Notes from the Chair

Oops...

Firstly, apologies to anyone who tried to e-mail me at the address I gave in last month's Notes – I gave the wrong address (too many c's). I wonder if anyone out there in the internet world has been receiving unexplained emails from clinical psychologists? If anyone would like to make any comments on this column and what you'd like to hear more about in it, please e-mail lynn.hartshorn@bps.org.uk. Thanks.

DCP Strategy days

Well, this has been a month of meetings and consultation responses, and no exotic travel. Next week, though, I am off to Cardiff for our annual Strategy and Representative Assembly event, which is taking place on 10 and 11 April. For those of you who haven't been involved with the Strategy meeting before, its one of two meetings the DCP Executive has each year with chairs or representatives of all the subsystems within the Division (the regional branches and faculties). During the two days we'll be discussing a number of strategic aims for the Division over the coming year and will hopefully get a lot of input on your behalf from your representatives. I will report back next month.

Unite and Caseloads

So, this month's meetings kicked off with a teleconference with Antony Vassalos of Unite (formerly Amicus), the union which represents clinical psychologists. Amongst other things we discussed the pros and cons of producing joint guidance on caseloads for clinical psychologists, a topic that's also been the subject of discussion on the Managers Faculty e-mail list recently. Will it help individual members or clinical psychology as a profession to have clear guidelines about appropriate caseloads, or will we just be providing the powers that be with unhelpfully rigid ways of judging our work? Would it be too difficult to come up with guidelines that properly took into account grade, speciality etc.? Please do e-mail me with any thoughts on this one.

IAPT

We had a DCP Executive meeting in mid-March, and I was going to say 'the minutes of which will be available on our website'. However, I'm not sure we *are* posting them there at the moment. I shall look into that and hopefully make them available so that you can get a more detailed sense of what we're discussing on your behalf (should the fancy take you!) A large part of our time was spent discussing the IAPT programme and the opportunities and threats it could pose. We're aiming to ensure that clinical psychologists (both those yet to be trained and those already qualified) are suitably positioned to be involved in delivering the IAPT agenda, should they wish to do so, alongside monitoring the impact that IAPT has on recruitment of clinical psychologists to other clinical areas. I also attended a Workforce Planning meeting where again IAPT and its implications for clinical psychologists were high on the agenda.

Statutory regulation

Statutory regulation continues to plod forward. As I explained in previous columns, the final consultation on this, the Section 60 Order Consultation, closed last month. Unfortunately, we didn't feel that the DCP's mainly positive view towards the proposals was adequately reflected in the Society's response to the HPC, and so have written to Pam Maras and the HPC to make this point. Those of us who have been deeply involved in the process do feel strongly that it is very important for us to engage helpfully with this legislation as we do, after all, represent the majority of the psychologists who will be regulated by the Order.

As you may be aware, timescales for HPC regulation are shifting, and it now seems unlikely that the register will open before early 2009. As stated previously, the HPC remains clear that all chartered clinical psy-

chologists will automatically transfer to the HPC register on the day it opens, so this remains the most straightforward route to ensuring you are registered promptly.

However, the good news is that it now seems likely that all clinical psychologists who have qualified via 'an approved course' will be able to have their application for registration considered for a £50 'scrutiny fee' (in addition to the registration fee) even if they are not chartered – considerably less than the £400 scrutiny fee we had feared! There are also 'grandparenting' and 'international' routes, both of which will involve the £400 scrutiny fee in addition to the registration fee.

I would still encourage all clinical psychologists eligible for chartership but not yet chartered to become chartered for two reasons – we still don't have a definite date for HPC regulation, so chartership remains the key method for quality assurance for employers and service users, and the information regarding alternative fees and routes for those who are not chartered may be subject to change in the interim.

And finally...

I've also attended a meeting of the Standing Committee for Psychologists in Health & Social Care, and a further Society/BABCP meeting, but I think I'm running out of space so I'll save feedback on those for another column.

Enjoy the May bank holidays, and watch out for those morris dancers!

Jenny Taylor, DCP Chair

Committee on Training in Clinical Psychology

Call for expressions of interest: Ordinary membership

The Committee on Training in Clinical Psychology is responsible for promoting and ensuring high standards of training in professional practice in clinical psychology in the UK. The committee would welcome statements of interest from chartered clinical psychologists who are familiar with clinical psychology training issues, and would be willing to serve on this committee. The committee would be particularly pleased to hear from:

1. Heads of psychology services or colleagues in other management positions who have an interest in the quality of clinical psychology training and the extent to which it prepares trainees for employment in the NHS, or other settings; and

2. Clinical psychologists who are experienced supervisors who have an interest in the quality of placement and supervision experiences, and in the development of clinical competence on placements.

