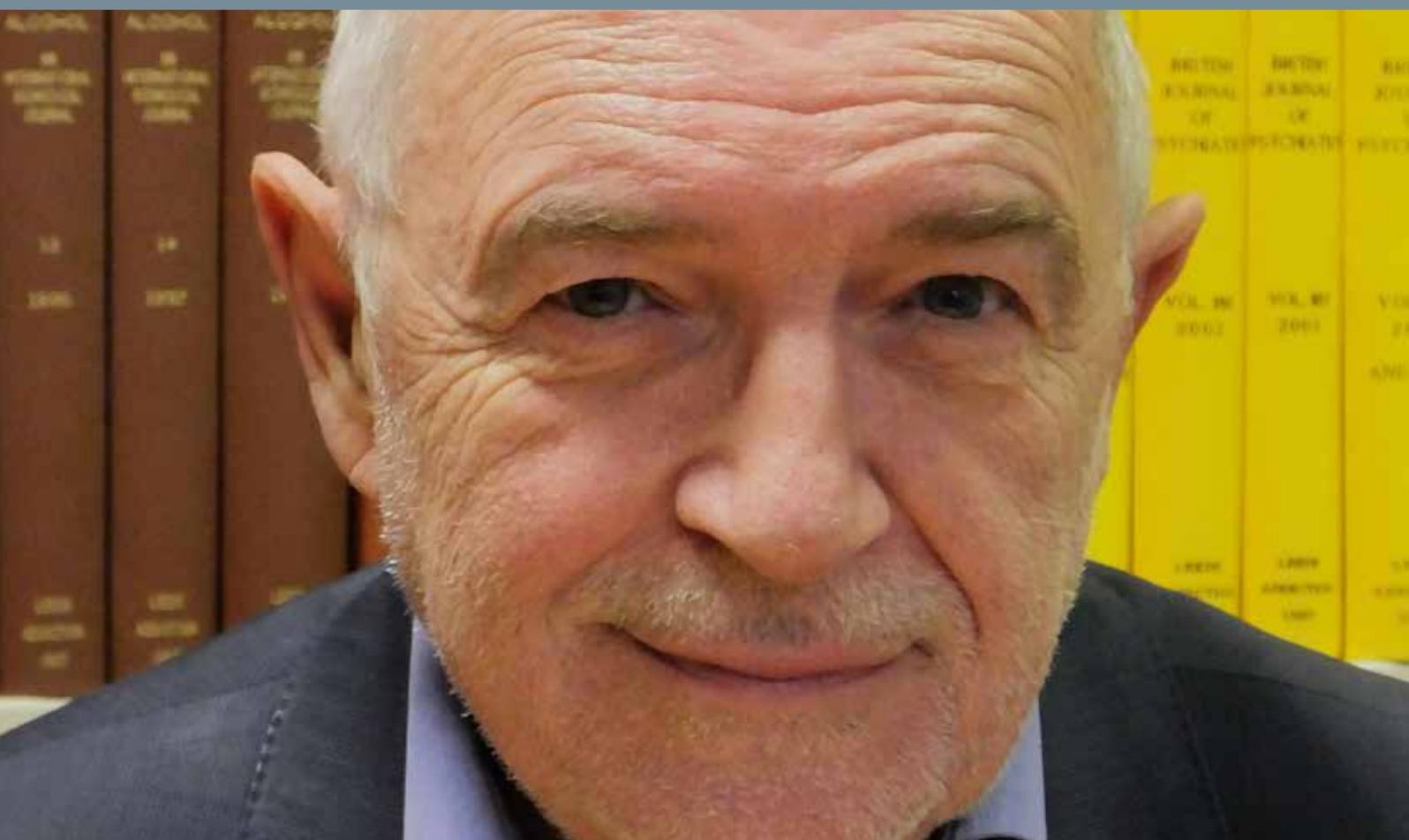




Innovation

Research and Development Newsletter



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To what extent does social support influence alcohol dependency?



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

Welcome to the summer edition of Innovation

Welcome to the 33rd edition of our Trust's Research and Development (R&D) newsletter, Innovation. I would particularly like to thank Zara Brining, our R&D administrator, for her work liaising with staff and external researchers, collecting the summaries that we use to compile the newsletter, collating all the information for each edition from a range of sources, editing, proof-reading and working with our Communications Team and with me to make this a stand-out Trust publication.

We have seen some changes in the R&D team. We wish Damian Reynolds well in his new role, which is a promotion, working in primary care research in the region. We are pleased to have Satti Saggi in post as Research Programme Manager in Leeds. He will introduce himself in our next Innovation. Satti replaces Rebecca Hargate who has excelled in gaining a place as a medical student at University of Nottingham from September. Becca has been seconded to Rotherham Doncaster and South Humber NHS Foundation Trust, developing their research networks, for the past year, alongside leading the York Child

Oriented Mental health Intervention Centre (COMIC) R&D team. Becca's role has been taken

on by Danielle Varley whom I congratulate on her successful promotion to Research Programme Manager. Satti and Danielle are working together to lead R&D across Leeds and York.

A new draft research strategy for 2018-2021 is out for consultation, to be published in the autumn. If anyone wishes to comment, please contact me for a copy.

