

Clinical Psychology

Issue 30 October 2003



Eating disorder services surveyed
Have you got children of your own?
The oblivion pill

Editorial Collective: Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Garfield Harmon, Helen Jones, Craig Newnes, Mark Rapley and Arlene Vetere.

Clinical Psychology is circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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- Articles of 1000-2000 words are welcomed. Send two copies of your contribution.
- When sending hard copy, make sure it is double spaced, in a reasonably sized font and that all pages are numbered.
- Give a 40-word summary at the beginning of the paper.
- Contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e. avoid clustering terminology like "the elderly" or medical jargon like "person with schizophrenia". If you find yourself using quotation marks around words of dubious meaning, please use a different word.
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- Include a word count at the end (including references).
- Spell out all acronyms the first time they appear.
- Include the first names of all authors and give their employers, and remember to give a full postal address for correspondence.
- Give references in *Clinical Psychology* style, and if a reference is cited in the text make sure it is in the list at the end.
- Don't include tables and figures unless they save space or add to the article.
- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.

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News

Hungering for the truth

On 16 August six 'psychiatric survivors' from across the USA arrived in Pasadena, California, to begin a hunger strike for human rights and choice in psychiatry.

The six are refusing all solid food until the American Psychiatric Association (APA) and several other bodies respond to challenges sent to them or admit that psychiatry does not meet the standards of orthodox science. These challenges call upon the recipients to:

- prove the biological basis of mental illness;
- show that there is a reliable test for such illnesses;
- define medically what a normal person is;

- prove that there is such a thing as a chemical imbalance; and

- demonstrate that violence can be prevented with drugs.

Any responses will be reviewed by a panel of academics and practitioners which includes DCP member Professor Mary Boyle.

David Oaks, one of the hunger strikers and the executive director of MindFreedom Support Coalition International said:

This hunger strike is about the growth of an alliance between psychiatric survivor human rights activists on the one hand, and mental health professionals and scientists who are willing to speak out about the truth, on the other. We must alert the public that the drug industry and groups they fund are squeezing out the right to choose in the mental health system. For the past few decades, these corporations have had one message for the public: That emotional and mental problems are primarily a biologically-based brain disease. We say 'prove it.' We say that our lives, our minds, our communities are far more complex than that.

Soon after the strike began, Dr. James H. Scully, Jr., the APA Medical Director, responded to the challenges:

The answers to your questions are widely available in the scientific literature, and have been for years. I suggest you begin your review with Surgeon General David Satcher's report, *Mental Health: A report of the Surgeon General*. In addition, I recommend the *Introductory Textbook of Psychiatry (third edition)*, edited by Andreasen and Black. This is a 'user-friendly' textbook for persons just being introduced to the field of psychiatry.

After 14 days of the strike, four of the original participants were still taking part and a growing number of people were fasting in support of them.

DCP Chair Elect

Are you interested in the future of clinical psychology and want to influence it? Do you have substantial management or training experience?

If so, we are looking for an able person to be Chair Elect of the Division 2004-5, Chair 2005-6 and Vice Chair 2006-7. For more information please contact Dorothy Fielding (Chair), Mike Wang (Vice-Chair) or Peter Kinderman (Chair-Elect); contact details can be obtained from Gwen Ward or Lesley Dexter on 0116 252 9517/9903 or gwewar@bps.org.uk, lesdex@bps.org.uk.

The Division is able to underwrite or make a contribution to employers of up to £15,000 in order to allow the officer concerned to carry out Division duties whilst acting as Chair. There is also agreement to develop this to provide a fully-funded half-time secondment during the Chair year.

Correspondence

✉ **Mandatory CPD**

Firstly, I would like to respond to Michael Church's letter in my role as Chair of the Society's Standing Committee for CPD (scCPD). The BPS membership voted in 2000 to make CPD mandatory for members holding a practising certificate, and individuals have a duty to show that they are undertaking CPD. The scCPD is currently engaged in a project to look at the most appropriate way of implementing this.

Whilst self-regulation of professionals may be considered as an ideal, the Society has a duty of care to ensure the protection of the public and so is trying to find a workable balance between facilitation and validation. The aim is to develop a framework which allows individual psychologists as much flexibility as possible within the boundaries of a mandatory system.

A key aspect of the CPD proposals is a change in emphasis from an inputs-based system recording hours spent on CPD activity, to one which shows engagement in the whole learning process, including planning, reflection and evaluation of the outcome relative to an individual's own professional practice. Within such a framework, individuals would have a great deal of scope for identifying their needs, choosing appropriate development activities and relating the learning to their own personal practice.

Consultation with the membership has been carried out throughout the CPD project, and updates of progress can be viewed on the Society's Website: www.bps.org.uk/careers/cpd2.cfm.

Secondly, I would like to put forward my view as an individual psychologist. What struck me immediately about Michael Church's letter was that it made no mention of the people on the receiving end of the psychologist's services.

I became involved in the BPS's scCPD shortly after starting work at the Manic Depression Fellowship (MDF). I was incensed by the amount of damage so-called professionals had inflicted on this often very vulnerable population.

To say that interventions were frequently not 'evidence-based' would be an understatement.

We hear of reflexologists who advise clients to stop their medication, GPs who prescribe medication which triggers a psychotic high, psychiatrists who have told their patients that CBT will only benefit people who wish to sleep with their mothers etc. etc. Unfortunately, the list goes on.

In fact, we are now starting to log this information. If the professional bodies themselves are unwilling to raise the standards, then the drive will come from patients who are unwilling to accept this level of service.

The MDF has members who have relied on the services of a whole range of practitioners, some accredited to professional bodies, others not. We have found that patients frequently do not discriminate between the two; they are often desperate to find help, especially when they are at their most distraught. Self-regulation is a great idea in theory, but there is evidence that it's simply not happening in many instances. The list of complaints we receive is testimony to that.

What assurances could we offer the members of MDF about the quality of the service they will receive from chartered psychologists? I hope that most psychologists will want to be part of a professional body which does its utmost to protect the recipients of its services.

Amanda Harris

Chair, Standing Committee for CPD

✉ **Word-upmanship?**

Murray et al.'s report in **CP28** regarding the use of the WAIS-III with people with a learning disability raised pertinent points about the language used for subtest instructions, as well as our profession's use of language in general.

Using the WAIS-III with my clients has been an experience not unlike reading CP recently, and I am forced to ask in all areas of psychology, who are we writing for? Most of my clients do not understand 'alike' (similarities instructions), don't understand the concepts in letter-number sequencing, and have forgotten the lengthy instructions by the time I say 'begin'.

Of late, CP has been filled with rhetorical articles made up of psychobabble-jargon which I've needed a dictionary to decipher, and I have certainly forgotten the beginning by the time I reach the end. As a tool for increasing empathy for my clients, it works, but shouldn't we as a profession be confident enough to call a spade a spade, rather than engaging in word-upmanship? Expressing ideas or instructions simply gets our message across to a wider audience and kicks away the pedestal our words seem to have placed us on.

Rebecca Crook

North West Wales NHS Trust, Caernarfon,
Gwynedd

✉ **Stephen Wright**

Just a brief addition to the obituary of Stephen Wright, a man whom I did not know but whose death saddened me. I too am a cycling nut (as well as a psychologist).

I remember the articles in New Cyclist in the 1980s. I am sure Stephen went much further than his colleagues describe in the obituary. He used a device on the rear of his bike which measured the distance by which cars passed him. He tested out all manner of 'visibility aids' of the kind marketed as increasing your safety as a cyclist. He demonstrated that at least one of these devices (a horizontal flag that attaches to the bike and which sticks out into the road so that cars have to take you more into account) was actually counterproductive. In fact drivers passed more closely when cyclists used this aid. The reason, of course, is target fixation.

I always liked the elegance of the experiment and the fact he was a cycling nut like me.

Chris Mearns

Clinical Child Psychologist, Northumbria
Healthcare Trust, North Shields

✉ **Abandoning 'MLD'**

I agree with Simon Whitaker's article (CP29) arguing that we should abandon the concept of mild learning disability as we may be excluding clients from a service. There are further points that strengthen his arguments.

First, the white paper *Valuing People* (Department of Health, 2001) states that learning disabled

clients should be seen by mainstream services where possible. In theory this is good practice, but it has meant that some clients with mild learning disability have become the focus of debate between adult mental health and learning disability services as to who provides a service. The practicalities of this White Paper have not always been thought through.

This class of client often includes those with poor cognitive abilities (i.e. mild or borderline learning disability) who have difficulties with social and adaptive function. They may have fragile support structures and be open to exploitation; they are surviving but not thriving. If their support structures break down or they come under extra stress this can precipitate psychological distress (depression, anxiety). By reason of IQ scores they will be excluded from Health and Social Services Learning Disability Services and only receive intervention in emergencies, often returning to unchanged circumstances afterwards. Ongoing support with adaptive and social functions from a learning disabilities or other service (vulnerable adult?) would be preferable to, and lessen the need for, emergency treatment.

The White Paper has also defined learning disability to exclude a large number of people with autistic spectrum disorder and who do not have 'intellectual impairment' who previously would have received a service from Learning Disability Services (National Autistic Society, 2001).

Second, there are reasonable arguments against there being such a thing as 'intelligence' that can be measured by 'IQ'. Space does not permit expansion of this point, but see, for example, Lezak (1995: 24) for arguments against the idea of general intelligence from a neuropsychological point of view, see Cosmides and Tooby (1994) for an evolutionary psychology perspective and for balance see counter arguments from Panksepp and Panksepp (2000).

Third, the American Association on Mental Retardation has abandoned the use of mild, moderate, severe and profound learning disability and concentrates on classification by aspects of adaptive and social behaviour which are support-need based (AAMR, 2002); see Turk (in press) for a review. Perhaps we should consider moving away from DSM-IV and ICD-10 criteria to AAMR criteria.

I would argue that, in the case of mild learning disability, the basis for service inclusion should be the risk to that client if a support-based service is not delivered. This is the criterion used by some Social Service departments for service eligibility (NE London Sector Strategic Health Authority, 2002).

Debate on this topic within the DCP and its Faculty of Learning Disability would be welcome

John Rowe

Clinical Psychologist, Learning Disabilities Service, City and Hackney Teaching PCT and Clinical Neuropsychologist, Adult Mental Health, East London and the City MHT.

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Division of Neuropsychology Post-Qualification Training Day

Memory Rehabilitation

Friday 14 November 2003 (9.30 for 10 a.m. start)

London Voluntary Sector Resource Centre, 356 Holloway Road, London N7

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Assessment of memory for rehabilitation: functional and standardised measures

Dr Jonathan Evans

General principles in memory rehabilitation

Prof. Barbara Wilson

Recent technological developments in memory rehabilitation

Dr Jonathan Evans

A goal setting approach to memory rehabilitation

Dr Linda Clare

Managing the emotional consequences of memory impairment

Dr Fergus Gracey

For further information contact: Prof. Michael Oddy, Brain Injury Rehabilitation Trust, 32 Market Place, Burgess Hill, RH15 9NP; Tel: 01444 237287, Fax: 01444 244 978, e-mail: birt@disabilities-trust.org.uk

A survey of locality eating disorder services within England, Scotland and Wales

Lorraine Bell, Havant, Hampshire

A survey was carried out of locality eating disorder services within England, Scotland and Wales. A range of features are described and analysed, including level of service provision, referral criteria and staffing. Staffing and the professional background of the lead clinician vary appropriately according to whether services have in-patient beds or not. The monitoring of key features of services is a valuable exercise and can help address a range of questions raised in the commissioning of specialist services for people with eating disorders. Uniprofessional and multiprofessional specialist training in eating disorders is a priority for the NHS.

In recent years there has been increasing demand for treatment for both anorexia nervosa (AN: van Hoeken *et al.*, 1998) and bulimia nervosa (BN: Turnbull *et al.*, 1996). Specialist treatment may reduce mortality (Crisp *et al.*, 1992; Nielsen *et al.*, 1998). Given the risk of chronicity and associated disability or morbidity, and the challenges involved in helping those with eating disorders, specialist services are recommended (Robinson, 1998; Palmer, 2000). There have in recent years been an increasing number of specialist teams or services set up. There is little information documented about these services, a challenge to any psychologist or other professionals new to the field tasked with developing services for people with eating disorders.

Methodology

Specialist eating disorder (ED) services were identified through the British Psychological Society Division of Clinical Psychology special interest

group in eating disorders (EDs) and participant lists for the last two London International Eating Disorders Conferences (1999, 2001). A total of 35 services were identified and 32 sent a brief questionnaire (one side of A4). Services which predominantly help patients 'out of area' (three in total) or private units were not included as these are not representative of services commissioned to help local populations though the former all serve local catchment populations as well as taking referrals from elsewhere in the country.

Twenty-nine replies were finally received. Three services did not reply (one group A and two group B or C, see below) and one service had been absorbed by another. Twenty-eight services were included in the results. All but one treated EDs exclusively; one treated a range of behavioural disorders. Where there were omissions in the data, respondents were contacted by telephone and further information obtained where possible. However, some omissions in the data remained.

Results

Number and type of service

All services see outpatients, but they vary in whether they provide day treatment programmes or inpatient treatment. Services were divided into four groups, according to the services they provide, lettered A to D.

Most services (15) had outpatient services only (Group A), seven services had both beds and day care (Group B), four had day care but no beds (Group C) and two had beds but no day care (Group D). Services which provide partial day care (less than four days per week) were classified within group A.

Results are based on current provision at the time of the survey. (Two services were preparing for other provision in the near future. Two ser-

vices had had a day programme which they had closed through lack of use.)

Mean number of beds and day places where provided

Where day services were provided, the mean number of places was 9 (2–25). Where there were beds, the mean number of beds was 6.5 (3–12).

Mean and range of population size served

The mean population served was highest for group B (1920K), range 570,000 to 5.2 million. Group C had a mean of 719,000 (range 475,000 to 1.1 million). Group D had a mean of 679,000 (667,000–691,000) and group A 519,400 (290,000–750,000).

Mean and range of number of referrals/patients seen per annum

The average referral rate per year was 189, but the range varied widely between 46 and 500. Again group B had the highest referral rate (mean of 266), Group C 233, Group D 155 and group A 133.

