assisted in training, interviewed staff and provided ideas for improving our service. We continue to learn from them on a daily basis as we constantly ask the question – are we good and are we safe?



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STEPWISE

Being overweight if you have schizophrenia or psychosis is very common. People diagnosed with these conditions are more likely to die early than in the general population, and losing weight and being more active can reduce the risk of diabetes and heart disease and help people with psychosis live well for longer. The NHS recommends that people with psychosis or schizophrenia, especially those taking antipsychotics, are offered a weight loss programme by their mental health provider. However, how best to do this is uncertain.

Objectives

We wanted to see if an education programme aimed at supporting people taking antipsychotic medication to lose weight would be better than the usual health and social care provided by NHS trusts.

Methods

In total, 414 people with psychosis took part. Half were invited to attend an education programme run by trained facilitators while the other half attended their usual healthcare appointments. A computer decided whether they were invited to the programme or received their usual healthcare.

Results

In the short term (three months) and after 12 months we found no important difference in weight between the two groups. We also found that the programme did not provide good value for money. Service users told us

during interviews that they liked the education programme and that it helped them eat healthily and lose weight. However, when we looked at their diet and activity patterns, there was no change. Facilitators thought that the programme could benefit service users but were not sure if the NHS could afford it. They also wanted to know if service users were losing weight or not during the programme.

Conclusions

Despite concerns about running a trial for people with psychosis, the trial ran very well. People were interested in taking part and volunteered readily. They also stayed in the trial until the end. Unfortunately, although some people benefited, overall, the programme did not help people with psychosis to improve their lifestyle and lose weight, and so we need to look for better ways to help them look after their weight.



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The association between ADI-R scores and clinical diagnosis of Autism

Introduction

Diagnosis of autism in adults can be challenging and requires comprehensive assessments. Of the different diagnostic tools available in England, ADI-R and ADOS are the most widely used. This project was conducted at Leeds Autism Diagnostic Service (LADS) which is a diagnostic service for adults irrespective of intellectual ability. As part of the pathway, after initial screening, ADI-R is conducted followed by a clinical decision meeting (ADOS) to arrive at a clinical outcome.

There is a knowledge gap in relation to the use of ADI-R in adults, with existing research primarily based on children and those with intellectual disability.

Aim

The aim of the study is to establish the strength of association between ADI-R scores and the final outcome in an all IQ adult autism diagnostic service and also to identify if there are any differences in the association of ADI-R scores by gender or intellectual ability.

Methods

The sample includes all referrals to LADS in 2015 that received a clinical outcome. Out of 175 completed referrals, ADI-R was conducted in 90 cases. The rest progressed to clinical decisions meeting for an outcome without the ADI-R and were excluded from the study. Of these 90 who had ADI-R, 61 were males, 25 were females, 35 had intellectual disability,

51 did not have an intellectual disability and four did not receive any clinical outcome.

Sensitivity, specificity and positive and negative predictive values were calculated to evaluate ADI-R outcomes compared to the final outcome.

Using a logistic regression model, we explored the main effects of scores in each of the three domains, sex, presence of intellectual disability and all two-way interactions between the two categorical variables and the three scores, on the outcome of Autism diagnosis. ROC (Receiver Operating Characteristic) curves were used to calculate the Area Under the Curve (AUC) for the final selected model.

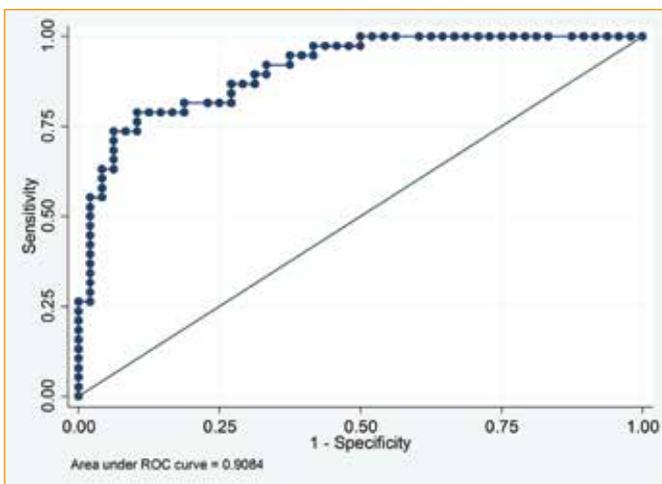
Results

ADI-R has a high sensitivity and low specificity and is useful to rule out the presence of autism, but if used alone, it can over diagnose. Restricted stereotyped behaviours are the strongest predictor for autism and this suggests that the threshold should be increased to enhance its specificity.