In this newsletter, we bring you summaries of completed projects ranging from a pilot study validating the current Nutritional

Screening Tool, dynamic risk assessment, OTs' perception of their role in secure forensic mental health settings, to studies making sense of CTOs from the service-user experience, MH Nurses' knowledge of adverse events related to anti-psychotics and in the areas of personality disorder, sexual health, learning disabilities and addictions.

You will also find information about an exciting new study led from York 'Alleviating Specific Phobias Experienced by Children Trial (ASPECT)' that compares six session CBT treatment to a much shorter intervention, plus an article about secondary care memory clinics in primary care sites and the usual funding information.

Correction: Issue 32 incorrectly named Tom Isherwood as the Lead Researcher for 'Decision making regarding pro re nata (PRN) medications' when it was Neil Whale. Tom, in his role at the University of Leeds, was Neil's supervisor.

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A pilot study validating the current nutritional screening tool

Introduction and background

Numerous research studies have shown that people with a mental illness and/or learning disability are at higher risk of obesity, malnutrition and serious health problems compared to the general population (Disability Right Commission, 2006; Emerson & Baines, 2010; Public Health England, 2013). Early detection of under and over nutrition is therefore vital, with nutritional screening tools being the most effective first line approach (NICE, 2012). However, there are no validated nutritional screening tools for this population which makes it impossible to know if any of the tools available are appropriately screening. As a result, Leeds and York Partnership NHS Foundation Trust (LYPFT) developed its own nutritional screening tool but it was never validated to understand its reliability, specificity and accuracy (NICE, 2012) for mental illness and/or learning disabilities. The pilot study sets out to test this and establish whether it is a validated nutritional screening tool for this population.

Methods

This was a prospective cross sectional study carried out by expert dieticians at LYPFT comparing a nutritional screening tool used by LYPFT against a validated nutritional screening tool used nationally called Malnutrition Universal Screening Tool (MUST). Our aim was to recruit 100 research participants across 12 different inpatient areas across the Trust. Over one week the local nutritional screening tool was completed via staff and the designated dietitian for that area as routine practice. The Malnutrition Universal Screening Tool was completed via the dietitian.

Results

Ninety service users and 31 staff were recruited to take part in the study. There was an equal division across gender; the mean age was 46.5 years; the majority were white British (78.9%) and there were a wide variety of mental health and learning disability diagnoses, with the largest being depressive disorders (25.6%) and psychosis (21.1%). Results showed the LYPFT Nutritional Screening Tool was more reliable for this population than MUST ($p=0.00$, $r_s = 0.56$). Additionally staff and dietitians received very similar results ($p=0.00$, $r=0.93$) when completing the Nutritional Screening Tool on the same person.

Discussion and conclusion

The study highlighted a gap in nutritional screening for this population and a general lack of consensus on validation for nutritional screening (Elia & Stratton, 2012). However it gives assurance that LYPFT's nutritional screening tool is reliable, specific and accurate for this population in comparison to the Malnutrition Universal Screening Tool. To be conclusive on whether the nutritional screening tool is validated for this population, further research is recommended with a larger sample size and to include those who do not have capacity, particularly for diagnoses such as dementia and learning disabilities.

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Addiction treatment outcomes: predicting expectations

This service evaluation aimed to give both help-seekers and staff an expectation of treatment outcome based on a dataset of information. The dataset used was available through the Leeds Addiction Unit. Since this evaluation the clinical service of the unit is currently operating under the banner of Forward Leeds.

The dataset, which had been used in routine practice, would demonstrate:

- i) a capacity to measure clinically significant change in treatment outcomes
- ii) a factor structure reflecting the key outcome measures of addiction, namely: dependence, psychological wellbeing, and social wellbeing
- iii) and produce an outcomes profile understandable by all stakeholders and yet derived from sophisticated statistics.

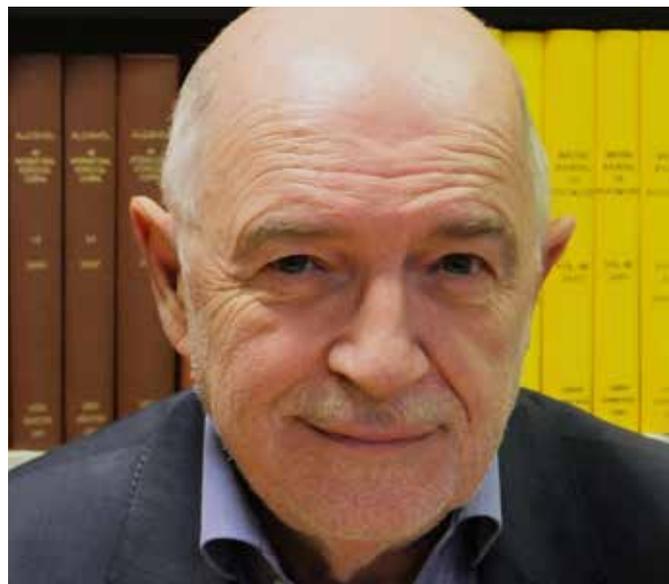
The three main measures (all Patient Reported Outcome Measures – PROMs) are: the Leeds Dependence Questionnaire, the Clinical Outcomes in Routine Evaluation (10 item version), and the Social Satisfaction Questionnaire. Other non-scalable information such as substance use and demographics are included in the dataset.

The main task has been to enter the paper records anonymously into an electronic dataset and then to pair records so that outcomes can be analysed. We will undertake analyses as follows in due course:

- i) a factor analysis of the three scales to show that they are independent measures – we predict that psychological wellbeing will be closer to dependence than social wellbeing
- ii) a calculation of clinically significant change for different drug groups.