Referral practices and criteria

All services saw people with anorexia nervosa (AN). One service did not yet treat other disorders as it had been established for less than a year. Only one service treats simple obesity; 26 of the 28 services treat AN, BN and eating disorder not otherwise specified (EDNOS), though seven services stated they did not treat BED.

Seventy-five per cent of services accepted GP referral. Most services (89 per cent) did not accept self-referrals, 15 services treated patients from out of area and three occasionally accepted OATs.

Most services (16) accepted referrals from the age of 16, although eight only took referrals from the age of 18. One provides a service to children and adults; no service treated patients over 65.

Staffing

Staffing breakdown is given in Tables 1–7 for 27 services, as one Group A service was not a unique eating disorder service.

Therapies provided

All services provided individual therapy and 24 stated they provided group therapies (83 per

cent). One third of services stated they provide family therapy, but responses to this question were incomplete.

Day care

The hours covered range between 4 and 12 (mean 7.7) and meals provided between 1 and 3 per day (mean two meals).

Discussion

Most NHS specialist services for adults with EDs were identified in the survey; a further four have been identified since. The total number exceeds those NHS adult services surveyed in the recent Royal College of Psychiatrists' report (2000), which identified services by writing to trusts and excluded those not led by a consultant psychiatrist. A number of common points arise from the two surveys: concern over variability in provision and inadequate provision in many areas, the need for training to improve recruitment and retention and meet the increasing numbers of services which should be developed. Some findings differ, namely the relative proportions of different professions and the professional background of lead clinicians.

It was difficult to analyse some data because not all responses were complete, in particular staffing levels, specific therapies provided and bed use.

In-patient services

Nine services had beds. The number of beds ranged from 3 to 12. This suggests that some beds are within generic psychiatric settings, as three beds are unlikely to warrant staffing a separate unit. The service with three beds was in group B, i.e. it also has day places. It may well be that the bed numbers have been reduced with the development of the day service.

Day services

There is preliminary evidence that day treatment for anorexia nervosa is an effective alternative for many patients (Piran *et al.*, 1990; Freeman, 1992; Kaplan & Olmsted, 1997; Gerlinghoff *et al.*, 1998), including men (Woodside & Kaplan, 1994). However, patients with major weight loss may fail to benefit from day treatment (Howard *et al.*, 1999). In addition to effectiveness and efficacy, acceptability to patients should be considered (Doll, 1973). Day treatment is likely to be more accept-

able to patients and has many advantages. It is a more appropriate setting to learn eating-related skills such as shopping for and preparation of food, which are essential to maintain a healthy weight independently. Day care also has an important role in providing transitional care between inpatient and community settings (Dalle Grave *et al.*, 1993) – a transition which many patients find difficult and a time when weight is commonly lost (Crisp *et al.*, 1991).

Eleven services provide day treatment for 4–7 days per week (mean 3.8). The number of places ranged from 2–25 for those with beds and 6–12 for those without. Three services provided day treatment for 1, 2 or 3 days. The hours covered

range between 4 and 12 (mean 7.7) and meals provided between one and three per day (mean two meals). An additional service accesses a generic day care service. Most services providing day treatment also had inpatient facilities (7), but four did not – one of which was about to open beds. The advantage of having day places and beds together is that patients can be transferred between the two as appropriate and that a partial day programme can be sustained when numbers on a day programme are low. (Some group work could be shared between in-patients and day patients but this is generally not recommended). Clearly, having both beds and day programme provides maximum flexibility and also a

Table 1. Medical staffing

	Total with input	No. with consultant (mean WTE)	No. with other grade (mean WTE)	No. accessing generic services	None
Group A	9	8 (0.4)	1 (0.4)	1	4
Group B	7	6 (0.9)	4 (1.4)		
Group C	3	2 (1.0)	2 (0.4)		1
Group D	2	1 (0.2)	1 (0.8)		
Total	21	17 (0.6)	8 (0.75)	1	5
<i>Mean & range WTE</i>	0.8 (0.2 - 2.0)	0.6 (0.2 - 1.8)	0.75 (0.3 - 2.0)		

Table 2. Number of services with clinical psychologists

	Total with input	No. with consultant (mean WTE)	No. with other grade (mean WTE)	No. with assistant (mean WTE)	No input at all
Group A	13	10 (0.6)	10 (0.65)	4 (0.7)	1
Group B	7	6 (0.8)	3 (1.3)	1 (1.0)	
Group C	4	3 (1.1)	4 (1.4)	1 (1.0)	
Group D	2	1 (0.2)	1 (1)		
Total	26	20	18	6	1
<i>Mean & range WTE</i>	1.2 (0.2 - 3.0)	0.7 (0.2 - 1.3)	1.0 (0.2 - 3.0)	0.9 (0.2 - 1.2)	

Table 3. Nurses and nurse therapists

	Total with input	No. with nurse (mean WTE)						None	Mean & range WTE
		<i>I</i>	<i>H</i>	<i>G</i>	<i>F</i>	<i>E-A</i>	<i>Unspecified</i>		
Group A	11		2 (2.0)	10 (1.8)	3 (0.7)			3	1.5 (0.6 - 3.0)
Group B	7	1 (1.0)	2 (1.0)	2 (3.0)			3 (9.2)*		3.5
Group C	4		1 (1.0)	2 (1.0)		1 (1.0)	2 (6.3)		2.3 (1.0 - 10)
Group D	2	1 (1.0)		1 (2.0)	1 (1.0)	1 (1.5)	1 (3.4)		1.8 (1.0 - 3.4)
Total	24	2 (1.0)	5 (1.3)	15 (2.0)	4 (0.9)	2 (1.3)	6 (6.3)	3	
<i>Mean (range)</i>	2.3 (0.6 - 10)								

* This is an underestimate as two services did not provide data from in-patient staff.

Table 4. Number of services with dietitians

	Total with input	Chief	Senior	Unspecified	Access generic	No input
Group A	10	2 (0.65)	8 (0.4)		2	2
Group B	6		6 (1.0)			1
Group C	4		3 (0.7)	1 (0.4)		
Group D	2		1 (0.4)	1 (1.1)		
Total	22	2 (0.65)	18	2	2	3
<i>Mean & range WTE</i>	0.6 (0.2 - 1.0)	0.65 (0.3 - 1.0)	0.6 (0.2 - 1.4)	0.75 (0.4 - 1)		

critical service size both in terms of referrals received and staffing. Three UK services which have provided day programmes no longer do so; two of them stated in the survey that they closed through under use. It would be useful to repeat the survey at a future date and identify if independent day services of this size are sustained.

Unfortunately responses regarding bed use were not complete so it was not possible to estimate the relative bed use of services with and

without day care. This would be an important priority if the survey were repeated.

Size of service

As expected, services with both beds and day treatment serve the largest populations. The smallest population served is 290,000. Though demand between geographical areas will inevitably vary, the data revealed in the survey suggest what is viable for a service to provide day

treatment or inpatient treatment. It would seem that a population of 300,000 warrants a small specialist team. This echoes the suggestion of the *Health Which?* report (1998). However, joint commissioning or specialist Trusts serving larger populations could provide a more robust service. A population of half a million may be sufficient for a day service, though a million is usually recommended to remain viable. The two in-patient units without day services served a similar and small population (667-691K). One can speculate that a day service could significantly reduce bed use in those services. One way of sustaining a service with fluctuating referral levels is to take 'out of area' referrals, which most services do. These issues are critical to services considering developing a day programme, two of which reported they had closed from under use.

Referral criteria

Almost all services treat AN, BN and EDNOS, though one in four stated they do not treat binge eating disorder (BED). This is probably a capacity issue and that the disorder was not included in original commissioning agreements. However, more recently the National Service Framework (DoH, 1999) requires that protocols are agreed for the treatment of common eating disorders in primary care. With Primary Care Trusts taking responsibility for commissioning, some provision for the treatment of BED will need to be made, if not in a centralised clinic then through a stepped care programme for people with bulimic disorders which could be delivered in primary care.

Three quarters of services accept referral from GPs. This is welcome as it will speed access and reduce the number of gateways and assessments

Table 5. Number of services with occupational therapists

	Total with input	Head	Senior	Unspecified	Access generic	No input
Group A	5	1 (1.0)	3 (0.8)	1 (0.4)	1	8
Group B	7	2 (1.0)	4 (0.8)	3 (1.3)		
Group C	3		2 (0.8)	1 (0.5)		1
Group D	1			1 (1.4)		1
Total	16	3 (1.0)	9 (0.8)	6 (0.9)	1	10
<i>Mean & range WTE</i>	1	1	0.6 (0.2 - 1.4)	0.9 (0.4 - 2)		

Table 6. Other staff

	Social worker (mean WTE)	Family therapist (mean WTE)	Unspecified (mean WTE)	Physio-therapist	Art, dance or movement
Group A	2 (0.6)	1 (1.6)	1 support worker (1.0)	1 (0.2)	1 (0.4)
Group B		2 (0.3)	0.5	2 (0.25)	1 (0.4)
Group C		2 (1.0)	1 housekeeper (0.6)	1 (0.1)	1 (0.4)
Group D		1 (0.1)			1 (0.1)

Table 7. Professional background of lead clinician

	Consultant psychologist	Consultant psychiatrist	Nurse	OT	Dietitian	Other
Group A	7.5	2	2	1	1.5	1 (family therapist)
Group B	1	6				
Group C	3	1				
Group D		0.5	1	0.5		
Total	11.5 (41%)	9.5	3	1.5	1.5	1

for a patient before receiving specialist treatment. (Standardised mortality rates are highest during the first year after presentation so effective early treatment is essential, Nielsen *et al.*, 1998.) This may reflect primary care having a greater influence in the commissioning process. One implication of this finding is that the terms 'secondary' and 'tertiary' are unclear. The services which accepted direct GP referral were spread between groups. Seven out of nine services with beds take direct GP referral.

Two thirds of services accept out of area referrals which is helpful for those areas with no specialist eating disorder service and for inpatient treatment in NHS services when local beds are full.

The majority of services treat patients over 16 (61 per cent). However, eight services only treat patients over 18 (28.5 per cent), probably because this is consistent with the age threshold for the general adult mental health services. This is of concern as the peak age of incidence for AN is adolescence, i.e. 15–19 (Graber *et al.*, 1994; Hoek *et al.*, 1995). Standardised mortality rates are highest during the first year after presentation and delay in effective weight restoration can worsen long-term outcome (Nozoe *et al.*, 1995; Zipfel *et al.*, 2000). Effective early treatment is therefore essential (Nielsen *et al.*, 1998) so patients with anorexia nervosa between the ages of 16 and 18 should have access to ED specialists, as is the case in the majority of eating disorder services. Eating disorder specialists in child and adolescent services are rare outside of large metropolitan areas (Royal College of Psychiatrists, 2000).

There is general consensus that treatment for adolescents should ideally be provided in separate settings by adolescent specialists where developmental and educational needs are kept in clear focus. Some adult services treat patients between 16 and 18 according to what seems appropriate for that individual. Certainly those who have passed their 16th birthday but remain at school should be treated in child and adolescent services. However, it is likely that the criteria are largely shaped by local demarcation between youth and adult mental health services rather than treatment philosophy.

Staffing issues

Most services employ psychologists, psychiatrists, nurses, dietitians and OTs in descending order of frequency. (These results differ from the recent survey of the Royal College of Psychiatrists which included private services, services for children and service in Northern Ireland but fewer outpatient-only services.) All but one service had input from a clinical psychologist. Services without beds are most likely to be led by a consultant clinical psychologist. All services with beds have psychiatric input and are led by a consultant psychiatrist. One of the four 'stand alone' day services has no psychiatrist input, though it is planning to in the near future and does have on its establishment. Five of the 15 outpatient services have no psychiatrist input. This may be because it is not on the establishment or because they have been unable to recruit. Some 78.5 per cent of services had psychiatrist input; in four of them it was not pro-

vided by a consultant. Nurses have the highest WTE and dietitians the least. The number of nursing staff naturally varies widely according to whether inpatient treatment is provided. Three outpatient-only services did not have nursing input but all others did. These are likely to be small teams where therapy is provided by psychologists and CPN provision is from local mental health teams.

There is a diversity of service models, arising partly from historical anachronisms, limitations in funding and availability of staff, but staffing and the professional background of the lead clinician may vary appropriately. Community teams which primarily provide outpatient therapy are legitimately led by psychologists and may achieve 'best value' (NSF, 1999) relative to a consultant psychiatrist. Professionals with a medical or nutritional training have an important contribution, but the core interventions for patients are psychological. Clinical psychologists therefore have an important role in providing, leading and evaluating eating disorder services (British Psychological Society, 2001).

There may be problems when teams have a contribution from a key profession, notably a psychiatrist or psychologist, working only two sessions. It could be difficult in practice for someone (particularly a consultant psychiatrist) to protect this time or maintain and develop specialist knowledge and skills. Equally, where services employ dietitians on a very part-time basis this will militate against their developing a greater contribution to the service. It can also be difficult to replace such staff if the person leaves. These situations have probably arisen because of limitations in budgets but also because of recruitment problems.

Recruitment and retention problems are experienced by many services. The numbers of WTE staff employed in the services included in this survey total 140.4. The numbers of people including those with part-time specialist roles is even higher. In addition, there are three supra-regional units, three services which did not contribute data and four not originally identified. Some unidisciplinary (e.g. for dietitians and nurses) and multidisciplinary (e.g. by the Leicester service) courses are available, but increased specialist training is a priority – a con-

clusion of the recent College of Psychiatrists' report (2000). All larger services need to take on a training role, in addition to the supra-regional London units, to help develop the necessary experience and skill base to fill these posts. In addition, a mentoring system by experienced practitioners within major professions could be established.

Therapies provided

Family interventions may have better outcome than individual therapy for the treatment of AN in those under 19 (Eisler *et al.*, 1997; Robin *et al.*, 1999). However, this is not provided in many services, a common finding of the Royal College of Psychiatrists' report (2000). Whilst experienced staff may be able to provide family counselling, skilled family therapists have a valuable role in providing supervision and helping dysfunctional families.