Conclusion

The research has had a very practical application for the Leeds Autism Diagnostic Service. Previously the ADI-R had tended to suggest a diagnosis of autism in those people who clinically do not meet the criteria – i.e. false positives – but the research has provided an increased cut off for repetitive and restricted behaviours that reduces this problem and helps inform the final clinical decision

This is a single site study with small effect size, so results may not be replicable. It supports the combined use of ADI-R and Autism Diagnostic Observation Schedule and suggests increasing ADI-R cut-offs to increase the specificity (i.e. to prevent over diagnosis of autism).



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Mobilising knowledge across health and social care boundaries

This project investigated what knowledge sharing looks like in inter-professional neighbourhood teams and how it can be improved.

What helps people to share knowledge?

There are a number of key things that seem to help team members to share knowledge when discussing people with complex health and social care needs during case management meetings. They include:

- having a shared aim of using the meeting to make things better for the people being discussed
- admitting unease, uncertainty and concern about cases being discussed and exploring that uncertainty with the group
- asking questions about how and why things are happening or have happened, not just what is happening or has happened
- making connections between the case being discussed and previous cases and experiences, and considering what has been learned that could be applied here
- being open and receptive to knowledge from various sources and willing to learn from others (including people from different backgrounds and/or with different levels of experience)

Questions about		
The key area(s) of concern	What is known/not known	Accessing and using knowledge
Example questions		
What is the biggest/ underlying issue?	What do we know/think/ feel about this issue?	What do we need to know to move forward?
What are we worried about?	What do other people affected by the issue know/think/feel?	How do we find the knowledge we need?
What is the issue we want/need to address?	Do we all know/think/ feel the same?	Who else might know something about this issue?
Why is this an issue?	Have we tried to do something about this issue before?	Who do we need to talk/ listen to?
What are we struggling with?	Have we dealt with something like this before?	Has anyone else tried to do something about this issue?
Why do we want/need to do something?	What do we know about how to address this issue?	Has anyone else dealt with something similar?
Who is this an issue for?	What do we usually do about this type of issue?	How do we share what we know with other parts of the system?
	How do we capture what we know?	How do we use what we know/ find out to develop a solution?
Ask these questions when		
There is a lot of generalised worry, concern or frustration about a case	Team members are using phrases like 'I don't know', 'I'm unsure'	There is little consideration of what is known outside the immediate team
The discussion is going round in circles without any forward movement	There are noticeable similarities to other cases	The issue is with another part of the system/another service
Lots of ideas are being put forward which seem to address different aspects of the case	There has been a sudden or surprising breakthrough with a case (this represents an opportunity for learning)	The discussion is going round in circles without any forward movement
	Only a few team members are contributing to the discussion	

- taking time/space to think, reflect and tell stories (about the case being discussed and previous cases/experiences)

How can we improve knowledge sharing?

Asking questions is an important part of encouraging people to share knowledge. Questions about the key area(s) of concern, what is already known (and not known), and how to find and access relevant knowledge are

particularly important because these are the hallmarks of how people share knowledge.

The table on the previous page shows a range of questions that can be used to encourage knowledge sharing during case management discussions. The questions are divided into three areas, each of which represents one of the key aspects of sharing knowledge. The table also gives an indication of when to consider asking the questions.

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No exclusions – developing an autism diagnostic service for adults irrespective of intellectual ability

Autism is a spectrum condition, yet many autism services limit access based on IQ score. From the beginning, the ethos of the service was to break down the artificial 'service silo' barriers to assessment which so frustrate people with autism: we see patients of any age over 18, of any IQ, and accept referrals from all sources including self-referrals.

Leeds Autism Diagnostic Service (LADS) was launched as a pilot in 2011. The number of referrals was higher than expected – a baseline of 20 per year rose to 150 per year as soon as the service opened. The current rate is over 400 referrals per year. Other unexpected findings include relatively low diagnosis rates (32%), high rates of past trauma, and patient dissatisfaction when a diagnosis of autism is not given.

In 2014, following a successful business case to the local Clinical Commissioning Group, LADS was permanently commissioned. In 2015 LADS merged with the Leeds adult ADHD service under the umbrella of the Leeds Neurodevelopmental Service. In 2017 we moved into new larger premises at Aire Court Community Unit. There are plans to expand the service further: including ideally by creating a Lifeskills Training flat for people with autism

to improve their independent living skills – this is based on innovative new work in Canada. The ultimate aim of this would be to develop an expert service user manual for independent living for autistic people via a further research project.