We have undertaken a similar, smaller scale evaluation before and expect this evaluation to be confirmatory and add some more variables to the profile. We will publish the findings in an addiction peer reviewed journal and make them available at www.result4addiction.net, the assessment scales website. We would hope that Forward Leeds would champion using this outcomes package – Drs Duncan Raistrick and Gillian Tober who developed the package are no longer directing the Addiction Unit and so use of the package locally is uncertain.

Duncan Raistrick (Formerly LYPFT), and Gillian Tober, LYPFT.



The aim of this service evaluation was to evaluate a new, dynamic risk assessment and management plan framework within a community forensic mental health team. This 'dynamic' way of assessing risk of violence was first introduced within the Newsam Centre in Leeds and assesses risk in terms of a series of changeable factors that have been identified to increase or reduce risk of re-offending.

This service evaluation used semi-structured interviews to collect qualitative data. The researcher interviewed clinicians working in the community forensic mental health team within LYPFT. A thematic analysis (pulling out common themes from the data) was run on information gathered in these interviews.

Map of emerging themes:

Revisiting the findings according to the initial aims of the Service Evaluation Project

Aim	Findings
<p>a) Does the management plan framework have advantages and disadvantages when compared to previous methods?</p> <p>b) Has it impacted on multidisciplinary team (MDT) thinking/discussion and decision making about risk?</p> <p>c) Does it provide a formulation of risk that helps the team and service users to understand/make sense of their risk?</p>	<ul style="list-style-type: none"> • Overall the team reported that they could gain relevant information in less time when using the framework. • The framework is more flexible and tailored to the individuals than previous methods. • Information within each service user's framework is current rather than static. • Links between pieces of information are more easily made when using the framework. • The general sense from the team was not that it should replace the HCR20 (Historical Clinical Risk Management-20) which the team still complete routinely for each service user, but that the Dynamic Risk Assessment Framework (DRAF) is a helpful tool in its own right. The HCR-20 is used by other trusts and can be used as a means of communicating risk between services. • They do this collaboratively and consider new ideas. • The framework provides a structure to discussions however this can be disjointed at times. • The framework guides thinking and focuses discussions, but some concerns about the frameworks being too formulaic. What is being missed? • The framework improves confidence in decision making. • The framework does not make the decisions for the team but supports clinical judgement. • The framework provides a structure for team discussion that aids problem solving through team discussion and risk formulation, which ultimately contributed to their confidence in decision making. • The team explained that the framework gave them grounding when it came to communicating risk formulations and decision making to service users and other staff teams.

Assessment to inform a management plan

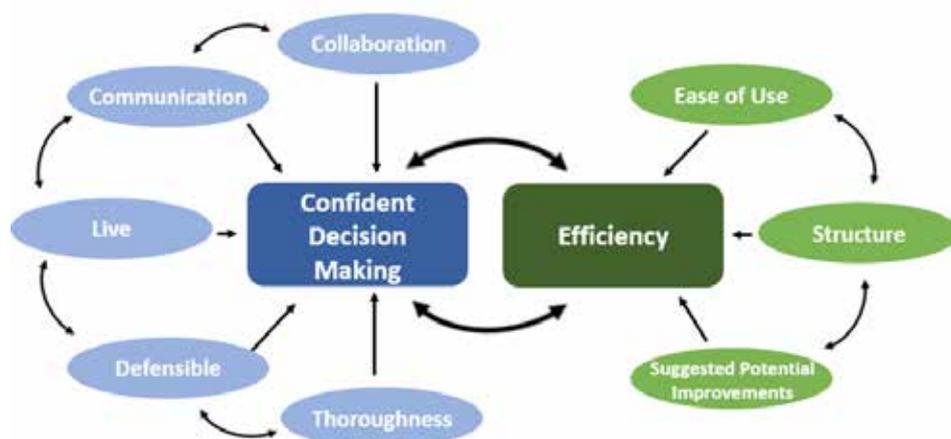
The framework appears to increase confidence in decision making by the teams by providing transparent risk formulations that were thorough, individualised and that supported clinical judgement. For the majority, the team spoke positively about the framework and felt that it provides a structure to risk assessment and intervention planning within the Forensic Outreach Team (FOT) Multidisciplinary Team (MDT) meetings. However, a narrative emerged around the concern that the framework might be used in an overly formulaic way leading to information, not included on the DRAF, being omitted. This has been found in previous methods of risk assessing where there appears to be a stand-off between making a succinct and relevant framework, and a comprehensive. One benefit of the tool that the team felt was important was that the framework was not time consuming and provided a snap-shot of the service user's current presentation and context. Therefore, there is the dilemma of how much information should be included.

This is where the importance of maintaining flexibility within the tool is crucial. Various team members suggested a series of prompts to consider the presence of risk factors that are not already included in the tool. This may ensure that all relevant risk factors are considered without need for a section within the framework.

Rebecca Anderson, University of Leeds

Supervised by:

Alex Brooks and Kerry Hinsby, LYPFT



Alleviating Specific Phobias Experienced by Children Trial (ASPECT)

A specific phobia is a type of anxiety disorder that causes an overwhelming fear and avoidance of a thing or situation (e.g. a dog, spider, going on a bus). It is estimated that between 5% and 10% of children have a specific phobia which impacts on their everyday lives. Without intervention, phobias last an average of around 20 years and can cause problems at school or college and considerable personal distress, yet fewer than 10% of people with phobias ask for help. We are comparing two types of treatment for phobias (Cognitive Behavioural Therapy or CBT and One Session Treatment or OST), to see whether they can provide similar results in the treatment of phobias for children aged 7-16 years old.