Further issues of interest

- Bed use relative to other provision and clarification of context of inpatient facility;
- proportion of patients referred or assessed with different disorders;
- treatments provided – body image therapy, interpersonal therapy, stepped care for bulimic disorders;
- patient database, audit and research;
- outcome measures if used;
- age of service and any changes in model or provision;
- policies or protocols for borderline patients, long-term AN and treatment of EDs in primary care.

Conclusions

There has been a considerable increase in specialist teams or services treating people with eating disorders. There are 14 NHS units with beds for the treatment of adults with EDs, including three supra-regional units centres. There are a further 20-25 specialist teams which provide outpatient

treatment, a few of which also provide day treatment. Staffing and the professional background of the lead clinician varies appropriately according to whether services have inpatient beds or not. The monitoring of key features of services is a valuable exercise and can help address a range of questions raised in the commissioning of specialist services for people with eating disorders. Recruitment and retention of staff is a problem in many services. Uniprofessional and multiprofessional specialist training in eating disorders is a priority for the NHS.

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How much do service users want to be involved in planning local mental health services?

Cailzie Dunn, Jane Hambleton, Olive Bucknall, Roger Addison and Rachel Cox, Shropshire County Primary Care Trust

Most initiatives in the health service now include reference to user participation. This study found that a significant number of users of a Community Mental Health Team wanted to be more involved in planning services.

Service users are increasingly being encouraged to contribute to the planning of mental health services. The National Service Framework for Mental Health refers specifically to involvement of service users in planning and delivery of services, and also to the need to 'develop effective mechanisms for service user and carer involvement to occur regularly' (Department of Health, 1999). Rose *et al.* (1998) demonstrated that people with 'severe and enduring mental illness' could have a voice in decisions about the mental health services they receive. Viv Lindow has gone further in suggesting that service users design and run their own services (Lindow, 1999).

Our local services have involved service users for a number of years in planning new mental health developments and now have a policy of paying service users for their expertise and time. The Shropshire Primary Care Trust has appointed a user development worker tasked with training and encouraging service users to act as consultants in a variety of areas including service planning. The development worker sits on the directorate management team in addition to supporting the patients' council and running a regular focus group on the in-patient wards. This initiative has already succeeded in raising the profile of service users in contributing to the Trust's aims. Service user consultants also sit on the

locality management groups, the Shropshire Partnership Board and the Telford and Wrekin Operational Management Group.

In addition, the department of psychological therapies in Shropshire has also begun to fund and support service users in carrying out their own research, and has for several years employed them as planning consultants and as consultants on interview panels (Long *et al.*, 2000). The department has worked alongside the Shelton patients' council in publishing research into the views of service users (Goodwin *et al.*, 1999).

We are a group of mental health workers and two service users from an urban Community Mental Health Team. Our aim with this survey was to ask service users whether they wanted to be more involved in planning mental health services in the area (North Shrewsbury) and, if so, in what ways.

Method

A questionnaire was sent to everybody receiving a service from North Shrewsbury Community Mental Health Team (172 people) and 12 members of the Shrewsbury System Survivors group. There were two questions:

- Are you involved in the planning of the mental health services you receive? If no, please say why you think you are not.
- Would you like to be more involved? If so, how would you like to do this? If no, please tell us why not.

The responses from service users were categorised using a content analysis. An independent researcher then used the suggested categories to

reclassify the statements. There was an 80 per cent agreement between the researchers on how the responses should be categorised.

Results

Fifty-seven people replied; a response rate of 36 per cent.

Involvement in planning

Twenty-three respondents indicated they were involved in planning mental health services, 19 were not. The yes answers predominantly reflected the point of view of the individual's own particular care (22 replies), for example;

Yes, my social worker and I discuss my next move – to get me outside more.

Yes, in as much that I phone for a visit rather than prearranged.

Only one person answering 'yes' looked more broadly at planning services in general:

Yes, through the adult subgroup of the joint collaborative team.

Reasons for non-involvement

A range of reasons were given for non-involvement; some gave as their reason for not being involved their lack of knowledge or a lack of information made available to them as to how to do this (7 responses):

No! Never asked.

No. I have never been approached to be so.

No – don't know how to be.

Others saw it as due to a personal deficiency in themselves, or because they didn't believe their role as a patient allowed it (5 responses):

No, not sufficiently qualified or confident enough.

No, because I am a patient.

or as due to a deficiency in the service, in not encouraging users to be involved (3 responses):

Lack of interest by service providers.

To a certain extent, but mostly no. I feel quite powerless and vulnerable (I am currently 'stuck' on an acute ward in Shelton). It is very hard to 'stand up for yourself' when caught up in the mental health system.

No – I think you are told who to see and it is a case of, take the treatment that's offered or go away.

One respondent said they did not want to be involved, and there were three answers that could not be clearly categorised.

Wanting more involvement in planning

Thirty-one respondents wanted to be more involved, compared to 14 who did not. Most of the positive responses were accompanied by direct suggestions for the service to change in some way, or ways in which the service could encourage user feedback (23 responses):

Yes, I wish existing groups and services paid more attention to social/communication skills and friendship/relationship skills. Courses I have attended have been woefully brief. I have learned a lot through books, but I feel that others who have not made the effort are severely emotionally and socially impoverished. Also, I have met other users with speech impediments who are not getting speech therapy. One of the people was recently sectioned after a crime they committed. I am convinced that with adequate social skills and speech therapy they would never have got into this appalling mess.

Yes I would like to be able to choose my psychiatrist.

Yes. Outside the hours of 9–5 very little support is available in the community.

Even a phone-in support organisation would aid the services and be complementary. Illness is a 24-hour scene and when it strikes at night, is despairing.

Yes. Mental health providers deal too much in practical activities and not enough with mind stimulation.

Some respondents requested more information from the service (5 responses):

Yes. I think it is of paramount importance to give as much choice/control to the patient as possible, especially with respect to therapy/treatment.

Yes. I would like to make a point concerning newly 'diagnosed' patients in that if GPs issued them with leaflets, etc. a lot of stigma could be eliminated at source and at an earlier point in time.

Yes I would like to have things explained more before you start treatment – like what it can do for you and what it can't.

Others asked to be consulted more about what they wanted (4 responses):

Yes – provided this did not involve attending meetings. Responding to written or telephone surveys or giving views via these media would be acceptable.

Yes I would want to give feedback about how I feel there should be improvements to existing programmes and groups.

Notification of events and possibly a group meeting for suggestions.

By telling people about my experiences.

Two people specifically said they wanted to understand the nature of the problems and diagnosis that had brought them into contact with the services in the first place, and the remainder gave no specific suggestion but felt they would like to be more involved, for example,

Yes – however I can be.

Some people's answers fitted into more than one category.

Reasons for not wanting more involvement

The reasons given for not wishing to be more involved were that the respondent thought things were all right as they were (9 responses):

No. Because that is the only contact I wish to have and the way I want to keep it.

No. I am quite happy at the moment.

That the person felt unable to cope with more involvement (4 replies):

No I don't think I would be able to manage any more involvement at the moment.

I'm finding it hard enough to cope with what I'm doing now.

That there was no point in being more involved (1 response):

No. The reason that I would not like to be more involved is that to do so would be continuing a pretence that national and local health authorities are actually sincere in improving standards and functioning, when in reality it is, as always, doing more with less.

Discussion

In talking about whether they were involved in planning the mental health services they were currently in receipt of, most people referred to their own particular care. In contrast, when considering whether they would like to be more involved than they were, the majority seemed to be referring to ways of being involved more broadly. About half of the sample felt involved, and half said they would like to be more involved in planning mental health services, and gave various suggestions for how this might happen, including giving written feedback about their views and experiences, attending management meetings or running a seminar on psychosis. In addition, there were a number of suggestions about how the services could be improved, for example more information at GP surgeries and availability of telephone support out of hours.

There are a number of possible reasons for the response rate of only 36 per cent. The majority of people may not after all have been interested in being involved in planning; people may not have expected their responses to be taken seriously, or perhaps some mental health difficulties or medication make it harder to concentrate or

to feel motivated to fill in questionnaires. People may have felt disinclined to participate in the survey, having started to move on and away from services. Our study would nevertheless indicate that there are a number of people who use the mental health services in the north of Shrewsbury who would like to be more involved in planning these services, on a variety of levels, and who, moreover, have their own ideas how to do this.

This suggests that Community Mental Health Teams would benefit from welcoming this enthusiasm and develop ways of listening to and acting on users' suggestions and feedback in a variety of more regular ways, for example by meeting regularly with interested user representatives, by actively seeking their opinions and making it easy for users to give feedback. The Trust should explore the provision of literature in GP surgeries and should advertise the availability of telephone advice. The lack of involvement some

users experience in relation to their direct care is concerning as the Care Programme Approach is supposed to support such involvement. As one aspect of the Trust's ongoing audit of the CPA, service users need to be routinely asked about the degree to which they feel involved in care plans.

As noted above, the Trust already employs user consultants in a variety of ways. To date there has been no specific budget for these activities. At CMHT level there is little flexibility within budgets. Any organisation taking the payment of user consultants seriously needs to budget for this. One of the authors, a former service user, is particularly concerned that users should not be involved in a tokenistic way, as has often been her experience in the past, but that their contributions should be given real value. This is sometimes very hard for professionals to do, however good their intentions. Organisations wishing to signal that these activities are not optional extras need to fund them.

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‘Have you got children of your own?’

**Jenny Doe and Caroline Savidge, Bedfordshire & Luton
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In this article, we explore some of the issues that have arisen during supervision and informal discussions about clinical psychologists who have children of their own, and who are working with children and families.

How many times have you been asked this question by a client? Or the related question: ‘If this was your child, what would you do?’ We have often also asked ourselves the question: ‘Is your clinical practice any different since you had children of your own?’ We think it probably is, and have reflected below on some of the ways in which we think parenthood has altered our working practice, sometimes generating unexpected complexities.

Our experience has been that having our own children has given us different perspectives on child development from the textbook views we were taught, and thus a broader sense of what can be included under the heading of ‘normal functioning’. We are more empathic towards parents who are enduring sleepless nights, and also more tolerant of childish behaviours that others may want to label as pathological.

In particular, we have found that psychological processes that we had only read about, such as Winnicott’s primary maternal preoccupation and the notions of containment and attachment, can be more deeply understood when one has been the adult part of a parent-child dyad oneself, and it becomes startlingly clearer how disruptions in these processes can lead to the emotional and behavioural presentations we see in our clinic. Other concepts seem even more helpful than before, for example that of the good enough parent when you realise yourself just how difficult it can be to get it right every time.

We have found that commitment to a child of one’s own has resulted in more careful guarding of one’s own boundaries. We are forced to

honour stricter limits on working hours in order to fetch our child from school or crèche on time. Flexible working environment and supportive management makes an enormous difference. In Bedfordshire and Luton we are able to work flexible hours and extra days during term times and take blocks of time in lieu during school holidays. Our leave policy clearly allows for up to five days a year of unpaid leave to be taken in order to tend to sick children or other crises at home, at the discretion of our managers. All of this goes a long way towards establishing a workable balance between home life and working life.

However, not having children can give a therapist a useful distance from the difficulties faced by the families with whom they work. As trainees we offered advice on controlled crying, ‘time-out’ techniques and potty training believing, as any good behaviourist would, that it would work. And often it did. But when you’ve battled with these situations yourself as a parent, and realised that it’s not always easy to follow professional advice, there’s the danger of overidentification with your clients’ frustrations, which makes it harder to sound convincing when suggesting solutions. As Crellin (1998) puts it:

If a problem is defined by its meaning for the client, the question of whether psychological therapeutic practice derives from psychology as a science of behaviour ... or more broadly, from psychology as the art of experience, is left open.

Now you find yourself on the other side of the fence – a healthcare user rather than a provider, and it is sobering to recognise how professionals’ attempts at help can feel patronising, irritating and frankly unhelpful. The need to be perceived as collaborative, rather than an ‘expert’ proffering ‘advice’, becomes more acute. As well as the potential for increased empathy, the experience

of parenthood can make us feel more committed to the welfare of others' children. It brings the necessity to enable change in a child whose conduct is disordered more sharply into focus when you realise it could be your child they are attacking in the playground.

Studies have suggested that in the early days following return from maternity leave women's thoughts about their child occupy them to the extent of interfering with their ability to concentrate at work (Beckman, 1978; Easterbrooks *et al.*, 1985). The guilt of the working parent has been explored in depth in early feminist writing dealing with the concept of the 'double shift'. How do you explain to your own child why you spend half of each day with someone else's children and not with them? And what about our own children – is there any evidence that the children of workers in child and adolescent mental health are better or worse adjusted than everyone else?

We have been prompted to revisit the use of self-disclosure in our work, for example sharing with parents suggestions for ideas that we have employed successfully in managing conflict with our own children. McCourt (1999) reminds us that the fact we cannot detach our personhood from our work is one of the features that sets our profession apart, and that our own experiences can be our most valuable assets. He recognises that we need an element of detachment in order to be able to understand and contain the therapeutic material, but 'where expertise is gained at the expense of empathy ... then our original endeavour is lost'.

Certainly it is valuable to have colleagues who can give you advice on your own child based on their expertise. But our experience has sometimes been that colleagues do not seem to apply the same thinking to our children as those of clients – as though there were two entirely different populations of children, not a continuum, those children belonging to us being immune from any disorder by virtue of having a parent 'in the business'. But learning about the many ways in which 'normal development' might go wrong, from seeing babies with birth defects on paediatric units to meeting pregnant teenagers following their suicide attempt, can make one an extremely anxious parent. In a variant of what

has been called 'medical student syndrome' (in which medical students recognise in themselves the symptoms of whichever nasty illness they are currently reading about), there is a danger that we are overvigilant for signs of maladaptive behaviours in our own offspring.

It would be fascinating to survey all clinical psychologists who are parents to discover which, if any, literature on childcare and development they read. Do they return to theoretical texts, for example John Bowlby's *Child Care and the Growth of Love* or Adam Phillips' *The Beast in the Nursery*, or do they make more use of popular psychology books such as Steve Biddulph's *Raising Boys* or *You can say No and your child will still love you* by Norma Ross?