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11th Annual Research Forum

The 2017 Annual Research Forum showcased the fantastic research and evaluation work completed by our Trust and academic staff. Almost 100 delegates from a range of disciplines including nurses, allied health professionals, psychologists, academics, researchers and psychiatrists and service users and carers attended the event, which was held at Horizon, Leeds on Thursday 9 November.

The event was opened by Trust Chair, Professor Sue Proctor, who celebrated the achievements of the past year and highlighted how the Trust has outperformed in a number of areas including exceeding its recruitment target for the number of people recruited to National Institute for Health Research (NIHR) portfolio research studies.

Ten presentations covered a wide range of topics and included a mix of study outcomes and future research priorities. Outcomes included sharing the much anticipated results of the STEPWISE trial, which is looking at a weight management program for people with psychosis. This was a scoop for us as these results were shared for the first time at an international conference in Berlin on the same day as the Annual Research Forum.

Visit our website to see the full list of presentations, abstracts and photographs:

www.leedsandyorkpft.nhs.uk/news/events/annual-research-forum-2017

During the event, 19 posters were displayed and delegates had the opportunity to vote for their top two. After the votes had been counted, the winners were announced:

1st prize

I-SOCIALISE: Investigating Social Competence and Isolation in children with Autism taking part in LEGO-based therapy Clubs in School Environments

By Dr Barry Wright, Ms Danielle Varley, and Miss Ellen Kingsley



Dr Barry Wright and Ms Ellen Kingsley

“

I like the variety of presentations. Good opportunity to network and hear about research in the Trust.

”

“

I like the intro of workshops good to break up the day make it more interactive.

”

“

it was just a shame we could only pick one workshop

”

Joint 2nd prize

Challenging the stigma attached to mental health problems in healthcare professionals and students

By Dr Ahmed Hankir, Dr Charlotte Wilson Jones



Dr Ahmed Hankir

Supporting Service Users through Media: A Survey of Communication, Internet and Social Media use in the Personality Disorder Clinical Network

By Miss Aliya Zamir



Miss Aliya Zamir

This year we held three parallel one-hour interactive workshops on new ways of thinking about patient involvement in research, top tips for preparing for research funding and research on professionals sharing lived experience with service users.

After making some changes to the event following feedback from our delegates last year, we were delighted to see that 93 per cent of respondents rated the 2017 event as 'very good' or 'excellent'. There was also a lot of Twitter chat on the day. Comments, quotes and photos from the event can be viewed using the hashtag #ResearchForum17



@GabiC1710 tweeted "Interesting day so far finding out about the research going on in #LYPFT #ResearchForum17 @LypftResearch



Diverse and demonstrates the range of research occurring across the organisation.



@Miri_rose_ tweeted "Great day at research forum hearing about great work and catching up with folk @LeedsandYorkPFT @LypftResearch #LYPFTResearch17



Finding the Evidence training dates for your diary

The following courses are free to all Trust staff. Alongside the schedule of courses below, the library runs a number of sessions on request. These include

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 (on request) – Aimed at staff who wish to set up and use email and RSS alerts and feeds to support their practice or professional development.

E-journals and e-books – Aimed at staff who wish to use e-journals and e-books to support their practice or professional development.

Google and beyond training (on request) – Aimed at 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.

NHS OpenAthens account (on request) – Aimed at staff who wish to better understand their Athens account and learn about the e-resources that are available to them.

FEBRUARY

2	Fri	13.00 - 15.00	Google and Beyond	IT Training Room, Bexley Wing SJUH
7	Wed	09.00 - 16.00	Finding and Appraising the evidence	IT Training Room, Bexley Wing SJUH
15	Thur	10.00 - 12.30	Healthcare databases	IT Suite, Mount Annexe
19	Mon	10.00 - 12.00	Google and Beyond	IT Suite, Mount Annexe
20	Tue	10:00-12:00	Critical Appraisal	IT Suite, Mount Annexe
21	Wed	09.30 - 12.00	Healthcare databases	RiO training room, St Mary's Hospital

MARCH

5	Mon	10.00 - 12.00	Healthcare databases	IT Suite, Mount Annexe
7	Wed	09.00 - 16.00	Finding and Appraising the evidence	LGI, Bay 3
14	Wed	14.00 - 16.00	Critical Appraisal	Stockdale House, Meeting Room 1
20	Tue	14.30 - 16.30	Google and Beyond	IT Training Room, Bexley Wing SJUH
21	Wed	10.00 - 12.00	Google and Beyond	Stockdale House, Library
27	Tue	10.00 - 12.30	Healthcare databases	IT Suite, Mount Annexe

The 'Current awareness' and 'Making the most of your Athens account' courses are now offered on request as a tutorial. Please contact libraryandknowledgeservices.lypft@nhs.net for more details.