We don't know exactly why people develop phobias, but in general it is associative, meaning it is a learned behaviour. This can be by direct experience (like a frightening experience with an aggressive dog while they were little), through negative information (like being told scary stories about what happens when it gets dark), or in some cases modelling (where the phobia manifests because they are modelling a parent or caregiver's behaviour towards what they are scared of).

The most common treatment for phobia is Cognitive Behavioural Therapy (CBT), however waiting lists for CBT are generally long, and since it is multi-session therapy, people often don't complete all their sessions. One of the promising alternatives to CBT is One Session Treatment (OST). OST is based on similar principles to CBT, but is a single intensive session involving exposure to the source of fear, alongside strategies for managing fear and to promote coping (with follow-up work for the family to continue at home). OST has been found to be successful, but it hasn't yet been

researched in children. Since it only involves one session it may be more child friendly than multi-session CBT, and could have the added advantage of lower cost and lower demand on therapist time.

The study is a randomised controlled trial, currently open in eight trusts. We have many different therapy delivery arms. We are collaborating with CAMHS services as well as low intensity treatment pathways like the School Wellbeing Workers in York, or Psychological Wellbeing Practitioners in Leeds. Despite phobias being relatively common, recruitment to the trial is lower than we had expected. With long CAMHS waiting lists, phobia cases are often not priorities, especially since phobia often co-occurs with things that are perceived to be more serious (like General Anxiety Disorder or depression) and take priority in terms of treatment plans. This is not surprising, and entirely understandable. However, it may be the wrong way of thinking about it, because preliminary evidence indicates phobia intervention can have a helpful effect on comorbid anxiety disorders.

This is a pragmatic trial with the aim of improving the delivery of mental health services to young people with phobias. If you know of anyone who may benefit from taking part, please do contact us.

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How OTs perceive their role in secure forensic mental health settings

Forensic mental health services in secure settings have developed and expanded significantly over the past 40 years with greater clarification of services across high, medium and low secure settings. Though traditionally medically dominated, there is a continuing trend towards multidisciplinary approaches in the treatment and care of mentally disordered offenders. Occupational therapists (OTs) are a recognised part of this multidisciplinary approach.

The role of occupation in reducing future risk and recidivism* is becoming more widely recognised. Major reports provided for further expansion of rehabilitation services within forensic mental health settings and occupational therapists are key to delivering these services in practice. The mixed method study aimed to gather occupational therapists' perceptions of their role in secure forensic mental health settings. Through an online survey and a series of semi-structured interviews, a detailed description of current occupational therapy practice in NHS secure forensic mental health settings in England was developed. Thematic content analysis of the qualitative data was undertaken and findings merged with the quantitative data.

The main themes identified were:

- Role: Balancing core occupational therapy roles and responsibilities with those deriving from the role of forensic mental health practitioner.
- The importance of considering offending histories and antisocial occupations in practice.
- The importance of vocational interventions and socially inclusive practice.
- Risk: The centrality of risk and the role of the occupational therapist in promoting positive risk taking.
- The role of occupation in increased wellbeing and as a protective factor in reducing further violence and recidivism.
- Multidisciplinary Team (MDT) Working: Role identity and the professional voice in the forensic setting.
- Resources and service developments.

*Recidivism - the tendency of a convicted criminal to reoffend.

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Making sense of CTOs: the service-user experience

Since their introduction in 2008, Community Treatment Orders (CTOs)* have become an increasingly common feature of mental health treatment. Although compulsory community treatment is used in many countries, there is a lack of consistent evidence of its clinical effectiveness and a lack of methodically robust studies. The international use of CTOs remains contentious based on the ethics of coercion and infringement of autonomy.

Detailed understanding and interpretation of the impact on service-users is necessary to inform the ongoing use and development of CTOs. Although some of the literature acknowledges the effect of historical and contextual influences on the implementation of CTOs, these influences have not been comprehensively evaluated. Existing studies reveal wide-ranging, often conflicting responses from service-users, describing mainly ambivalent reactions to a CTO. This indicates a need for rich detailed data and analysis of the service-users' experience of CTOs.

This study aimed to investigate how service-users make sense of their CTO experience. Ten active CTO service-users were purposefully recruited from an Assertive Outreach Team caseload in LYPFT. Each participant undertook one or two semi-structured interviews facilitated with photo-journals and diaries. A total of 18 interviews were completed and the data subject to Interpretative Phenomenological Analysis.

Themes were generated and organised into three clusters: Pained and Powerless; Alignment and Reconnection; and Consolation and Compensation. Some participants felt powerless to challenge the 'sentence' imposed as therapeutic intent. Many participants described feeling disadvantaged, different and labelled, but were also committed to recovery

and reintegration into the community. Some participants perceived that small interactions could combine to leave them feeling more secure, less anxious and, paradoxically, more in control. The study proposes a theoretical framework that may unlock the therapeutic potential of CTOs, improving lived experience without compromising their social significance or effectiveness.

* Community Treatment Order - Part of the Mental Health Act, a CTO allows you to leave hospital and be treated safely in the community rather than in hospital.