The Committee generally meets four times a year, either by teleconference or at the Society's London office. Committee members must also be prepared to participate in accreditation visits.

Travel and subsistence expenses will be reimbursed by the Society. Statement of Interest forms and further information are available from Lucy Horder at the Society's Leicester office either by telephone on 0116 252 9596, or by e-mail at lucy.horder@bps.org.uk.

Correspondence

✉ Clinical psychologists in palliative care

I am writing to let members know about the Special Interest Group in Oncology and Palliative Care (SIGOPAC) subgroup which comprises those of us who work in specialist palliative care. We are a small, yet rapidly growing, group of professionals comprising clinical and counselling psychologists who provide clinical, consultancy, research and training into the field of palliative care.

In the past two years members have:
- developed services;
- supervised or conducted research into a variety of areas including assessment of distress and Mindfulness as a treatment for complex grief;
- trained as Advanced Communication Skills Trainers for the National Cancer Action Team;
- contributed to national conferences on the Mental Capacity Act and provided consultancy to a variety of national groups.

They have also contributed to a forthcoming Society document on the role of psychologists in End of Life care.

The group meets approximately three times a year, and provides an invaluable support function for those of us who work in isolation. It also gives members an opportunity to exchange information, share examples of good practice and explore how to manage the many professional dilemmas that working in this challenging and rewarding area presents each of us with.

If you are interested in coming along to meet the group, please contact:
- For times of meeting etc., Shelagh Jenkins: Tel: 02392 250001; e-mail shelagh.jenkins@ports.nhs.uk
- For more information about the group, Christine Kalus: Tel 02392 250001; e-mail: christine.kalus@ports.nhs.uk

Christine Kalus
Chair, SIGOPAC

✉ Electronic records: The new reality?

In the article entitled 'Clinical psychologists and electronic records: The new reality', (**CPF183**) Michael Berger and Adrian Skinner requested comments from practitioners whose services have planned or introduced systems that raise issues that are either not covered, are contrary or support the experiences they described.

I am writing with my own perspective after four years working in two integrated (Health & Social Services) community mental health teams (secondary care), three of which have been spent using a computerised 'carenotes' system which is available across the various sites of the trust via a password system for staff of clients within the service.

I welcomed the article as it raised many important issues – including the issue of the power of NHS Trusts to do things in their own way. This has implications both for psychologists who may feel quite isolated in teams and for other therapists who are unable to draw on the same professional and ethical guidance.

As a lone psychologist working across two community mental health teams where there has been no previous psychology resource, I found the DCP and Society guidance on clinical notes and record keeping invaluable. The various documents gave me a reference

point from which to negotiate minimum standards for notes at a time when I was being instructed to store all notes in a central filing system. However, the position is constantly changing with physical space for paper notes being progressively reduced and Trust guidance stating that there should be no separate notes. I have found this uncertainty raises difficulties when discussing with clients what will happen to their process notes in the future and making decisions about disposal of notes.

It was helpful to read the distinction between the types of electronic records and the options to 'seal' sensitive information. This is forming the basis for discussion with the teams and will perhaps help us to understand and influence the development of such systems in the trust. It is notable that non-psychological therapists had already begun to enter process notes onto the system when our trust subsequently advised them not to and I think this raises the importance of client confidentiality and privacy as well as adhering to ethical principles. It also highlights the NHS dependency culture, where individuals feel they are expected to follow orders. In rural areas particularly, there are additional risks in regarding clients as public property (as workers are more likely to know friends, partners and the wider family network). Whilst recognising the importance of shared information, good communication and team working, I feel that this is being used to push through measures that many of us would find unacceptable for ourselves and rides roughshod over people's sensibilities. This is a particular issue for individuals whose capacity to consent may be compromised by mental health problems.

I was also concerned at the statement in the article that clinicians will need to contribute to or enter diagnoses and the acceptance of purely financially driven ways of operating. Is this really the *fait accompli* the article suggests? If so, it has real implications for future therapies. The US model suggests that anyone without private healthcare will have very few choices and the high proportion of incarcerated people (mainly in penal institutions) with severe mental health prob-

lems in that country is not a recommendation for this model of operation for the UK. There are serious implications for equitable access as those with the means to do so are likely to pursue private therapies and those without means will have very few choices or rights.