A parallel question to that in our title – and one we are often asked by friends and family – is 'How does your work as a child psychologist affect you as a parent?' We have touched on some of the issues here, but maybe for the definitive answer to this we will have to ask our own children, in 20 years' time.

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Clinical psychology for in-patient settings: principles for development and practice

Fiona Kennedy, Michelle Smalley and Tina Harris, Isle of Wight Healthcare NHS Trust

This article addresses the business of establishing a new service from systemic and professional perspectives, with preliminary audit data after one year

The task of establishing a new single-handed consultant psychologist service for in-patients provided a refreshing opportunity for reflection before action, generating a model for input and principles for practice.

The setting

The inpatient services covered were to be two wards, one open and one locked, and a rehabilitation unit. Altogether these serve a maximum of 47 people at any one time and employ 67 WTE staff. The physical environment is of a high standard (see www.withdesigninmind.org). The staff teams are new, young and enthusiastic, and good nurse leadership has made the nursing teams assertive and proactive in their relations with psychiatrists. There is not the squalor and anti-therapeutic environments found by the Sainsbury Centre for Mental Health (1998), but there is the 'higher concentration of craziness' compared with 10 years ago, as described by Johnstone (2001).

Despite the positive environment, the predominant model remains that of biosocial psychiatry. This is, of course, a different paradigm from the scientist-practitioner model embraced by psychologists. We are left speaking different languages, with a consequent difficulty in understanding each other's decisions. Slade (2002) lists mental health service beliefs and myths that highlight some of the accepted wisdoms we find unacceptable.

These include beliefs such as 'schizophrenia is a valid concept' and a 'brain disease'; 'psychology has nothing to contribute to psychosis'; 'depression is a medical disorder'; 'psychiatrists must lead the clinical team because they are responsible for the practice of others'.

Bearing in mind that dissent can be dangerous and may lead to marginalisation (Johnstone, 1997), the system required to be joined as well as challenged (Ugazio, 1985).

The stakeholders

The clients

The average stay is 19 days, with problems including acute anxiety, depression, psychosis, serious self-harm and suicide attempts. There are significant numbers of 'revolving door' clients who have repeat admissions, usually because of psychotic relapse or repeated parasuicide. There is a weekly consumers' meeting and an advocacy service. Care is taken to involve service users, but caution is also required: Campbell (2001) suggests the use of terms such as 'partnership' and 'social inclusion' can serve to disguise power issues. The CBT concept of collaboration, important in the psychologist's work, may be subject to similar criticism. Are we really collaborating or is the client's behaviour more constrained by circumstances than the psychologist's?

The service provider

Experience as well as attitude and value base may be critical predictors for effectiveness (Nicholson & Carradice, 2002). The psychologist has been qualified for 19 years, working in various specialties with a range of orientations. She has in the past worked within Jungian, Personal

Construct, Systemic and Cognitive-Behavioural traditions. This breadth of experience helps deliver high-quality brief interventions for a wide range of problems at the direct client work level. Teaching and training experience in many settings helps in planning and delivering skills transfer programmes (the indirect client work level). Experience in learning disability allowed the development of many systemic skills, which have transferred successfully to the mental health setting. Organisational training at the Harrogate Centre and management experience as head of department allow additional systemic perspectives and empathy with stakeholders. These skills allow psychological input at the organisational level.

The managers

Managers' agendas include improving in-patient services, reducing suicides and developing services for people with personality disorders. Agendas such as cost-cutting (how many of the right people complain when a psychologist disappears?) and skill-mix review (couldn't a nurse do this just as well?) could be threatening, but could also be useful (reducing admissions, inpatient stays and specialist placements also save costs). Managers often value the systemic perspectives that can be brought to bear on their agendas, but sometimes have difficulty grasping the multi-level nature of the psychologist's role, which is different from other clinicians'.

The psychiatrists and the nurses

Formally recognised and rewarded as powerful players in the mental health care delivery system, the psychiatrists represent the biosocial model mentioned above. They have needs for consultancy and advice around, for example, risk carrying, personality disorders, psychoneurological assessment and psychological treatment provision.

Often unrecognised as the most powerful influence, with maximum client contact time and greatest number of personnel, nurses can be seen as key to all strategic interventions (Nicholson & Carradice, 2001). Other professionals, such as occupational therapists and CMHT members, are also arguably stakeholders, but have not been prioritised this first year.

The model

Wright (1996) advocates cognitive interventions with in-patients providing evidence-based structure for treatment and for the unit, with advantages for immediate impact, psychoeducation and relapse prevention. Outcome research in in-patient settings is limited but positive, with a focus on direct work. Nicholson and Carradice (2002) suggest that only in in-patient settings can we truly behave as described by Hall and Parry (1988) and summarised in the MPAG report of 1990: as therapists (level 1), consultants (level 2) and strategic change agents (level 3). They emphasise the need for psychologists to formulate themselves within the system rather than as external consultant, being receptive to other perspectives and highly integrated within the team, viewing themselves as a resource rather than an expert.

The model adopted was that outlined in the MPAG report and summarised by Nicholson and Carradice, namely three main levels of intervention: direct client work, indirect client work aimed at enhancing multidisciplinary thinking and action, and strategic work towards team, policy and practice development.

The objectives, principles and practice

Socialise clients and teams to psychological perspectives

The main focus here should be on the nursing teams as key stakeholders in the system. Collaboration with nurses and clients to build CBT formulations for each referral. The sharing of this formulation with the client and the MDT is seen as the key intervention. This is because, in the limited amount of time available, a good formulation can be a powerful systemic intervention, changing the meaning of the client's subjective experiences and the team's thinking about the way forward in the context of the new meaning. Level 1 and 2 work can be carried out simultaneously in this way.

Transfer of skills, good communication and learning from others

If nursing (or other) staff sit in during sessions and their input is requested and valued, all three levels of work are addressed: team-building between psychologist and the rest of the MDT;

skills transfer through modelling, shaping and reinforcement of skilful behaviour (in both directions); direct client work. Using shared communication systems (nursing process) to feed back reduces paperwork and makes the psychologist part of the team. Nurses and clients can be empowered to represent psychological perspectives at ward rounds and case conferences. Signed confidentiality agreements are needed which allow the consultant to share all information with the wider team.

Team working

Inconsistency and contradictions between points of view are to be expected, noticed and validated. Clients can be helped to notice this too and work with it. Yet somehow sufficient consensus or compromise is needed to allow care plans to be drawn up, referrals made and a sense of direction felt. The less formal setting at handovers allows for expression and debate. Ward rounds can be used to formalise the more relaxed discussions.

Engaging with all levels of the system and having a good time

To produce strategic change all levels of the system need to be engaged (Huffington, Cole & Brunning, 1997). At level 2 (consultancy, supervision, training) work can be an informal part of life on the ward. It should be fun (potentially naturally reinforcing), aiming to increase behaviours consistent with a psychological perspective and decrease others. Requests for team building and staff support need formulating in a similar way to individual cases for maximum impact. This level 2 work can also formulate management agendas as part of the system. Audit and needs identification as well as attendance at formal management meetings and consultation to managers moves to level 3 work, with formulations for needed or desired change being equally useful here.

Self-care

Single-handed posts and psychologists' jobs in general tend to be inherently stressful as demand always outstrips supply. Methods of limiting demand and balancing activities are essential. Adequate supervision is of course a major factor

in ensuring self-care as is applying basic behavioural principles to one's own activities.

The audit

A tick-box audit was used to seek stakeholders' views of the service. Questions were based on the above objectives and the multi-level working principles, and were adapted for each stakeholder group. A two-tailed scale of -5 to +5 was used to rate collaboration in treatment, access, communication, usefulness, education and change influence.

Results showed excellent response rates (for example, 70 per cent from patients and 83 per cent from nurses) and entirely positive outcomes on all questions asked of all stakeholder groups (the lowest rating being +3, the lowest possible being -5). Psychiatrists' responses were the most positive of all. Qualitative data showed all groups would like more psychology input and highlighted the gap between the 'instant' service received in the hospital and the lengthy wait for community psychological therapies. Clients and staff regretted that some people had not been seen because of lack of psychologist time.

Clients' comments included being made to feel 'normal' and having gained new understanding of their problems. Nurses wanted more training, psychiatrists more CBT and DBT interventions. Both groups highlighted the usefulness of the service for people diagnosed with borderline personality disorder and the lack of follow-up in the community. Managers wanted more nurse training and advice on the role of the psychologist in wider service provision. The general manager for the Care Group reported herself relatively unaware of the psychologist's role.

Discussion

This is an encouraging outcome for a new service. The main lack was seen as not enough of the service, which can be a positive comment about the service itself. The data collection method could be criticised despite the high response rates, as those choosing to reply might do so because they felt positive. The audit department of the host Trust assures the authors that most audits produce a significant number of negative replies. In

addition, the use of a two-tailed response scale gives plenty of opportunity for negative evaluation.

As well as the positive ratings and comments, the audit demonstrates the impact of the service at all levels, from patients and nurses to psychiatrists and managers, with evidence of all three MPAG levels of work. Managers' responses reflected a tension between their agenda to get the most possible patients seen and to have available psychological advice and systemic intervention at the organisational level. In the authors' experience this is a common tension in providing psychology services and needs careful time management to balance these demands. The relative lack of awareness of the consultant psychologist's role on the part of the general manager is concerning. This result has allowed plans to be made to rectify the situation, including a formal presentation of the audit to the management team and efforts to involve the general manager directly and indirectly in decisions about psychological services to in-patients.

Other recent developments in response to the audit include the establishment of more formal training afternoons for nurses that SHOs can also attend, and the establishment of a psychologist-led dialectical behaviour therapy (DBT) service. This is beginning to address the needs of the large numbers of inpatients diagnosed with borderline personality disorder, and also provides a bridge across the in-patient/outpatient divide. The service offers individual and group work across settings and specialties and is intended to reduce suicide attempts, self-harm and recurrent readmissions. It has already shown positive effects on some client outcomes, staff and psychologist morale and attitudes to this client group. DBT offers validation strategies and strategies to increase commitment which have proved tremendously useful with stakeholders at every level of the organisation.

Conclusions

In terms of the principles of service delivery set out above, it seems a balance of activities as described by MPAG so many years ago remains key. Strategic intervention and collaboration rather than confrontation appear more conducive to positive change. The application of psychological theory to one's own practice at

each level helps both define and improve chances of a successful outcome. The authors hope this article continues the debate on inpatient provision and would welcome comments and contradictions.

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Establishing prior consent: an audit of referrals into a clinical psychology service for people with learning disabilities

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This paper describes an audit of referrals into a clinical psychology service for people with learning disabilities. The audit identified significant concerns in relation to informed consent for the referral, leading to a redesign of the referral form intended to prompt referrers either to ensure valid consent or to flag up areas of uncertainty.

Most adult clients who attend an initial consultation with a clinical psychologist do so voluntarily, and it is usually reasonable to assume that the client has been well informed of the nature of the referral. However, when the client has a learning disability, the first meeting with a psychologist is usually facilitated by another professional (for example, a social worker) or a carer, and in these circumstances it is far from reasonable simply to assume either that clients are well informed about what to expect from a psychologist or that they are attending voluntarily.

The present study arose from the observation that some learning-disabled clients arriving for their first appointment with a clinical psychologist appeared ignorant of the purpose of the referral. While this may be acceptable if the severity of the client's learning disability raises significant questions about their capacity to consent (which might be better assessed by a psychologist than by a referrer), it became clear that some clients with a mild learning disability, who were certainly able to provide informed consent for the referral, had not been invited to do so. As some referrals to a clinical psychology service could have outcomes with potentially serious implica-

tions for a client's future (for example, changes in entitlement to benefits), it seemed important to investigate the extent to which potential clients were providing informed consent for the referral. This study therefore examined the extent to which referrers obtained consent for psychology referrals and the extent to which such consent was well informed. (This paper does not address the subsequent process of obtaining consent for further contact within the clinical psychology service.)

Method

In common with other learning disability services in Wales, all service users referred to our department are supported by care managers, who are social workers or community nurses working within community support teams (CSTs). The clinical psychology department serves three CSTs, who represent the main source of our referrals. Additional referrals come from the nursing and psychiatric staff of an in-patient assessment and treatment unit (ATU), and some arise from *ad hoc* sources, such as GPs and health visitors. For the purposes of the present study, permission was obtained from the relevant line managers to circulate a questionnaire to referrers within the three CSTs and the ATU. The survey was aimed at individuals who had made a referral within the past three years, and were still in post at the time of the survey. After we had excluded referrers on long-term sick leave, a total of 31 potential participants were identified from our records.

The survey was restricted to information relating to clients with a mild learning disability, in order to avoid issues around capacity to consent that can arise in relation to clients with more severe

learning disabilities. It consisted of a single-page questionnaire, which asked mainly open-ended questions about 'your most recent referral to the Clinical Psychology department of a client with mild learning disabilities'. Participants were asked to identify themselves, so that it would be possible to chase non-respondents, but the clients who were the subject of the referrals were not explicitly identified.

Results

A total of 28 referrers (28/31) completed the survey: three psychiatrists, 17 social workers and eight nurses. Their clients were referred for three reasons: gatekeeping assessments (3), assessment with a view to treatment (17) and consultancy, with an expectation that there would be direct contact between the client and a psychologist (8). None of these referrals fell into a fourth category, consultancy with no expectation of direct contact. There were no striking differences in responses to the questionnaire between referrers from different professions, or as a function of the purpose of the referral.

Consent for the referral

Participants reported that 24 of the 28 referrals had been discussed with the client; however, four had not. Of 23 clients for whom a primary carer could be identified, the referral was discussed with 20 of the carers, but three carers were not consulted.

The question 'How did the client give consent for the referral?' was intended to encourage the referrer to provide detail of the conversation. In the event most participants stated simply that consent was 'Verbal'; however, six of the 28 responses implied that active consent was not elicited (for example, 'The client did not refuse.') Consent for the referral was recorded in the referrer's notes in only 10 cases.