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Supervised by:

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Mental health nurses' knowledge of adverse events related to anti-psychotics



This research aimed to explore registered mental health (MH) nurses' knowledge of adverse events related to antipsychotic medication within NHS inpatient settings.

It involved conducting a national questionnaire which collected quantitative data only. There were six questions exploring demographic data and a further 24 multiple choice questions with one correct answer out of a possible four options.

The findings from this study suggest there are some gaps in knowledge. In the three lowest scoring questions, only 17.1%, 25.9% and 31.2% of respondents answered correctly. These questions related to antipsychotic medications, such as Quetiapine, with less sedating and fewer anti-muscarinic, and hyperprolactinaemia side effects.

In the three highest scored questions, nearly all the respondents answered correctly. These were looking at side effects of Olanzapine (94.6% correct responses), Akathisia (93.7% correct responses) and Haloperidol (91.2% correct responses).

Only 8.8% of respondents scored 80% or more of the answers correctly. When this threshold was lowered to 60%, a significantly higher number of respondents (66.8%) were able to meet these criteria.

The 80% threshold was based on the Nursing and Midwifery Council (NMC) standard of "clinical pharmacology" where

an examination testing pharmacological knowledge and its application to practice requires a minimum 80% pass mark.

The lower threshold was based on the NMC Test of Competence pass mark for nurses and midwives who trained outside the European Economic Area that are seeking UK registration.

The findings from this research have potentially identified knowledge deficits in the mental health nursing profession that require further education and/or training in the overall assessment and management of adverse events related to antipsychotic medications, at all levels of education and practice.

This study has looked at an area that had not been systemically examined previously. The findings give the mental health nursing profession an opportunity to reflect on the best means to increase knowledge and increase patient safety awareness and benefits for mental health service users.

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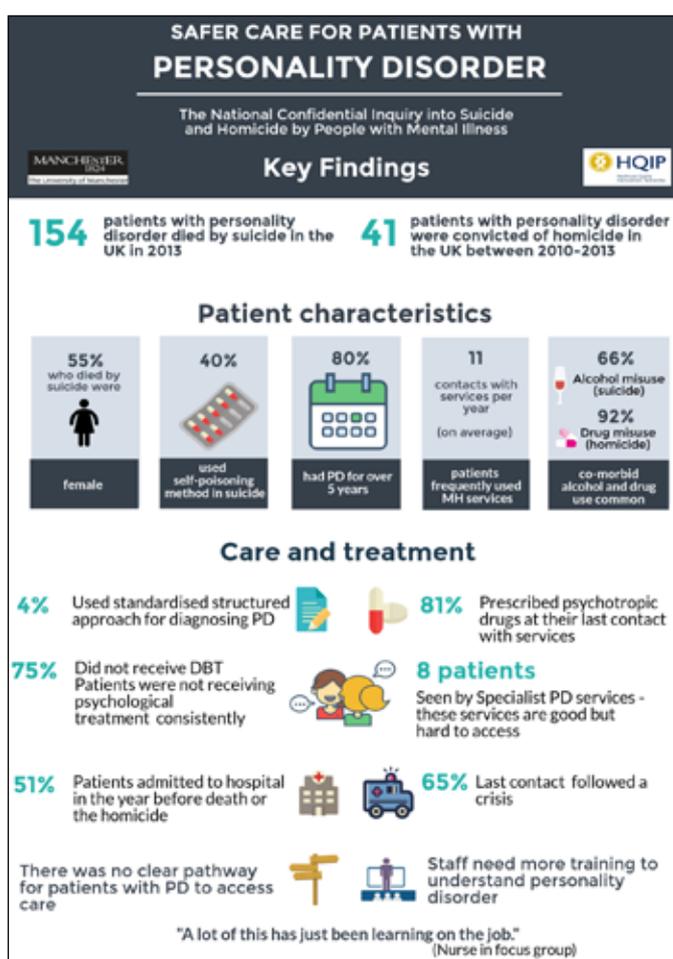
Supervised by:

Chris Flood and Stanley Mutsatsa,
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Individuals with personality disorder (PD) are often frequent users of mental health care. However, management of PD patients is notoriously challenging and influenced by the type of PD, the degree of severity and the presence of comorbid psychiatric disorders. Patients with PD, particularly borderline PD, are at high risk of suicide and commonly feel marginalised from mainstream mental health services. We wanted to analyse the characteristics of patients with PD prior to suicide and homicide to learn more about their treatment and pathways into care. We wanted to examine whether services followed NICE guidance for PD. Finally, we wanted to learn from patients and staff about their experiences and how they think services could be improved.

Key findings

- There were 154 patient suicides and 41 homicides identified in the study period.
- 55% of patients with PD who died by suicide were female.
- 40% used self-poisoning as a method.
- 81% prescribed psychotropic drugs at their last contact.
- 80% had a diagnosis for more than five years.
- Co-morbid alcohol and drug misuse was common - Alcohol misuse was noted in 66% of suicides and 82% of homicides and drug misuse in 53% of suicides and 92% of homicides.
- A structured approach to diagnosis was only found in 4% of cases.
- The average number of contacts per year was 11. With 25% having received Dialectical Behaviour Therapy (DBT) in the 12 months prior to death/offence. There was no clear pathway for patients with PD to access care.
- Despite NICE advice to avoid hospital admissions, 51% of patients were admitted to hospital in the year before death/offence.
- Eight patients had been seen by a specialist PD service - these services are good but hard to access.
- Staff need more training to understand personality disorder.