In the section 'Team (and other?) access to all parts of the record' (p.55) it stated that all parts of the record will need to be accessible for the team to function safely and efficiently. However, there are several problems with this, which I outline below.

Firstly, psychiatrists' secretaries currently input all information to our carenotes system and psychiatrists, through lack of time, rarely consult these records. The system is constantly changing and a certain familiarity is needed to access it effectively. It is resulting in less communication as some workers no longer send paper copies out.

Secondly, if all information is on the system, how is a psychologist to protect their intellectual property, which may be incorporated into medical reports to outside agencies, such as the courts? There are financial, professional and confidentiality concerns about this. The article suggests there will be very little control over where the information goes.

A third consideration concerns the recording of electronic information in the absence of paper records. Currently, our consulting rooms contain no computers and, on a busy clinical day, it could be 24 hours before access to a computer is possible. Computers are in a very busy office where there are constant interruptions, difficulty accessing a computer (currently 7 for 16 staff). Concerns about accuracy and omissions are inevitable.

A further problem is the absence of a mechanism to record consultations for patients referred into (but not at this stage accepted) by the team. Decisions have to be made about the appropriate care pathway at this stage. They are not opened to a CMHT episode on the system,meaning there is no current system route to register a clinical note; therefore a significant aspect of the psychologist's work is not audited by the system. Recording telephone conversations with

and about clients is completely impracticable both in terms of time (the system is slow to open) resource (telephones, private space and computers are not together) and communication (key team members do not currently access the system, for example, ward staff and psychiatrists). However, I accept these may be glitches with our local system and that other specialities may have very different concerns.

I have to disagree with the concluding comments of the article which state that future generations may well ask what the fuss about the changing culture was all about. Surely, a fundamental change of this kind to the whole philosophical basis on which we operate as a profession merits much more fuss than we have seen? As psychologists, we are aware of the profound influence of language and systems on our perceptions and beliefs. The move to diagnostic bases for treatment indicates a death knell to recovery models, diversity, equality and respect for other approaches.

Finally, the authors assert the need for active constructive engagement at local and national level, highlighting, in my opinion, the need for psychologists to develop overarching communication networks that counter both growing isolation of clinical psychologists in the NHS and provide a means by which policy can be thought about and, where necessary challenged in a coherent and coordinated way.

Dr Hazel Chipchase
Clinical Psychologist, CMHT North & Central, Macclesfield

DCP West Midlands Branch

Trauma focused CBT for PTSD: Integrating theory with practice for adult survivors of trauma

Convener: **Dr Deborah Lee**, Consultant Clinical Psychologist, UCL and Berkshire NHS Trust

Wednesday June 25 2008 & Thursday June 26 2008; Uffculme Centre, Queensbridge Road, Moseley, Birmingham

This workshop will examine recent clinical and theoretical developments in the treatment of PTSD. It will present contemporary theories which aid and inform clinical practice from a cognitive therapy perspective and look at identifying meaning themes within a reliving framework, work with complex emotional reactions and systematically structured clinical interventions.

❍ **Day 1:** Using the technique of reliving to work with traumatic memories, flashbacks and intrusions.

❍ **Day 2:** Using cognitive therapy to reappraise meaning within the context of PTSD.

Deborah Lee is a consultant clinical psychologist who has specialised in the field of Trauma for 14 years. She ran the Adult Traumatic Stress Service (Traumatic Stress Clinic, London) for many years and helped set up the Oxford Cognitive Therapy Trauma Service. She now works for the Berkshire NHS Trust and is also a lecturer at University College London, where she coordinates supervision and training in CBT.

Cost: W Midlands DCP Members £ 100, Others £ 115, Trainees (only two places) £50. Details of local accommodation and relevant reading material can be provided.

Closing date for applications: **Monday 9 June 2008**

Enquiries to: Irene Aggus 20 Launceston Drive, Nuneaton CV11 6GN; Tel; 02476 346751 or e-mail: dcp.wmidlands@googlemail.com

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From the Editor's Chair

I'm afraid that Special Issues are a little like buses – they are never around when you want them but turn up in threes quite un-expectedly. I am pleased to publish a third special issue this year on autistic spectrum disorders, which has been compiled by Paul Skirrow and Dougal Hare, and edited by Alan Jones from the *CPF* collective. There is much to interest readers, even those who do not work in services for people with autistic spectrum disorders, with papers around solution focused brief therapies, service organisation, accreditation and planning, multidisciplinary team working, attachment and much more. We have further Special Issues in the pipeline but also need to focus on publishing our backlog of accepted manuscripts.