Understanding of rights

The survey included three open-ended questions exploring clients' understanding of their right to decline the referral or to withdraw from treatment. First, participants were asked 'How did you make clear to the client that (s)he could choose whether or not to accept the referral?' Positive responses were received from 20 partic-

ipants (for example, 'Discussed ...', 'Explained ...', 'Client given time to decide'), but eight participants indicated that this was not made clear (for example, 'Unnecessary', 'Assumed').

A second question asked 'How did you assure yourself that the client understood that (s)he could decline the referral?' Positive responses were received from 18 participants (for example, 'Discussion', 'Asked two ways') and three more referred to previous refusals, but again there were seven negative responses (for example, 'Assumed').

The third question was 'How did you assure yourself that the client understood that (s)he could withdraw at any time from contact with the Clinical Psychology department?' In this case there were only 12 positive responses (for example, 'Discussion') and four references to previous refusals: 12 responses were negative; these included two *post-hoc* responses of 'Client did withdraw.'

Understanding of 'psychology'

Two further questions explored clients' understanding of the purpose of the referral. In answer to the question 'How did you explain 'psychology' to the client?', 17 participants gave an informative answer (for example, 'Help with emotions/problems/behaviour'), and three referred to the client's previous contact with the psychology department. However, eight participants indicated that they had not explained the referral to the client. In answer to a follow-up question, 'How did you satisfy yourself that the client understood your explanation?' a further six participants indicated that either they had not explored this issue or they felt the client had not in fact understood. Only 14 of the 28 participants indicated that they felt that their clients knew what to expect of the psychology department.

Pressure to comply

A final question asked 'How did you ensure that the client was not subject to undue pressure to accept the referral?' Only 18 participants gave an acceptable response (for example, 'Offered choice', 'Given time to think/decide', 'Client attended independently', 'Previous refusal'). The other 10 participants appeared not to have considered this question.

Conclusions

It seems from this, admittedly small, survey that a significant minority of referrals are made without the client's consent; and while some degree of consent was usually reported, in the majority of cases consent was not recorded in the referrer's notes. Actually, the true proportions are likely to be higher than these figures: questionnaires were not returned anonymously, and it is unlikely that participants placed much weight on a statement in the covering letter, intended to decrease social acceptability bias, to the effect that 'there are no right or wrong answers'.

Although the majority of participants did obtain consent for the referral, the extent to which this consent was well informed is questionable. In a significant minority of referrals, participants indicated that either they did not make clear that clients could choose not to accept the referral, or they failed to assure themselves that clients understood that they could decline the referral or withdraw from treatment. In all, 17 referrers provided questionable responses to at least one of these questions. Furthermore, in fully half of referrals, it is not clear that the client knew what to expect of clinical psychology. Again, these figures are likely to be underestimates.

Finally, a significant minority of participants were unable to identify any steps they had taken to ensure that clients were not placed under undue pressure to comply, suggesting that in these cases clients could potentially have been coerced to accept the referral.

Discussion and recommendations

In the light of these findings, and following discussion with referrers, a section was added to our referral form requesting information about the consent process, and asking referrers to explain shortfalls in the information provided. Care was taken not to place an unwarranted burden on referrers or to cast doubt on their professionalism. The following considerations were applied:

1. *Consent should be obtained and recorded.* Consent is only meaningful if the clients understand that they can say 'no', which involves two steps: providing the information and then checking that it has been understood (Rowson, 1993). A reference to prior instances of refusal provides compelling corroborative evidence, but does not in itself confirm that consent has been elicited on this occasion. And as the DCP (1995), the UKCC (1992) and the NHS Management Executive (1990) all require that consent be recorded in the patient's notes, we now ask referrers to confirm that this has been done.
2. *Consent should be informed.* As a consultation with a psychologist is not an invasive procedure, and the psychologist is required to obtain further consent for any assessment or intervention that might ensue, the information provided to the client need not be as detailed as in the case of a referral for medical treatment (for example, Hart, 1999; Wong *et al.*, 2000). However, the client should be provided with some information about both the reason for referring, and the role of the psychologist, though this could be a very basic account (for example, 'someone who will talk to you about your feelings'). Again, it is important not only to provide the information, but also to assess understanding: for example, by asking clients to repeat the information in their own words (Grisso & Appelbaum, 1998). We therefore ask not only 'How did you explain the referral?' but also 'How can you be sure that the client understood your explanation?'
3. *Freedom from undue pressure.* Many people with learning disabilities are highly acquiescent (Gudjonsson, 1986) and therefore at risk for coercion. On the other hand, referrers believe that the referral is in their client's better interest, and 'it is unclear ... what constitutes unwarranted coercion and where this interfaces with encouragement to take a recommended course of action' (Power, 1997). For this reason, we simply ask referrers to flag up cases where there might be cause for concern by asking, 'Is the client easily influenced by people in authority?' and 'Did you persuade the client to accept the referral?'
4. *Lack of capacity.* While it is clear that a client's capacity to consent may be influenced by a number of factors, including the clarity of the

communication (Reder & Fitzpatrick, 1998; Wong *et al.*, 2000), referrers may feel that they lack the skills to explore these issues with the client. As a result, there may be many cases in which referrers are uncertain as to whether a client has provided valid informed consent. The proportion of cases in which the referrer is uncertain of the client's capacity (or is certain that the client is not capable) increases with the severity of the learning disability. Where the referrer is unable to state with certainty that the client has provided informed consent, we now ask for confirmation that the referral has been discussed with the client's primary carer, in line with BPS and Department of Health guidance (DCP, 1995; DoH, 2001). We recognise that there may be cases in which discussion with a carer might be inappropriate (for example, where there are allegations against the carer); in such cases the requirement for discussion with a carer is waived, and an explanation requested.

5. *Direct contact not anticipated.* With rare exceptions, referrals without the informed consent of the client or the support of a carer are accepted only in cases where no direct contact between the client and the psychologist is anticipated. In line with BPS guidance, the

decision whether to ask the referrer to consult the client in such cases is made on a case-by-case basis (DCP, 1995).

A copy of the revised referral form is available from the author on request. Although designed for use in a learning disability context, a similar form might be applicable to other vulnerable client groups, such as children or older adults.

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User perspective on information leaflets for children, adolescents and their carers

Paul Russell, Lancaster Doctorate in Clinical Psychology, **Carol Hey**, Bolton CAMHS, and **Rebecca Linnell**, Wythenshawe Hospital, Manchester

This audit canvassed user opinion on the helpfulness of information leaflets designed for primary age children and adolescents that described the Child and Adolescent Mental Health Service.

Bolton's Child and Adolescent Mental Health Service (CAMHS) takes referrals from a variety of sources (general practitioners, school nurses, educational psychologists, social services, paediatricians and so on). These referrals are generally initiated by parents seeking help from those services. Historically, children and adolescents have played a passive role within this process and parents are commonly identified as the consumer (Johnson, Cournoyer & Bond, 1995). It could also be argued that referrers and commissioners are also CAMHS consumers, which may further minimise the role of children and adolescents within the process. The Children Act (1989) suggests greater autonomy for children in the delivery of their health care. It emphasises the importance of considering the needs and wishes of children and young adults as well as the need to achieve informed consent. The Children's Legal Centre (1994) makes a number of recommendations for good practice, also enshrined in the Children Act, including greater consultation with children to gain full informed consent when undergoing therapeutic intervention.

Calder (1995) cites lack of information about services or even the failure of professionals to provide information to the client as a way of fostering dependency, restricting choice and facilitating powerlessness. He also warns that this

approach may engender resistance to the treatment or therapy. Calder thus argues that providing information to children may help to remove dependency and lessen the chances of resistance to therapy or treatment. The Division of Clinical Psychology's *Professional Practice Guidelines* (1995) propose that clinical psychologists should obtain consent from both parent and child. Shalan and Griggs (1998) argue that this should include giving the child information about the referral process, the service and choice of intervention. Reed *et al.* (1993) recommend that good practice should include the provision of information leaflets for children themselves.

The current study followed on from an earlier unpublished service audit carried out by the then Child and Family Psychiatry and Child Clinical Psychology services in Bolton (now an integrated CAMH service), which canvassed user opinion about their service (Linnell, 2001).

The main findings of this previous study were that around half the sample of children reported that they had been worried about the appointment prior to attending. Examples reported included 'being diagnosed or labelled', 'worry about the unknown', 'getting an injection' and 'being punished'. Despite the fact that appointment letters contained parent information leaflets and information about the CAMHS, 70 per cent of families reported that they would have found information about what the CAMHS does and what would happen at the appointment helpful, also expressing a preference for leaflet format.

A major recommendation from this audit was the provision of information leaflets aimed at

both young children and adolescents that could be given to families and referrers prior to attending appointments with CAMHS. This article will describe how Bolton CAMHS canvassed user opinion on the usefulness of the information leaflets as a resource within CAMHS.

The information leaflets

Information leaflets were designed to provide primary and secondary age children with information about why children come to CAMHS, what CAMHS can do to help them and what will happen when they come to CAMHS.

Two versions were designed to reflect developmental differences among the client group (Table 1 highlights these differences). Members of the CAMHS multidisciplinary team, which included clinical psychology, psychiatry, nursing, social work and occupational therapy, designed the leaflets. A survey design was used to canvass user opinion on the usefulness of the leaflets.

Participants

Sixteen families responded to the questionnaires over the period March–April 2002. The sample consisted of 16 carers and 12 children or adolescents with four of the children or adolescents failing to respond to their part of the questionnaire. The children and adolescents who took part con-

sisted of eight boys and four girls, with ages ranging from 5 to 15 years. The audit used two versions of a questionnaire consisting of both closed and open questions relating to how helpful both children and their carers found the information leaflets provided prior to their first appointment. The questionnaires were devised in consultation with members of the CAMHS multidisciplinary team.

The audit

During March and April 2002, all first appointment letters included standard information leaflets for carers and newly designed leaflets for the children and adolescents being referred. Appointment letters were altered to include the line 'you might find the enclosed information leaflets useful in helping you talk to your child about the appointment'. Participants were invited to opt in to the study on presentation for the first appointment and informed written consent was obtained from each parent or carer for their child to be asked about the information leaflet by the clinician seeing the child.

Children and adolescents' perceptions of the information leaflets

As displayed in Table 2, this audit found that four of the 12 children were reporting worries and eight reported no worries at all. Of those chil-

Table 1. Differences between primary age (5-11 years) and secondary age (12-16 years) information leaflets

Primary age information leaflet	Secondary age information leaflet
Brief descriptions	Lengthy descriptions
Informal tone	More formal tone
Pictures	No pictures
No mention of professionals' titles	Names professionals' titles
'Worried, angry, upset'	'Thoughts, feelings, behaviours'
Refers to 'talking' and 'make things better'	Cites therapies 'individual, groups'
No reference to length of session	Cites duration of sessions 'one and a half hours'
Concrete language	Abstract language

dren who did report worry, examples included concern that they would be 'punished' or 'told off'. Seven children reported that a family member had talked to them about the appointment. Four children reported that their mothers went through the child's information leaflet with them and three reported that they had found the leaflet 'easy to read' and 'made sense'. Six children made a number of suggestions about what else might have helped prepare them for the appointment. Examples of suggestions provided by children and adolescents included 'more details in leaflet', 'video/DVD format' and 'photographs of staff and the building'. This audit also found that 12 of the 16 carers reported that they knew whom the family would be seeing at appointment and what would happen at appointment. The majority of carers (87.4 per cent) reported that they found both the carer and the children/adolescent leaflets 'helpful' in preparing the family for the first appointment.

Discussion

The addition of the child information leaflet and slight changes to the appointment letter suggesting that they could use the enclosed literature to talk to their children seem to have been helpful for families in preparing for the first appointment. During initial consultation with the referral agent families may be overwhelmed and information about CAMHS imparted verbally may be forgotten. Clients' recall of verbally presented information has been found to be poor (Gauld, 1981). The leaflets provided families with written information, which they could re-read prior to attending the appointment.

The previous study canvassed referrer's knowledge about CAMHS and found that the majority had gaps in their knowledge about CAMHS. The quality of their information will not only impact on families ability to give informed consent to the referral but also on children and adolescents' anxiety about attending CAMHS appointments. It may be hypothesised that the written information provided to children and their carers in this audit accomplished this to some extent, as the frequency of reported anxiety was low.

The findings of this audit suggest that the provision of information leaflets to children could be beneficial in a number of ways. First, they

Table 2. Responses to child, adolescent and carer questionnaires

Child/adolescent responses (N=12)	N (%)
Worried about coming to appointment	4 (33)
No worries about appointment	8 (67)
Someone talked to child about appointment	7 (56)
'Leaflet was easy to read/made sense'	3 (25)
Carer responses (N=16)	N (%)
Leaflets explained what would happen	9 (56)
Carer information leaflets helpful	14 (88)
Child/adolescent information leaflet was helpful	14 (88)
'Leaflets easy to read/made sense'	11 (67)
Leaflets reassured carer	5 (31)
Child understood leaflet	5 (31)
'Leaflets helped me talk to child about appointment'	5 (31)

may help children to feel less anxious about being referred to CAMHS as they can provide correct information about what will happen to the child. Second, information leaflets may help to empower children within the paternalistic culture of services that can potentially reduce autonomy, disempower children and restrict choice, as Calder (1995) highlights. Although parents will continue to gatekeep the information that their children can access, the provision of leaflets specifically aimed at children sends a powerful message of social inclusion to young people themselves, their carers and referral agents. Third, information leaflets can increase children and parents' understanding of services in a way that verbally presented information alone may not. Finally, information leaflets equip parents with a language to help them explain mental health ser-

vices to their children. The relatively inexpensive provision of information leaflets to families especially the children and young people themselves may be an important early step in facilitating therapeutic engagement.

Limitations of the audit

The low recruitment and sample of 16 families reduced the generalisability of the findings. This may have been due in part to the audit being carried out during a period of service reorganisation when administrative support was significantly reduced. Designated research time carried out by clinical staff may have increased response rates. Given the context in which this study took place, children may have underreported the extent of their fears and worries for fear of being punished or informed on. Abramovitch *et al.* (1991) found that around half of children aged between 8 and 12 thought that the experimenter would tell their parents if they wanted to know, despite having confidentiality explained to them. This has implications for children's participation in therapeutic work where sensitive or difficult issues may arise, for example abuse by a parent. Open-ended questions and more explicit dialogue about children's understanding of being referred might have yielded more depth in the children's responses.