Key messages

- There is no clinical justification for patients with personality disorder to be excluded from care. This is a high need, vulnerable group who require appropriate and timely access to mental health care specific care arrangements to reduce the risk of self-harm.
- A diagnosis of personality disorder itself is part of the problem. The term continues to be used internationally partly because the diagnosis is required for admin or legal purposes. Work with patients is needed to identify a new way of formulating their experiences and difficulties.
- Stability of care is required in the service, with a focus on preventing rather than responding to crises.
- It is crucial that psychological treatments such as DBT and MBT (Metallisation Based Therapy) are available and continual supportive care is provided by mainstream staff while patients are waiting to be treated.
- Safer prescribing of psychotropic medications that could be used in fatal overdose is needed. Clinicians should be aware of the potential risks of prescribing these drugs long-term.
- Staff are currently not sufficiently trained to support and manage patients with personality disorder. Skilled staff should be available in all mental health services. Although not examined in this study, it would be valuable if training were extended to GPs and primary care mental health teams to increase understanding of the illness.
- Patients with PD often have complex needs including comorbid substance misuse. Substance misuse and mental health services should work closely to manage clinical risk.
- When specialist services and therapies were accessed by patients they were found to be good.
- Former patients are an under-used resource and should have involvement in staff training, advocacy and peer support where possible.
- Improving safety does not have to mean excessive burden on existing capacity and resources. These patients are already receiving care, but for many this is in a disorganised and costly way which compromises safety.

SAFER CARE FOR PATIENTS WITH PERSONALITY DISORDER

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Key Messages

MANCHESTER 2014

HQIP

Patients were not receiving care consistent with NICE guidelines:

- Psychological interventions
- Short-term prescribing
- Avoiding hospital admission

Survey and focus groups with staff and patients suggested these problems may be more widespread

Therefore...
an examination of personality disorder services is needed

Working with patients to understand their traumatic experiences would help reduce stigma

Safer prescribing of psychotropic drugs is needed to avoid fatal overdose

Risk is linked to co-existing drug and alcohol use; dual diagnosis services should be available

Former patients should be involved in staff training, advocacy and peer support

Jane Graney, University of Manchester, jane.graney@manchester.ac.uk

Secondary care memory clinics in primary care sites

In 2016, LYPFT memory services set up a new partnership arrangement with primary care. It comprised a link consultant, typically with a psychiatrist or memory nurse, running four to eight half day clinics per month in each of seven GP clinics, providing memory assessment and post-diagnostic support to patients in the locality. This service improvement project was carried out to evaluate the impact of these clinics from a patient and clinician perspective.

Methods

A mixed-methods evaluation was devised. Quantitative data were collected comparing patient assessment type, attendance and cancellation rates, and distances travelled both for Trust-based memory clinics and those based in primary care. Three questionnaires were developed for use with patients, LYPFT staff and GPs to understand what each group thought of the clinics and thematic analysis was subsequently undertaken of the results.

Results

There were 278 new patients and 469 follow up appointments conducted by LYPFT clinicians in GP clinics between October 2016 and September 2017. DNA (did not attend) rates were slightly lower compared with those located on Trust sites; however there was no meaningful difference in numbers of cancelled appointments by the patient.

Patient feedback was consistently positive with respect to their experience of attending clinic in a GP practice with 87.5% stating that, given a choice, they would prefer future appointments at the GP clinic. Reasons for this included improved ease of access and reduced anxiety.

LYPFT clinician feedback was more mixed. It was generally felt that GP clinics resulted in improved communication and better working relationships between the memory services team and primary care. There were however a number of logistical difficulties

which negatively impacted on the experience. Unfortunately, despite extensive efforts there were no responses from GPs.

Impact

With 90% of people with dementia having one or more other long-term conditions it has been suggested that centering dementia diagnosis and post-diagnosis management around GP practices would enable dementia to be better managed. Locating memory clinics in GP practices led to improvements in attendance rates, reduced distances travelled for patients and carers, and high patient and carer satisfaction. However, the degree of relationship between the LYPFT staff and GP site appeared to be important in the success of the project. Lack of feedback from any of the host GP practices is clearly disappointing. Significant investment was made by commissioners, LYPFT, primary care and clinical staff to set up these clinics. Although several benefits have been identified, a more in-depth (cost-benefit) analysis is suggested before system-wide roll-out is considered. This evaluation gives some support to this hypothesis but also highlights a few challenges for secondary care clinicians which would need resolving before further introduction of secondary care clinics in primary care is fully recommended.

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Staff experiences of the sexual health needs of people with severe mental illness

People with Severe Mental Illness (SMI) have been shown to be at higher risk of developing physical health problems compared with the general population. Whilst the assessment of physical health is improving, one area that is often neglected is sexual health (Hughes et al, 2016). Much of the current research focuses on the experiences of Mental Health Nurses (MHN) in addressing the sexual health needs of people with an SMI with little research into other areas of the NHS mental health workforce.

The aim of the study was to investigate the experiences of Healthcare Assistants (HCAs) in addressing the sexual health needs of people with SMI on inpatient wards. The research consisted of a non-experimental qualitative study carried out within Leeds and York Partnership NHS Foundation Trust (LYPFT). A convenience sample of five HCAs was recruited. Data was collected through face-to-face interviews and analysed using thematic analysis following the Framework Approach to generate themes and core concepts.