This may be a good opportunity to share some statistics about the performance of *Clinical Psychology Forum* over the last 18 months or so since Lesley Cohen and Jackie Munks established the *CPF* database which has enabled us to do some annual statistics for the first time. Currently the *CPF* receives around 11 manuscripts per month. The most popular months for submission are March, June and September; the least seem to cor-respond to school holidays. In addition, we also receive on average seven manuscripts, which have been revised following feedback from the reviewers. These are returned to the original reviewers, and if the revisions are satisfactory, they are accepted for publica-tion. Of the 11 submitted we only reject on average one manuscript per month, which is actually low if *CPF* is considered an academic journal. However, many of the papers we pub-lish are views and opinion, and are not meant to be research articles which are perhaps more easily scrutinised and found wanting. Nevertheless at our forthcoming *CPF* editorial meeting for new members we will be looking at our acceptance and rejection criteria.

Finally, on average we accept around five manuscripts per month, which also means that around five submissions which are returned for submission each month, probably are not resubmitted. Effectively, this means that we publish eventually around 50 per cent of what is submitted; the remainder is either rejected or the authors fail to resubmit.

How long does it all take? Unfortunately, due to the way the database was originally set up, which was just to track manuscripts, we cannot estimate the duration of every pro-cess within the system. However, the time from submission to a final decision (acceptance, acceptance of a resubmission or rejection) ranges from 69 per cent at one to three months, 21 per cent at four to six months, and 10 per cent for over nine months – these figures include the turn around time for returning the manuscript and receiving a revised version from the authors. These times demonstrate reasonable turn around.

From acceptance to publication, which also includes a final submission and receipt of a copyright form, 13 per cent are pub-lished in up to three months, 27 per cent up to six months and 30 per cent for seven months and over. Again, compared to many academic journals, *CPF* is able to turn around copy quickly, which is important given its role as a forum and newsletter as opposed to being an academic journal.

We hope to bring the publication lag down further and would appreciate any feedback about *CPF* that you may have. Please e-mail me at g.turpin@shef.ac.uk or via Jackie Munks (jackie.munks@nottshc.nhs.uk).

Let me finish this time by paying tribute to our longest-serving editorial collective member, Lesley Cohen, who has stood down after many years of service. Lesley edited *CPF* for the year before I took over this chair and has been an invaluable source of advice and support since then. Thank you, Lesley.

Graham Turpin

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subscribe-dcp-announce@lists.bps.org.uk

Division of Clinical Psychology Annual Conference 2008

Wednesday 10 December to Friday 12 December 2008
The Congress Centre, 28 Great Russell Street, London WC1

Keynote Speakers
Dr Tanya Byron: Child psychology and the media
Prof. Christopher French: The psychology of paranormal beliefs
Prof. Colin McLeod: Cognitive processes in anxiety
Prof. Robert Plomin: Nature, nurture and developmental delay
Plus the M.B. Shapiro Award and May Davidson Award lectures

Pre-Conference Workshops (10 December)
John Clements: The behavioural and emotional difficulties of children and young people with ASD: Working with families for positive change
Mark Sampson: Facilitating responsible recovery in borderline personality disorder
Prof. Roz Shafran: Perfectionism: A transdiagnostic approach

Call for Papers

Submission deadlines
30 June 2008: Symposia and papers
1 October 2008: Posters

For submission guidelines, access to our online submission system and all the latest DCP Conference news visit:

www.dcpconference.co.uk

Clinical psychology and autistic spectrum disorders: An introduction to the special issue

Paul Skirrow & Dougal Julian Hare

WE ARE DELIGHTED to present this special issue of *Clinical Psychology Forum*, which will focus upon the needs of individuals with an autism spectrum disorder (ASD) and the contribution that clinical psychology can make in providing for these needs.

In recent months, there has been a great deal of discussion and debate amongst clinical psychologists about the future role of the profession within the changing NHS climate. What is clear, however, is that clinical psychology continues to make an enormous contribution to the work of the NHS and, for this reason, is generally in high demand (e.g. BPS, 2007). In our experience, this pattern is particularly noticeable in services for adults with autism spectrum disorders, where clinical psychologists continue to make an active contribution to psychological research, practice and the development of services. This special issue presents a number of examples of good practice that we feel reflect the key areas of strength for clinical psychologists.