As highlighted by Atkinson (1991), children are often assumed by professionals to have consented because those professionals have gained parental consent or failed to provide children with information. The methodology of this audit was guilty of including children by assent rather than consent. This raises the issue of clinicians gaining consent to treat from parents despite the fact that children may not wish it. As an example of good practice, the British Psychological Society recommends that clinical psychologists should use their skills to engage with families and try to gain informed consent from both parents and children. However, the reality of clinical practice is that parents are still regarded as the main consumer within CAMHS.

The majority of carers had found the information leaflets for themselves and their children helpful, but two carers had prevented their children from reading the leaflet designed for them. In addition, two of the clinicians seeing the chil-

dren had decided not to canvass their opinion. One reported that the audit was 'administration' and not related to clinical work, and the other reported that they had not wanted to 'distress' the child by asking 'unnecessary questions'. Both these responses, though a reflection of appropriate clinical judgement applied to individual children, nevertheless mirror Calder's (1995) point that if clinicians do not check that children are as fully informed as possible about attending CAMHS then treatment resistance may be engendered and reinforced by clinicians assumptions and values about children.

Consent implies that the child understands what is happening or due to happen in the course of their treatment or therapy. Clinicians should enter into dialogue with children mindful of their own narratives and assumptions about children's behaviour, what is best for the child and how they should be involved within the therapeutic process. Given the pressures on CAMHS in terms of trying to assess and treat children and families, it is understandable that child empowerment is not a priority and that there is limited time for research and service development. Spending time and resources publicising a service that is severely limited in its ability to meet demand raises uncomfortable feelings in clinicians who are aware of the limited choices they are able to offer their clients. Continued development of information, including leaflets for children, is one way that services and clinicians can try to empower young people referred to CAMHS.

This audit was also limited in that children and young people were not involved in the development of the information leaflets themselves and the leaflets were only available in English. Potentially, with fully informed consent, children could enter into the therapeutic relationship with 'alternative understandings' that could open the door to 'the exploration of new possibilities of action' (White, 2000: 5). Such 'alternative understandings' should be canvassed and incorporated into the design of information leaflets for children. It would also be good practice to promote diversity by involving children from ethnic minority groups to inform translations of leaflets or even alternative forms of information provision, for example audiotapes or artwork.

Recommendations

This audit found it helpful for information leaflets to reflect the developmental nature of the children and young people being referred to CAMHS so there was more than one version of leaflets available. In addition it was helpful for first appointment letters to include both carer and children's information leaflets and also to explicitly refer to using the accompanying literature as an aid to talking to children about the appointment. This was a simple, inexpensive change within services, which could enhance parents' confidence to talk to their children about the referral. Any information leaflets should have translations available in other languages as well as audio versions for visually impaired or children with reading difficulty.

Copies of the information leaflets and questionnaires are available on request from the first author.

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Division of Clinical Psychology North Thames Branch

'The times they are a changing': Update on the Mental Health Act

Friday 12 December 2003 (2–5 p.m.)
includes Branch AGM

British Psychological Society offices,
33 John Street, London WC1
(nearest tube: Chancery Lane)

Speaker: **Douglas Naysmith MP**

Refreshments available

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Charlotte Curran on 020 8846 7765
or charlotte.curran@wlmht.nhs.uk

**Double CD available from last
year's conference**

War and the 'oblivion pill': Do psychologists have an opinion?

Dora Tsogia, University Hospital, Athens

The implications of a pill under construction that would make victims and perpetrators 'forget' their trauma are discussed. Clinical psychologists' opinion is called for, both on the role of witnessing, remembering and communicating one's trauma and on the potential political and other misuse of such a pill.

As early as World War I, but mainly after World War II, military psychiatrists developed the notion of Post-Traumatic Stress Disorder (PTSD). Although its recognition helped many soldiers who would otherwise have been simply considered cowards, originally the acknowledgement of this disorder had a different purpose: not treatment, but the rehabilitation of soldiers with the aim of returning them to the battlefield as soon as possible.

Similar, albeit more ambitious, are the apparent aims behind the 'psychological' work that has been taking place for some time now in US universities. As Eric Baard reports in *Village Voice* ('The guilt-free soldier', 22-28 January 2003), five different American institutes are examining the production of a medicine which, if given immediately after a traumatic experience as a pill or a vaccine, will reduce the emotional effect of that experience and consequently even the memory of it. This would happen by blocking the secretion of certain chemicals in the brain and especially in the amygdale, which are linked to the emotions of fear, guilt and anger.

It is not known whether this research is funded by external sources, but when Eric Kandel of Columbia University (Nobel Prize winner for Physiology and Medicine in 2000) was asked if his research was supported by the Pentagon, he replied 'no, but you are welcome to call them and tell them about me'. There are two major

areas of concern here. What would this enterprise of inventing such an 'oblivion pill' mean for the way we view and treat trauma? What would its potential use by an army entail?

Worrying similarities with the past

It is worth reminding ourselves here that Egas Moniz won the Nobel Prize for Physiology and Medicine in 1949 for his contribution to the technique of lobotomy (the surgical incision of the frontal lobe), the aim of which was to reduce the symptoms of psychological or simply behavioural disorders. The outcome of this technique ranged from 'success' in a third of the cases to fatality. Even in the best of cases, the patients experienced a complete loss of the emotional side of their personality, their spontaneity and will power. Nevertheless, when psychiatric asylums were full after the War, thousands of lobotomies took place all over the world. After 1949 approximately 5000 lobotomies were carried out in the US every year. In the Soviet Union the victims of this technique often included political dissidents. This practice only stopped when other methods for the reduction of disturbing symptoms appeared, for example the tranquillisers of the 1950s.

Against this background, the immediate question is whether this new pill of oblivion is but a more perfected technique for serving the same aim, that is the detachment of people's experiences from their emotional consequences to the point of turning human beings into cold observers of themselves. Of course, the moral dilemma arising from this questions has several dimensions. First, there are concerns about the victims of traumatic experiences; second, about the perpetrators - if there are any; third, about the social reactions triggered by the aforementioned parties; and finally, about the handling of such a medicine and the power interests that lay behind it.

The psychological and social need for truth*

There is an abundance of theories on trauma and on the different kinds of treatment available for it. These include perspectives which perceive trauma as a neurological association in our brains with a terrifying image; as a trigger which causes previous traumas to resurface thus adding an aggravating symbolic meaning to the new traumatic experience; as an event which challenges our basic assumptions about the world and its safety; or as a mere social construct that sees reactions to extreme events as pathological to the point of expecting people to be *ipso facto* 'traumatised'.

Whatever theory one takes, the potential problems arising from the use of such a pill are evident. Who should be given access to it? Should we be expected to predict who will develop symptoms of PTSD and have him or her registered, as someone's blood group is registered? Who will have the power to decide at the crucial point? What about the rights of traumatised perpetrators? Will it be only available in the rich countries, as is the case with many other medicines? And, ultimately, what kind of message would it send to traumatised people?

The most common phrase heard from victims of trauma is 'I wish I could take a pill to bring things back the way they were.' Research and clinical experience teach us that, despite this understandable wish, the main goal of any psychological treatment should be to help people come to terms with the fact that the fulfilment of such a wish is not feasible.

Furthermore, many scholars in the field agree that memory, rather than oblivion, helps in facing one's traumas more fully and in achieving psychic development. Horowitz (1999) provides evidence showing that traumatic memories must be actively dealt with in order to be resolved. Tzavara (1996) argues that 'individual memory is the only surface where a whole civilisation and history are inscribed, and narration the only method of imprinting it'. In cases where the traumatic experience has not been allowed to be recalled or to become speech, it would be

impossible to process it at a symbolic level by the individual – a prerequisite in the treatment of trauma and bereavement (Garland, 1998). A number of psychoanalysts, beginning with Freud himself, have argued that what has been repressed – and, therefore, cannot become part of the individual's story – will continue to disturb the person as well as future generations; this phenomenon is known as the 'cross-generational transmission of trauma'.

It is noteworthy that only through the memory of events and the truth, through the triggers of anger and the sense of injustice, do groups resort to organised and mobilised action against traumatic experiences. Via this route, traumatic experiences can often be transformed into something that gives meaning to people's lives. This need for the communication of the truth to others has activated political refugees from Central America to develop a self-help method of psychological help called 'Testimony' (Aron, 1992). Painful as it may be, this method turns trauma into a narrative, which then becomes action.

The role of psychologists: is there one?

So what is our role as psychologists in all this? Do we want to encourage further detachment and repression for the victims of trauma when so much effort has been invested in trying to help people develop more cohesive stories and make sense of their past? Are we going to sit still in our 'laboratories' (i.e. therapy or study rooms) and wait, once again, to see how psychological findings will be misused? As the line between inaction and collusion remains subtle, should we not feel obliged to disseminate such knowledge to the public?

Psychologists could have a say over whether the medicine under discussion should be banned altogether or, potentially, have some use; for example, if its management were limited to people who cannot be helped otherwise, if safe predictions can be made of the likely victims of PTSD, and if governments could be trusted with the task of using it. Of course, guarantees do not exist regarding the first two issues, while the third would require considerable work and good hope. Doubts arise from the well-known misuse of such methods by the state in the past – for example, the

* Truth in Greek is 'a-litheia' ($\alpha\text{-}\lambda\eta\theta\epsilon\iota\alpha$), etymologically meaning 'no-oblivion'.

vast majority of lobotomies in Japan targeted children who simply 'behaved badly' at school.

Psychologists ought to have an opinion about the use of such methods in the most extreme of all human actions: war. How do we view the prospect of future wars fought by a completely

new type of soldier whose relationship with reality is distorted? Can we accept the reversal of the psychological sequelae of a soldier's killings or should we seeking instead the containment of the experience of war and of the conditions that create it? If we are seeking the latter, we must conclude that wars cannot be contained by forgetting their horrors, but rather demand the constant and proper use of their memory. Oblivion will increase the horrors of war precisely because it eliminates its traumatic psychological impact.

Oblivion, moreover, cannot eradicate all the other consequences of war by simply deleting them from the soldiers' memories. In a war that nobody will remember, even in the case where both victims and perpetrators are given the 'oblivion pill', how can the mutilated and dead bodies be reversed? Will we then try to treat people for bereavement and trauma? And these are likely to occur in even larger numbers if soldiers are fighting without the memory of the horrors of their previous war.

It might be necessary to set aside controversies about what theory can more appropriately explain trauma and seek to find a common ground for action, that is for a definition of our role as psychologists in the production and misuse of experience-changing pills. As Bracken (1998: 58) puts it succinctly, it may be time we also attempted to remind ourselves about the 'humility of what we can offer and [accept] that there is no quick fix or magic bullet that will rid people of the suffering brought about by violence'.

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Division of Clinical Psychology Scottish Branch

Annual General Meeting and Scientific Presentation

Friday 7 November 2003

Queen Margaret University College,
Edinburgh

Further details

1.30 AGM

President's Report, Treasurer's Report,
Elections for new Committee Members

2.15 Tea and coffee

2.45 Scientific Meeting

Dr Rory O'Connor, Department of
Psychology, Stirling University on:

Understanding Suicidal Behaviour

- Models of suicidal behaviour
- Cognitive and emotional variables
- Implications for therapy

Please direct any enquiries to: Dr David
Craig, Department of Anaesthetics,
Victoria Infirmary, Langside Road,
Glasgow G42 9TY; Tel: 0141 201 5163;
e-mail david.craig@gvic.scot.nhs.uk

Body shame: conceptualisation, research and treatment

edited by P. Gilbert and J. Miles

Brunner-Routledge, 2002, £16.99

The purpose of this book is to summarise how shame at physical appearance or functioning is relevant to physical and psychological problems across the lifespan. It starts with an informative and comprehensive summary of the concept of body shame, which is helpful in initially orienting the reader. The following chapters cover a variety of topics including disfigurement, eating disorders, sexual problems and childhood trauma across a number of specialities.

Body shame is a relatively new era of research and this is particularly apparent in some chapters, where links to shame are sometimes speculative and suggestions for interventions appear to be premature given the limited evidence base. Occasionally, it is not clear how some interventions were specifically related to shame. An excellent chapter by Coughlan and Clark describes some clear strategies for working therapeutically with people experiencing problems related to disfigurement.

Overall, this book provides a novel contribution to our understanding of people's thoughts and feelings about their bodies and acknowledges the socio-cultural context in which these are based. In addition, many potential areas for future research are highlighted.

I would recommend this book both to clinicians and researchers, as it provides an interesting and accessible summary of a new area with broad applications within health and clinical psychology.

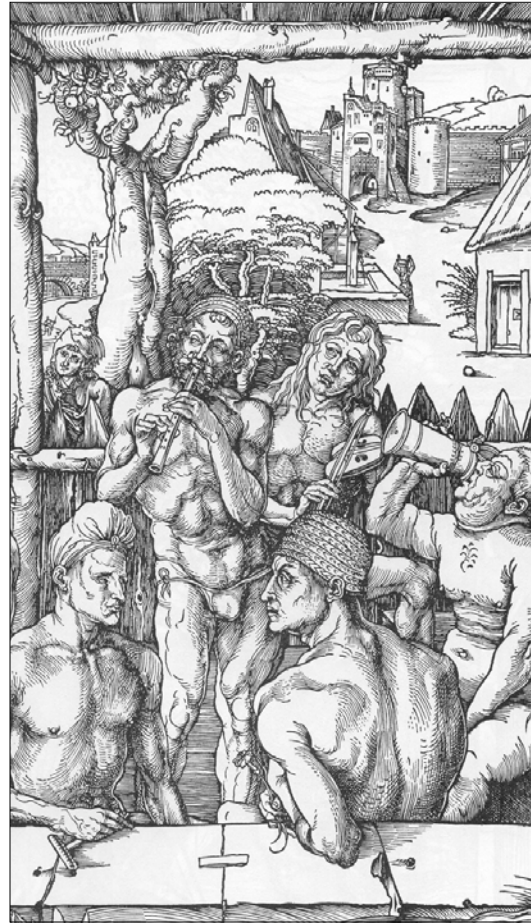
Catherine Bolton

Narrative and psychotherapy

John McLeod

Sage, £17.99

McLeod states at the beginning of this book that there is no such thing as 'narrative therapy' *per se*; rather, 'all therapies are narrative therapies'. He provides a fascinating account of the role of narratives in the history of cultures. As personal narratives provide the opportunity to make sense of novel situations, problem-solve and convey something about a person's



Book Cover

inner world, he suggests that therapy has become increasingly popular in a postmodern society which no longer makes spaces for people's 'stories'.