The study identified four core concepts:

1. Acute inpatient environment,
2. Barriers,
3. HCA role, standards and competencies and
4. Improving the situation were developed.

This study suggests that sexuality and sexual health is a complex issue and challenging on inpatient mental health wards. The experiences of HCAs were similar to that in previous research amongst Mental Health Nurses (MHN). HCAs reported many barriers in addressing sexual health needs such as feelings of embarrassment and a lack of

sexual health knowledge. Sexual health was often not addressed in a systematic way with HCAs relying on their own skills and experiences. It is therefore important that sexual health is routinely assessed as part of a holistic assessment and HCAs can play a significant role in this. HCAs tend to be the part of the workforce delivering most of the therapeutic interventions. Increased levels of training and integrating HCA into the decision making processes of the ward may lead to fully meeting the sexual health needs of service users.

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The research and experiences of Integrated

Lisa Roberts and Marlis Elliott are both occupational therapists (OTs) undertaking the Integrated Clinical Academic Programme Internship Scheme funded by Health Education England and the National Institute for Health Research. The scheme exposes non-medical clinical staff to the research environment and provides them with the practical skills to undertake a research project supported by an expert academic supervisor.

After the programme, interns are encouraged to apply their newly learned skills within their Trusts, become research champions, and consider a future clinical academic career.

For more information about the Integrated Clinical Academic Programme visit the 'Study here' pages at www.shu.ac.uk.

Lisa Roberts

My research described an international mountain biking population, their characteristics and preferences, and perceived benefits to health and wellbeing. It also looked at attitudes towards risk, social benefits, the role of nature, and benefits related to 'being in flow'. Data collection was in June 2016 as part of my Occupational Therapy Masters at Leeds Beckett University. This internship has enabled me to re-write this article with assistance from Dr Rob Brooks, my ICA mentor at Leeds Beckett University, and Dr Gareth Jones. The paper is currently in peer review with the journal *Frontiers in Psychology*.

Mountain biking is an increasingly popular outdoor activity on the extreme sport continuum. Recent studies have highlighted the therapeutic potential of extreme sports and similar outdoor activities. The aim of this study was to describe the characteristics of mountain biking participants, their engagement methods, and perceived benefits to mental health and wellbeing.

This was a cross-sectional survey and participants were recruited via social media. An online questionnaire specific to the domain of mountain biking was developed. Analysis of the full sample (n=1,484) and of three independent binary sub-samples was conducted. The sub-samples compared the results of males and females; younger and older riders; and those who have and have not recently engaged in downhill mountain biking.

The results identified some disparities in mountain biker characteristics and engagement methods. They suggest that some riders found pleasure in higher risk engagement. The study proposes various explanations for the disproportion of women in mountain biking. Irrespective of the confounding factors related to rider characteristics or engagement methods, mountain bikers reported copious benefits to mental health and wellbeing related to their engagement. There was a very high reported usage of mountain biking as a coping strategy. As such, this study provides insights that could inform the development of outdoor activities as interventions for mental health.

The ICA Experience

The ICA internship has given me a real feel for what a career as a clinical academic would be like. With 40 days of protected time out of work, I have not only had the opportunity to write and submit an original research manuscript for publication; but have also had the chance to work alongside many academics, PhD students and researchers, and to attend seminars and educational sessions. I now have far more confidence in my abilities to understand and present data, and in critiquing research papers; as well as networking and both written and verbal presentation skills.

I have had many opportunities to present my research at events e.g. Women in Cycling 2017

Clinical Academic (ICA) Programme Interns

conference in Bradford, and the International Mountain Biking Association (IMBA) 2018 Summit in Slovenia. At the IMBA summit I was also on a panel discussing how healthcare research could impact mountain biking policy and access issues more broadly. I have written an article for the quarterly Anxiety UK magazine and had a guest feature on their blog; with the intention of highlighting the numerous benefits of mountain biking on mental health and encouraging more people – with or without mental health problems - to become involved.

Marlisse Elliott

My research explores the transitional periods in the lives of ex-elite climbers and mountaineers, placing particular focus on the impact of injury, illness or ageing and the subsequent effects this has on identity, belonging and wellbeing. I was interested in pursuing this research because OTs have a good understanding of how a meaningful occupation could have a positive impact on mental health (e.g. the benefits of exercise, being outdoors, belonging within a community, etc.). I wanted to see what happens when an individual's ability to maintain engagement in such an occupation is threatened.

As mental health professionals, we often encounter service users during periods of transition, whether during an acute mental illness, coming to terms with a dementia diagnosis or coping with difficult life events. We are in a unique position to support people in making sense of these experiences, and for OTs, this often means enabling people to participate in occupations that are of value to them.

OTs are good at finding creative ways of adapting occupation. Gardening, for example, can be modified to suit diverse service users' needs: setting up an indoor garden for a service user with anxiety

about leaving the house, making a garden dementia friendly or raising flower beds for wheelchair users. This skill is central to the practice of occupational therapy, however, sometimes this tendency to focus on how previous interests can be made accessible to our clients can overshadow the fact that perhaps they no longer want to pursue these interests. This propensity to attempt to show our service users adaptive ways into their old interests may in fact have deleterious effects on their mental health by failing to account for the distress that may be caused by not being able to participate in an occupation in the same way or to the same standard.