For more information about any of our library courses and to book your place, visit www.leedslibraries.nhs.uk/home/



NIHR funding opportunities

The NIHR Clinical Research Network Portfolio is a database studies that shows national clinical research study activity. Clinical trials and other well-designed studies involving the NHS, funded by the NIHR, other areas of government and non-commercial partners are automatically

eligible for portfolio adoption. Studies that are adopted on to the portfolio can access infrastructure support and NHS service support costs to aid with study promotion, set-up, recruitment, and follow-up.

Funding stream	Deadline
Health Services and Delivery Research	Primary Research (stage 1) - 4 and 11 January 2018, 1pm
	Evidence Synthesis (Straight to full) - 11 January 2018, 1pm
Health Technology Assessment commissioned calls	Eol to full - 25 January 2018, 1pm
NIHR Fellowships**	Clinical Lectureships (Medical) - 31 March 2018, 1pm
Programme Development Grants	Competition 21 - 28 March 2018, 1pm
Public Health Research	Commissioned - 20 January 2018, 1pm
Research for Patient Benefit (RfPB)	Competition 34 (Stage 2) - Date TBC

Funding streams:

- 1. Health Services and Delivery Research (HS&DR):** Funding research to improve the quality, effectiveness and accessibility of the NHS, including evaluations of how the NHS might improve delivery of services. It has two work streams, researcher-led and commissioned.
- 2. Health Technology Assessment (HTA):** Funds research to ensure that health professionals, NHS managers, the public, and patients have the best and up-to-date information on the costs, effectiveness, and impacts of developments in health technology.
- 3. NIHR Fellowships:** Complex health and care needs in older people Themed Call. Find out more here - <https://www.nihr.ac.uk/funding-and-support/themed-calls/> Support outstanding individuals to become the health research leaders of the future by contributing to research costs needed to complete an identified research project.
- 4. Programme Development Grants:** Acting as a pre-cursor to the Programme Grants for Applied Research (PGfAR) scheme, the sole purpose of the Programme Development

Grant scheme is to increase the rate and number of successful applications by supporting applicants in the preparatory work required for a full PGfAR.

- 5. Public Health Research (PHR) Programme:** Funds research to evaluate non-NHS interventions intended to improve the health of the public and reduce inequalities in health.
- 6. Research for Patient Benefit (RfPB):** Generates research evidence to improve, expand and strengthen the way that healthcare is delivered for patients, the public and the NHS.

For further details about the funding opportunities through the NIHR, visit: www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/



National Institute for Health Research

Contact us R&D

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.

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SAVE THE DATE: Principles and Methods of Systematic Review Course

Date	Venue
January - April 2018	University of Central Lancashire, Preston

This successful course, which has previously run as a training opportunity for University of Central Lancashire staff, is now available as a post-graduate assessed module, 'NU4094 Principles and Methods of Systematic Review'.

The course is comprised of 12 sessions and is aimed at staff working in health or social care who need to access evidence for practice or policy development and who would like to advance their skills in review methods for practice or teaching whilst gaining 20 credits.

The 12 sessions are:

Session 1

Introduction to systematic review

Session 2

Types of systematic review

Session 3

Introduction to qualitative systematic review

Session 4 - Formulating a research question and an introduction to searching methods for a systematic review.

Session 5

Assignment preparation and peer feedback

Session 6

Practical session on searching (session 2 of 2)

Session 7

Writing a protocol and designing a review

Session 8

Practicalities of undertaking a systematic review

Session 9

Critical appraisal of qualitative and quantitative studies

Session 10

Analysis and synthesis of quantitative data

Session 11

Focus on specific methodologies

Session 12

Writing up a review

All sessions are free to those not wishing to undertake assessment or to those who wish to only attend ad-hoc sessions. The cost of the full module, with assessment, is approximately £880.

For registration and further details please email rsenquiries@udan.ac.uk