The role of narratives in different forms of therapy is explored. For example, within psychodynamic and cognitive therapies, narratives are used as a method of gathering information that lead the therapist to deduce underlying beliefs and unconscious context. As an alternative, McLeod suggests that a social constructionist narrative therapy has the potential to focus on the relationships between people, by providing a story-telling arena where the therapist and client co-author alternative stories.

The book is well written, and accessible regardless of therapeutic orientation. It also provides an excellent source of references. Give up a weekend and read it.

Andrea Davies

A guide to medical publishing and writing
edited by Peter Richardson

Quay Books, 2002, £10.99

This little book (12.5 x 17 x 1cm, 145 pages) is a compilation of articles, originally published in *Hospital Medicine*, on various aspects of accessing information, writing and publishing. While most of the chapters are geared to a medical readership, much of what they contain is also of relevance to psychologists looking for advice on how to get published. The 15 concise chapters cover topics such as finding health information on the Internet and how to write a case report, a book, a peer review, a critical letter, a review article and a CV. There is also advice on how to get your book published, on being a journal editor, writing for the popular press, publishing research findings, producing a multimedia CD and publishing on the internet.

This is a useful and practical book, particularly if you have an interest in writing about your area of interest or have been struggling to get published. The level of some of the articles may be rather basic for clinical psychologists, who through their postgraduate training may already have developed some of the skills and knowledge necessary for writing articles for publication. Despite this, the book covers all aspects of the publication process and some chapters, such as the one on writing a peer review, are particularly helpful. If you have an interest in this area, the book may be a useful addition to your library, but seems overpriced.

Leslie Pollock

Legal issues in counselling and psychotherapy

Peter Jenkins

Sage, 2002, £17.99

Psychologists, therapists and counsellors may not come into contact with legal issues as often as social workers, doctors and nurses, so it might

be tempting to practise in ignorance of the legal context of therapeutic work. This book covers a comprehensive range of issues that it is imperative to consider before embarking on this kind of work.

The book is split into two parts. The first focuses on the legal context of therapeutic practice, and the second on the legal challenges for therapy. The issues addressed in the first part include confidentiality, legal pitfalls in counselling and psychotherapy practice, the Data Protection Act and court work. Part two is a compilation of personal accounts of practitioners' experiences as they have come into contact with various aspects of the law. These areas relate to the regulation of therapists, work with victims of sexual abuse, counselling in legal settings, the legal and ethical implications for therapists dealing with recovered memories, and the implications of the Human Rights Act for therapists.

The book was stimulating to read, partly because of the style in which it is written, for example, the inclusion of case studies. I was particularly interested to read the chapter that gave an account of a client who took her therapist to court for negligence. This book will help prepare therapists for the legal challenges that they may have to face in their work. It is an absolute must for all in the field.

Carol Valinejad

Working with interpreters

edited by Rachel Tribe and Hitesh Ravel

Brunner-Routledge, 2002, £16.99

It is perhaps surprising, given the statutory obligation (Race Relations Amendment Act, 2000) upon services to provide equal access to health care for all, that there is such a paucity of literature available to clinicians on working with interpreters. Tribe and Ravel's edited book is an important contribution to laying the necessary foundations. In doing so, however, it demonstrates the need for the advancement of our theoretical and empirical understanding of the subtleties of working with interpreters.

Psychologists new to this work will find practical guidelines and advice on the main issues to consider when working with people whose first language is not English. Experienced clinicians

and interpreters explore their respective roles in diverse mental health settings, including child and family work, work with people with learning disabilities, adult mental health work, work with refugees and asylum seekers and in the specifics of medical or diagnostic interviews. Training issues for clinicians and for interpreters are considered, the theoretical frameworks that do exist are presented and an empirical study is described.

Many of the chapters adopt a social constructionist perspective, which may not be to the taste of all clinical psychologists. In this approach, where 'life is lived in language and language brings life to the lived experience', the interpreter is positioned to support the clinician in developing a shared understanding of the meaning behind the client's lived experience. It also promotes a collaborative relationship between clinician and interpreter as co-working professionals, allowing alternative perspectives on common challenges each member of the triad might identify.

The book achieves a balance between the difficulties of working with interpreters, which it describes honestly and realistically and the aspects of this work that make it interesting, stimulating and advantageous to working therapeutically across cultures. Overall, it will be a useful addition to the bookshelf.

Penny Blackburn

Education, entertainment and learning in the home

David Buckingham and Margaret Scanlon
Open University Press, 2003, £18.99

One of the great advantages of my job used to be that, although I spent many hours each week doing it, once I shut the library door I could leave all of it behind me, with the minor exception of reading review books for *Clinical Psychology* on the train. This, alas, is no longer the case. However late I get home, the PC glaring balefully from the corner of the sitting room reminds me that there is still plenty of work-related activity waiting for me. With the new generation of mobile phones, it seems all too likely that databases and catalogue record editing will soon be pursuing me even into the present haven provided by Connex SouthEast.

The blurring of the boundaries between home and school, between work and play, between education and entertainment, between teaching and parenting, and, concomitantly, between the public and private sectors, forms the theme of this important book. Though it has been unkindly suggested that 'education, education, education' was the main priority of the Labour Party only in the same way that the coalminers and the Argentinian navy were the main priorities for Margaret Thatcher, it is undoubtedly true that the British Government has pushed these changes more than most.

A clinician looking for similar changes will find that there has been less movement in the therapy industry than there has been in the world of 'edutainment'. Nevertheless, such changes as there have been have all been in the same direction. This book, if not directly relevant to the clinical psychologist, should at least provide food for thought for anyone interested in 'healing' as a discrete publicly supported activity.

Martin Guha

Archetype revisited: an updated natural history of the self (second edition)

A. Stevens

Brunner-Routledge, 2002, £18.99

As someone unfamiliar with Jung's work, I found this an accessible and thorough introduction because of the epistemological backdrop provided and the links made to Darwin and Bowlby. Stevens journeys through a vast terrain of literature, giving brief updates to the original edition, called *Archetype* and published in 1982. The book is split into three sections: archetypes in theory, archetypes in practice, and synthesis and integration. The basic message is that the true history of the mind is to be found in the living psychic organism of each individual, and that an important factor in evolution is consciousness.

Stevens reiterates Jung's metaphor for the individuation process as proceeding in a similar way to that of an alchemist – separation and analysis on the one hand, and synthesis and consolidation on the other. The first and foremost of separations to be made is between self and ego; the main synthesis is that between thoughts and feelings. What I found particularly interesting

was the outright assertion that symptom formation is an offshoot of the 'individuation process', and therefore it is said to have an evolutionary function.

Stevens says a number of things which are relevant to therapy. First, that 'archetypal projection is not something one chooses to do; it happens to us whether we like it or not' (p.77). Second, for some people, the individuation process may require therapeutic input to get started, to begin to connect with one's 'archetypal intent'. Finally, drawing on neurological findings he proposes that the goal of Jungian (or indeed

any) psychotherapy is 'to promote increased communication in both directions across the corpus callosum' (p.315) to oppose so-called left hemisphere 'imperialism'. Alternatively, in the words of Jung, we need to learn the art of letting things happen.

I recommend this book to anyone with a broad range of interests, and particularly to those who wish to understand the nature of contextual factors involved in therapy

Ceri Bowen

Psychiatry's Tribute to Professor Roy Porter

**Mentally Disordered Offenders in England
1750-2000: Who were they and where were
they treated?**

Friday 7 November 2003; Wellcome Foundation, London

Speakers

The Insanity Defence 1750-1850 – Prof Joel Eigen (Professor of Sociology, Franklin & Marshall College, USA)

How Were Mentally Disordered Offenders Managed in the pre-Broadmoor Asylum Era? – Prof Elaine Murphy (Professor of Psychiatry, University of London)

The History of Prison Psychiatry in England 1750-2000 – Dr Simon Wilson (Consultant Forensic Psychiatrist, Brixton Prison London)

Jonathan Martin: Management in the 'Liberal Era' – Dr Maurice Lipsedge (Senior Lecturer in Psychiatry, University of London)

The Insanity Defence 1843-1957 – Dr Tony Ward (Senior Lecturer in Law, De Montfort University, Leicester)

The Role of Broadmoor, the Asylums and Private Hospitals in the Treatment of the Mentally Disordered 1864-1959 – Dr Trevor Turner (Senior Lecturer, University of London and Chair, History Section of the Royal College of Psychiatrists)

The Interface Between the Psychiatric Profession and the English Judicial System 1959 to the Present Day – Professor John Gunn (Institute of Psychiatry, London and Chair, Forensic Faculty of Royal College of Psychiatrists)

Chairs

Dr Dominic Beer (Senior Lecturer, University of London & Head of History of Psychiatry Section Guy's King's St Thomas & Institute of Psychiatry, Consultant Psychiatrist, Bracton Centre, Oxleas NHS Trust, Kent)

Dr Adrian Lord (Consultant Forensic Psychiatrist, Bracton Centre, Oxleas NHS Trust, Kent)

Dr Jonathan Andrews (Senior Lecturer in History, Oxford Brookes University)

Further information

Oxleas NHS Trust; Tel: 01322 625757; e-mail: randd@oxleas.nhs.uk

The Oxford Branch of the DCP and Berks, Bucks, Oxon and Northants (BBON) Health Advisory Group present a one-day continuing professional development workshop

Working with Asylum Seekers and Refugees

Facilitated by the Refugee Psychologists Forum

Wednesday 26 November 2003; Warneford Hospital, Oxford

For further information and an application form please contact:

Marianne Peedell, Oxford Doctoral Course in Clinical Psychology, Isis Education Centre, Warneford Hospital, Headington, Oxford OX3 7JX; Tel: 01865 226431
e-mail: marianne.peedell@oxmhc-tr.nhs.uk

University of East Anglia Doctoral Programme in Clinical Psychology

Open Day

Thursday 6 November 2003

Are you an undergraduate or graduate in psychology?

Are you thinking of applying for clinical psychology training this year or in the future?

Come and meet current trainees, staff and supervisors involved in clinical psychology training at the University of East Anglia (UEA). The course is based at UEA in Norwich and services the counties of Norfolk, Suffolk, Cambridgeshire and Bedfordshire. During the day there will be an opportunity for informal discussion, to see the campus and teaching facilities, and to find out about the course itself, the academic, clinical and research components of training, and the entry requirements.

Please reserve your place by **Thursday 30 October 2003** by contacting:

Emma Godfrey, Course Secretary, Doctoral Programme in Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich, NR4 7TJ; Tel: 01603 593310;
e-mail: e.godfrey@uea.ac.uk



Division of Clinical Psychology – West Midlands Branch
Conference and Annual General Meeting

Trauma Across the Life Span

Thursday 4 December 2003; Lecture Theatre, Postgraduate
Medical Centre, Queen Elizabeth Hospital, Birmingham

Cost

West Midlands DCP members: £20

Others: £30

A programme and booking form will be distributed with the November issue of *Clinical Psychology*. In the mean time, if you would like further information please contact:

Irene Aggus, 20 Launceston Drive, Nuneaton CV11 6GN; Tel./Fax: 02476 346751;
e-mail irene@aggus.freemove.co.uk

White Hart Professional and Management Development Course for Clinical Psychologists

23 – 26 February 2004, 21 – 24 June 2004, 15 – 18 November 2004

This is the 18th course to be run at the White Hart Training and Conference Centre, Harrogate, North Yorkshire. The course offers an invaluable development opportunity for clinical psychologists who are in, or about to be in, management roles. The cost is £2,400 for three residential modules. We attract speakers of the highest calibre from the UK and overseas. The course will give an insight into the leading edge of strategic management in the NHS and an opportunity to gain practical experience through the completion of a project.

Further information and an application form may be obtained from the Course Administrator: Mrs Carol Northey, Course Administrator, The White Hart Professional and Management Development Course, 89 Lulworth Avenue, Jarrow, Tyne and Wear NE32 3SB; Tel: 0191 421 1267; e-mail: cnorthey@blueyonder.co.uk

Closing date for applications: **Friday 19 December 2003.**

DCP Update

A vibrant discussion

Glenda Wallace reports on the face-to-face meeting of the SDSC and representatives from SIGs, Faculties and Branches held in London on 20 June

The Committee welcomed three new members: Catherine Dobson, Theresa Moyes and Alice Reay.

■ The *Psychological Services Management Faculty* is working on a document focusing on the skills needed for management and leadership. It is hoped that the document will enable Trusts and National Assessors to assess services.

■ *Employment law.* Due to the number of complaints and requests in relation to employment issues (from assistant to B grade), the committee is supporting a request to the Finance and Membership subcommittee to fund training and production of a document by a specialist in employment law.

■ *National assessors.* Concerns arose about the difficulty of A grades moving into B grade posts. The National Assessors have seen a reduction in the management experience of applicants. A vibrant discussion concluded that clinical psychologists have to change the culture of 'non-leadership' and become more aware of the political context we work in. We agreed there is a role for the DCP to encourage leadership by support, documentation, training etc.

We also discussed the accountability of the national assessors themselves, the range of posts they advise on, and support and training for national assessors.

■ *Society Website.* There are to be lots of changes with the BPS site. We should soon see evidence of the new style.

■ *Publications. Supervision document:* there has been disquiet about this recent publication and

the document is to be rewritten. *Challenging behaviour guidelines:* ongoing. *Audit tool:* QUEST to redraft.

■ *Branch, SIGs and Faculties feedback.* The majority of the time available was taken up with discussions about:

Agenda for Change. 1) Impact at local level and need for local and regional discussion. 2) The use of the term 'Consultant', what does it mean in terms of Agenda for Change and other professionals in the NHS?