I was interested in extending the scope of practice beyond occupational adaptation to consider more broadly how we can support individuals to negotiate new but continuous senses of selves through and following times of transition. I have interviewed ex-elite climbers and mountaineers and employed a narrative methodological framework to account for the unique ways in which they have experienced key transitional periods out of their careers. This has highlighted the diverse and creative responses people have had to these experiences that have enabled them to maintain their connections to climbing/mountaineering or engage in new pursuits entirely. While this included those who have adapted to continue climbing/mountaineering in light of injury, illness or ageing, it has also considered those who no longer climb/mountaineer but have found other ways of maintaining a relationship with this occupation e.g. through landscape photography as well as those who have actively sought to cease their connections to climbing/mountaineering altogether.

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The experiences of boredom for adults with mild learning disabilities

Taking an occupational therapy perspective, it is appreciated that meaningful occupations are essential to achieving health and wellbeing. Few research studies have explored how adults with mild learning disabilities manage boredom and how their time is spent. The aim of the study was to 'explore the lived experiences of boredom with adults with mild learning disabilities'.

When exploring the experience of boredom with this small population sample, semi-structured interviews were conducted which were later analysed using Interpretative Phenomenological Analysis*.

Four themes emerged:

- 1) **Time Use (Leisure, Volunteering and Boredom):** The majority of the participant's time was spent engaging in leisure activities; whilst none of the participants were employed, four out of five were actively volunteering; participants found successful strategies for managing boredom.
- 2) **Co-occupations:** The participants frequently spoke of others being involved in their occupational engagement experiences, including friends and family, colleagues or support staff. The findings suggest that by participants engaging in co-occupations, their opportunities were greater than they would be if they did not have that level of support and group activities.
- 3) **A 'learning disability community':** There continuously appeared to be a sense of community amongst individuals who have learning disabilities, their social network and services that support these individuals. Three participants volunteered for learning disability specific services from which they were receiving support.
- 4) **Autonomy:** It appeared participants had the confidence and opportunities to express concerns and find alternative support and opportunities to engage in meaningful occupations.

This study has added to literature surrounding how adults with mild learning disabilities spend their time and highlights the value of autonomy within their daily lives.

*Interpretative phenomenological analysis (IPA) offers insights into how a given person, in a given context, makes sense of a given phenomenon.

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National Institute for Health Research (NIHR) funding opportunities



National Institute for Health Research

The NIHR Clinical Research Network Portfolio is a database of 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 help with study promotion, set-up, recruitment, and follow-up.

Funding stream	Deadline
Efficacy and Mechanism Evaluation (EME)	Commissioned (Stage 1) (straight to full) - 21 Aug, 1pm
	Researcher-led (Stage 1) - 21 Aug, 1pm
	Mental health themed call - 21 Aug, 1pm
Health Services and Delivery Research (HS&DR)	Researcher-led (Stage 1) - 06 Sept, 1pm
	Evidence synthesis (straight to full) - 06 Sept, 1pm
	Mental health themed call - 06 Sept, 1pm
Health Technology Assessment (HTA)	Commissioned calls: Primary Research (Stage 1) - 01 Aug, 1pm
	Commissioned calls: Primary Research (Stage 1) - 19 and 26 Aug, 1pm
	Researcher-led: Evidence synthesis and Primary Research (Stage 1) - 29 Aug, 1pm
	Mental health themed call: Evidence synthesis and Primary Research - 29 Aug, 1pm
Invention for Innovation (i4i)	Challenge Awards Call 8 - Mental Health (Stage 2) - 26 Sept, 1pm
Programme Grants for Applied Research	Competition 26 (Stage 2) - 02 Aug, 1pm
Public Health Research (PHR)	Mental health themed call - 30 Jul, 1pm
	Researcher-led - 31 Jul, 1pm
Research for Patient Benefit (RfPB)	Competition 35 (Stage 2) - TBC July

Funding streams:

1. Efficacy and Mechanism Evaluation (EME): Researcher-led and aims to improve health/patient care. Its remit includes clinical trials and evaluative studies.
2. 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.
3. 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.
4. Invention for innovation (i4i): Funds research into advanced healthcare technologies and interventions for increased patient benefit in areas of existing or emerging clinical need.
5. Programme Grants for Applied Research: To produce independent research findings that will have practical application for the benefit of patients and the NHS in the relatively near future.
6. 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.
7. 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 funding opportunities through the NIHR, visit: www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/

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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To what extent does social support influence alcohol dependency?

Previous research has identified a link between the severity of alcohol misuse and the amount of social support a person receives. Tessa Gillham and Saskia Fauguel, medical students from the University of Leeds, were interested in replicating some of this work with a local population.

Service users with mental health and alcohol problems, who were under the care of LYPFT, were invited to participate in the study anonymously. Those who agreed were asked to fill out a series of questionnaires which captured demographic data, the severity of their alcohol misuse and their perception of the amount and quality of social support they received.

Completed questionnaires were collated and analysed by the students. In total, only six people participated in the research which meant that the results were not statistically significant but did show a trend that people with more severe forms of alcohol misuse had the lowest levels of social support.

This small piece of work produced results which were broadly aligned with larger studies that identified social support as an important factor influencing a person's alcohol misuse behaviour. The students concluded that social support should form part of the therapeutic interventions offered to people with alcohol misuse disorders.

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