It is perhaps ironic that the present issue has been compiled to address the needs of individuals with a specific diagnosis, since we would argue that the diagnosis is, in itself, an extremely poor indicator of an individual's care needs. Indeed, we feel that one of the strengths of clinical psychology lies in the development of individualised, holistic psychological formulations, taking into account the individual's own strengths and weaknesses, together with their environmental context. Certainly, a clinical formulation can and should take into account the patterns of thinking, feeling and behaving that are frequently labelled as 'syndrome' or 'disorder' but we would argue that it is a poor clinician who considers the diagnostic label over and above the individual or, indeed, fails to consider the interaction between the person and their environment.

Clearly, there is no theoretical reason why generic models of therapy are unlikely to apply to individuals with autism. We present a paper from Vicky Bliss on the application of one such model – solution-focused brief therapy – to this population and there are examples of a number of others (e.g. cognitive behavioural therapy – Gaus, 2007; personal construct therapy – Hare et al., 1999). However, we would particularly stress the importance of a clear rationale for therapy and a coherent, holistic formulation that takes into account specific issues associated with autism. In this vein, we are pleased to present a paper by Andrea Flood and Ewan Perry that reminds us of the developmental nature of ASDs and the need to consider their lifetime context. Their paper also illustrates the particularly valuable contribution that clinical psychologists can make – both generally and specifically – in the field of autism, by going beyond specific models of therapy and applying psychological theory to understanding the clinical needs of our clients. Most clinical psychologists will have at least a basic knowledge of developmental psychology, particularly such issues as attachment and the development of 'theory of mind', since most of these issues are covered by undergraduate psychology training, and it is easy to forget that few other professionals receive formal training in these areas.

Certainly, we feel that the overall message from this issue is clear: people with ASDs typically present a challenge and do not fit with

traditional service models and approaches (Barnard et al., 2001). Individuals on the autistic spectrum have so far resisted the medical world's search for a 'treatment' or 'cure' and, perhaps for this reason, we feel that services should always be mindful of the true goals of psychological interventions: increased social adjustment and social inclusion beyond simple symptom management (e.g. Emerson et al., 1998). While we would argue strongly that services should be built around individual need, the reality in the NHS is that diagnosis typically defines the type of service you receive, which often leaves adults with ASDs at a particular disadvantage (Bennett et al., 2005). As Dougal Hare discusses in his paper, although many psychologists have chosen not to involve themselves in the process of diagnosis (cf. Jones, 2006), we must consider the possibility that this may be frequently to the detriment of our clients, rather than their aid.

Finally, in keeping with the view that clinical psychology has a role in challenging some of these issues at a more systemic level, we are pleased to present the papers by Rachel Brown, by David Wheatcroft and Marion Jones, and by Paul Skirrow and Joanna Farrington which we hope illustrate some of the innovative approaches to service delivery that have often been led and driven by clinical psychologists. Overall, we hope that this issue will particularly highlight the specific needs of this client group and the significant strengths of clinical psychology, both generally and specifically, in the field of autistic spectrum disorders.

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Solution-focused brief therapy and autism

Vicky Bliss

Solution-focused brief therapy (SFBT) offers a more person-centred and positive approach to working with people who have autism. SFBT focuses on strengths and ways of achieving desired futures, rather than on deficits and helping people fit into a 'neurotypical' world.

I LOVE BEING around people with autism. This is not to take away from people with learning disabilities, severe and enduring mental illness, dementia, stroke survivors or offenders, because I very much like being around them too. But being with them is more like being with 'cousins', whereas being with people who have autism feels like being 'home'. Getting to spend time learning about and conversing with people who think in autistic ways gives me the same luxurious feeling of digging my toes in warm sand; it is an interesting kind of bliss.

My practical training in working with people who have cognitive differences has been given to me most patiently by people of all ages in various kinds of settings. I have learned a lot about how to survive when one's liberty has been denied and when one's self-respect has been compromised by a service system. I have seen evidence that people can survive multiple years in an institution with a sense of humour and a genuine wish to please others still intact. How? How does that happen? I have learned how to get one's needs met, by hook or by crook, and how to dodge a service that seems to do more harm than good. I have seen cleverness creativity, strength, wit, resourcefulness and 'bounce-back-ability' the likes of which I have never seen before. My heart was alternatively tweaked with profound sadness and filled with laughter at the knowledge, skill and creativity of these teachers. They were generous to me, when there was no particular reason for them to be, and from them I learned so much that was at odds with what I was taught from the books.