It was agreed that the profession needs to take the lead and construct guidelines. There is to be a national conference on 13 October, venue to be confirmed. Contact Tim.Cate@tney.nhs.uk for information.

Policy. We talked about the need for the profession to react swiftly to policy documents and reply to national issues, as other professional bodies do (e.g. Royal College of Psychiatrists). We proposed that SDSC suggest the development of a policy unit.

Representation of the membership. Members and non-members are discussing whether the British Psychological Society is representing them. The outcome of the external review is awaited to see if there are any suggestions about the structure and organisation of the BPS and the DCP's place within it.

The next meeting of the SDSC will be a teleconference on 16 September 2003. If you have any issues or thoughts for the agenda, please contact your representative.

Update from the Committee of the Faculty for Children and Young People

This is a brief outline of a few key areas of committee activity reported at the June 2003 committee meeting of the Faculty for Children and Young People.

- Our briefing paper on *Psychology Services for Children with Medical Conditions* was published in April. We have now completed and agreed our position paper on guidance about workload for psychologists working in child services. This will be published and circulated to members shortly.
- Two draft briefing papers on *Psychology Services for Looked after Children* and *Transition to Adult Services* appeared in the next issue of *CYP Service and Practice*

Update in July for members' comments and further consultation with members at our conference in September 2003.

- Children's NSF. Miranda Wolpert, David Lucey, Judith Houghton, Hugh Firth and Ian Gale have been significantly involved in different External Working Groups and have had regular features in *Service and Practice Update*. The emerging findings document has now been published and can be downloaded from www.doh.gov.uk/childrenstaskforce.
- We organised two NSF Consultation Events, one in London and one in Manchester, for clinical child psychologists to meet to consider the implications of the NSF and help formulate a formal faculty response to the NSF Emerging Findings document. These events were well attended, with over 80 people coming to the two events. From members' comments at these events we have now identified and agreed the key points for inclusion in the formal Faculty response.
- The committee is keen to encourage and support the development of specialist networks and special interest groups within the Faculty, such as the paediatric network and the looked after children network. A recent example of this was Faculty support enabling a forensic child psychology study day to take place at the Society offices in London. A similar event is planned for psychologists working in services for children with disabilities.

- The Faculty welcomes new members, who may join at any point during the year. There are two levels of membership: subscribers, who pay £10 per year, and full voting members, who pay £17.50 per year. Membership of the Faculty brings many benefits including free copies of the publications, which are produced on an annual basis. Membership enquiries can be made to Doborah Thorp at traffchildpsych@yahoo.com.

DCP Northern Branch

Meeting for psychologists and psychological therapists working in acute psychiatric in-patient settings

Do you work as a psychologist or psychological therapist in or into an acute psychiatric in-patient service? Would you like to meet others informally to discuss networking, peer supervision and support or working together?

Come to a discussion meeting on **Tuesday 28 October 2003** at 2.00 p.m. in Seminar Room 1 at the County Hospital, North Road, Durham.

If you would like to attend, or for more information, contact either:

Catherine Allen, Clinical Psychologist, Department of Psychological Services and Research, St George's Hospital, Morpeth NE 61 2NU; Tel: 01670 512121 ext.3108/ 3616;
e-mail: catherine.allen@nmht.nhs.uk

Emily Street, Clinical Psychologist, Department of Psychology, Ground Floor, Tower Block, Shotley Bridge Hospital, Consett DH8 0NB. Tel. 01207 214488. e-mail: emily.street@cddp.northy.nhs.uk

DCP Affiliates Committee Meeting and AGM

Emma Bishop was at the event held on 25 July 2003

■ *AGM.* A new committee was elected at the AGM and will be continuing the work on behalf of DCP Affiliate members for the next 12 months. We are pleased that all positions have been filled for this term of office. Sarah Gasson (Assistant Psychologist) and Hamish Kemp (Trainee Clinical Psychologist) will be co-chairing the committee. For more details, visit our web pages: www.bps.org.uk/sub-syst/dcp/affiliates/home.cfm.

■ *Course packs.* For the second year running, packs will be sent to all first-year trainees in September via course administrators. Their contents include: DCP application form and leaflet, Affiliates leaflet, BPS Code of Conduct, a list of publications, BPS journal list, a copy of *Clinical Psychology* and key

DCP publications such as the *Professional Practice Guidelines*, *Case Note Guidance*, and *Core Purpose and Philosophy of the Profession*. The packs were well received last year and there was a marked increase in applications for Affiliate membership. We hope that these will be useful for the new cohort, and in particular raise awareness of the DCP and its role as a professional body.

■ *Revised Alternative Handbook.* The updated version with views from all current year groups will be available in September 2003 for the 2004 entry. We are pleased to announce that responses have been received from all courses. Any feedback on the new design would be gratefully received; contact us at dcpaffiliates@bps.org.uk.

DCP CPD

Sarah Newton and Helen Nightingale attended the CPD Subcommittee meeting held on 16 and 17 June 2003

The Committee met for a regular business meeting and then spent one and a half days reviewing the submissions of members who had volunteered their CPD logbooks for the BPS pilot study. Matters discussed at the business meeting included:

■ *Supervision Guidelines and training accreditation of supervisors.* A revision of the guidelines will be considered at the next meeting in September. Discussion took place about the role of DCLin Psych courses in relation to this.

■ *Presentations about CPD to SIGs, Faculties and Branches by members of the committee.* The committee would welcome requests and invitations.

■ *Funding for CPD.* In the absence of national guidance relating to clinical psychologists,

the committee considered how this is being addressed. We mentioned the importance of workforce development confederations and the role of Amicus in establishing our conditions under Agenda for Change.

■ *Membership of the Subcommittee.* Elma Porter was thanked for her contributions. An advertisement for new members will appear in *Clinical Psychology*.

■ *CPD Logbooks.* Thank you to everyone who volunteered, and to those who then responded to the request for submissions of their logbooks for the BPS Pilot Study.

■ *Guidelines from the BPS Standing Committee on CPD* facilitated our readings of the logbooks and subsequent discussions and action points. Our thanks go to Victoria Burt

and Richard Toogood for attending and guiding us.

- *Recommendations have now been sent to the BPS Standing Committee for CPD. These*

are wide ranging and cover both improvements to the forms and to the guidelines for their completion. The process of scrutiny in the future and decisions about issuing practicing certificates were also addressed.

Division of Clinical Psychology Special Interest Group in Oncology and Palliative Care (SIGOPAC)

The next meeting of SIGOPAC will be held at the Royal Marsden Hospital Education and Conference Centre, Fulham, on **Monday 17 November 2003**. This meeting will involve presentations on Solution Focused Therapy, an introduction to brain tumours, and art therapy with people with cancer.

The day costs £10 for SIGOPAC members and £15 for non-members. To book your place, please contact: Ann Orr, Fourth Floor, University Hospital of Hartlepool, Holdforth Road, Hartlepool TS9 2AH.

To join SIGOPAC, contact Dr James Brennan, Bristol Haematology & Oncology Centre, Horfield Road, Bristol BS2 8ED.

DCP Faculty of Learning Disabilities

Focus on practice: theory, research and clinical skills

10 November 2003; Holloway Road
Resource Centre, 356 Holloway Road,
London N7

Applications: Karin Fuchs or Natasha Alexander, Units 7 & 8, Stratford Office Village, Romford Road, London, E15 4EA;
Fax: 020 8250 7502; e-mail:
natasha.alexander@newhampct.nhs.uk
or karin.fuchs@newhampct.nhs.uk

Closing date: **17 October 2003**

Faculty for Eating Disorders Meeting

Wednesday 22 October 2003
British Psychological Society London
Offices, 33 John Street, London WC1

On the agenda are presentations and a business meeting. Topics include: ○ Dietetics and eating disorders: what are the issues? ○ Ego-state therapy for bulimia nervosa ○ Using EMDR with people with eating disorders ○ Update on NICE guidelines for eating disorders.

All welcome (members and non-members) but booking essential. Lunch available at £5 (please indicate if required when booking).

Contact Zach de Beer, Faculty Secretary:
Zacharias.deBeer@nemhpt.nhs.uk

Child Forensic Special Interest Group

Next meeting

Wednesday 1 October 2003

(11 a.m. – 4 p.m.)

British Psychological Society London Office,
33 John Street, London WC1

Following a successful inaugural meeting held in June 2003, clinical psychologists working in the field of forensic child and adolescent mental health are invited to join this Special Interest Group.

For further information or to confirm your place at this day please contact Lesley French:
Tel: 020 7530 6468/6422
lesley.french@cichs-tr.nthames.nhs.uk

Self-help



August 23

Clinical psychologist away. Missing her already. Quantity of advice on Net overwhelming. There must be a short cut to self-improvement.

August 27

Nigel round for a beer. Said he had always found the lists on making things better in *Men Are from Mars* ideal short cuts.

August 31

Borrowed N's copy of *MAFM* (Alison used ours to line cat's litter tray) and went to shed with Jack Black's *Mindstore* and Nelson-Jones' *Human Relationship Skills* for good measure. John Gray gives 101 ways to 'keep her love tank full'. List starts with 'Upon returning home from work, find her first, before doing anything else and give her a hug.' Haven't been to work for over a year but could wait behind door for when A gets home. Number 2: I should ask her questions about her day. No 18 is build a fire 'in winter-time.' Wonder if global warming will affect this. No 27 is make the bed.

Getting tired reading list so turn to Jack Black. Says I should develop a list of affirmations and repeat them every day. Mind a blank but he gives a list on page 50. Includes 'My financial matters

are in perfect order right now!' and 'Laughter ripples thru every cell of my body now.' Try to cut the list down but can't find any that fit. Settle on 'I have all the time I need for my life now' and 'The food I am about to eat is tasty, nourishing and enjoyable.' Alison calls that lunch is ready.

August 31 (later)

Tried focusing on food mantra during stuffed marrow. A said if I carried on grimacing she would place the marrow somewhere the sun never shone. Asked her if she wanted me to light a fire. If looks were lasers....

Sept 5

Made the bed. Repeated mantra about having time and read most of *Human Relationship Skills*. Says that I can be more assertive by paying attention to timing, making 'I' statements, being specific, making requests positively, paying attention to body language and several more. Add these to 101 ways. Some of these look a bit submissive but never mind. Wait behind door at 5.30.

Sept 5 (later)

On way to Doc's A said, 'What a bloody stupid place to hide and why make the bed on washing day?' Checked body language and said, 'Are you sure you don't want me to light a fire?'

Sept 12

Pub with Nigel. Gave me copy of *If you meet the Buddha on the road, kill him!* Great list at back.

Sept 12 (later)

There are no hidden meanings. Nothing lasts. You don't really control anything. Progress is an illusion. You can run, but you can't hide. This is gloomy stuff. Alison must have been born with this lot wired in.

Try *MAFM* again. A came in while I was cutting out 'sections of the newspaper that might interest her'. Snorted and picked up the *Buddha* book. Said she had read it at Uni. Really liked Eternal Truth number 43: Learn to forgive yourself, again and again and again and again.... Asked if she could consider applying it to me. Said she did; again and again and again....

Felix Q.

From My Study Window

The secret that never was

They don't let me out of College much these days, so I spend my time feeding the ravens and exploring the darkest corners of the Library.

Only this morning I was reading the blurb of a book from 1994 which dealt with Barnardo's and other charities' practice of resettling children from their Homes in Australia and Canada. It began:

In 1986 the author, an ordinary Nottingham social worker and mother of two received a letter from a woman asking for help to trace her parents. She claimed that at the age of four she had been put on a boat to Australia by the British Government. Margaret Humphreys replied that she must be mistaken, yet curiosity drove her to investigate the case.

And eventually she wrote *Empty Cradles*, winning such reviews as 'The secrets of the lost children of Britain may never have been revealed if it had not been for Margaret Humphreys' from the *Sunday Times*. The *Independent* said it was 'a story that defies belief'.

Margaret Humphreys and her reviewers would have been less amazed if they had read Philip Bean and Joy Melville's *Lost Children of the*

Empire, published in 1989, or Gillian Wagner's *Children of the Empire* from 1982.

These two books, dealing with the much same material, were also promoted and reviewed as though they were revealing a long-buried secret, but a little research reveals that it was not a secret at all.

Britain began sending children aboard as soon as it possessed colonies in the 17th century and the practice continued until as recently as 1967. It took place on a massive scale – 3264 children were sent to Canada in 1905 alone – and, far from being a secret, was widely and publicly discussed.

You will find accounts of child emigration in the Curtis Report of 1946, the document which revolutionised childcare after the Second World War, and official delegations went out to Canada (1924) and Australia (1952) to see how children sent there were faring.

Every biography of Dr Barnardo deals with the subject at length, whether a near-hagiography such as J. Wesley Bready's *Doctor Barnardo: Physician, pioneer, prophet* from 1930 or a more sceptical work like June Rose's *For the Sake of the Children* from 1987.

And sending children abroad was always controversial. A succession of murders and suicides in Canada kept the subject in the headlines, thanks to *John Bull* magazine.

Nor was Dr Barnardo himself free from controversy. More than one parent went to court in an attempt to secure the return of children who had been sent overseas. Strangely, these youngsters were always found to have been adopted by wealthy but eccentric philanthropists who made it a condition of the arrangement that their identities would never be revealed.

One mother, a Mrs Gossage, obtained a writ of *habeus corpus* and fought the good doctor all the way to the House of Lords. She won her case, but she never saw her son Henry again.

We know things like this, the ravens and I, but if I am invited to conferences I get excited and wave my arms about too much. That is why they don't let me out of College much these days

Professor Strange

Advertise in *Clinical Psychology*

Contact Jonathan Calder on 0116 252 9502 or joncal@bps.org.uk



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DCP Annual Conference 2004

15-17 April 2004; Imperial College, London

Provisional programme includes speakers on:

- Developmental psychology
- Research led by mental health service users
- Treatment of anxiety
- Personality disorder

Call for Submissions

Submissions are welcome on any subject relevant to clinical psychology. Guidelines and forms are available from the Society's website:

www.bps.org.uk

or from the Society's Conference Hotline:

0116 252 9555

Deadline for submission of papers: **20 October 2003**

Deadline for submission of posters: **31 January 2004**

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