I met people with autism in each of these stages of my training. They were woven throughout service settings, through groups of people no matter the diagnosis or ages and, luckily for me, throughout my life. They were in there teaching and shaping me with their humour and brilliance, shining along with the others.

The whole lot were creating dichotomies and conundrums for me where my professional learning, for example, meant that people with 'crooked thinking' should change how they think, when people with autism didn't want to change how they thought. They wanted to change how other people thought. People with autism often want other people to behave themselves rather than change their own behaviour. They sometimes said that other people were responsible for how they themselves felt because it is other people who constantly 'get at' them. Often, people with autism spot exceptions and inconsistencies in the rules that 'normal' people expect everyone else to follow, and they would prefer for the 'normal' people to become more flexible rather than rigidly expect all people to follow inconsistent rules. 'I don't want much,' Dean Worton (a colleague with ASD) said to me in conversation once, 'but if they ["normal" people] would just make the round hole a little bigger, we square pegs could easily fit in without damage to anyone.'

My practical teachers also taught me, through giving compelling real life examples, that people with disabilities and diagnosed differences do not have equal footing with professional people. Though there are more service-user groups 'informing' service management than ever before, these contributions are given on a voluntary basis and do not usually receive equal consideration along-

side professional recommendations. Likewise, patients who refuse medication, miss appointments or fail to do therapeutic homework assignments are still, more often than not, labelled as 'resistant', 'unwilling' or 'unable' to change. People in therapy settings are still, more often than not, required to use the language of emotions, even if this is a foreign concept to them, as it frequently is to people with autism. It is, more often than not, the professional therapist who decides the 'problem' areas on which work is needed. When therapy doesn't work it is still, more often than not, seen as a failure of the patient rather than of the therapy system.

I was trained by other people to do cognitive behavioural or applied behaviour analysis to a professional standard. I had, and still have, a natural respect for people who practise CBT, ABA or other types of therapies, though in common with others (Lambert, 1992; Hubble et al., 1999; Wampold, 2001), my instinct is to credit the success of these therapies mainly to the therapist's ability to create a good working relationship with the client rather than to the specific theory of change being employed.

Much to my relief and delight, I was trained to use solution-focused brief therapy in 2001. This, like being with people who have autism, felt like home for me as it allowed me, at last, to listen and learn about what works best from the client's point of view. I was relieved of having to know the 'right' treatment for various problems and, in fact, relieved of having to know about the problems at all. I have been using the guiding principles of SFBT for the past six years with incredible success from my point of view. I feel much happier getting referrals, and instead of having to see yet another 'problem', I get to meet people with thousands of competencies and strengths. The success of SFBT from my client's point of view is less effervescing than my own, though I have been able to establish working relationships with people for whom traditional approach has not worked, and in the main people do meet the goals they set for themselves. All of which I take to be good news.

The background

SFBT (de Shazer et al., 1986) has a background in social constructionism which gives premium value to reality as it is described by the client, and to the construction of new realities (and preferred futures) through conversations with the worker (O'Connell, 2005). It also fits with other postmodern developments in therapy (e.g. narrative therapy, NLP). It is minimalist in as much as the therapist is charged with doing only what is needed and no more. If something is not broken, then we don't aim to fix it (O'Connell, 2005).

Like other forms of therapy, SFBT aims to focus on an individual's preferred future (in other words, where they want to be or what they would like their life to be like) and then gather the strategies and resources that the person already has which can be used to help them meet their aims. This puts SFBT in the person-centred as well as goal-oriented schools of therapy, and keeps the therapist and client accountable for the direction their work takes. The essence of SFBT (i.e. what makes it different from other types of therapy) is that the therapist needs to listen closely to hear the client's theory of how change will happen for them. This requires a leap of faith from the therapist and a willingness to abandon academic theories of how behaviour change happens in favour of the client's belief about how change will happen.

SFBT concentrates on getting to know the person apart from the problem. There is a focus on existing resources rather than deficits and a view towards the present and the future rather than reviving a history of the problem. This often leads to discussions about the person's areas of interest, such as trains, buildings or videos. Allowing time to talk about areas of particular interest seems to put the client more at ease, and generally uncovers a wealth of competencies, abilities and strengths which the therapist can highlight to see if the client has noticed them too. The hope is then that these strengths, abilities and competencies can eventually be applied to help the person take steps towards their preferred future.

In SFBT the therapist, who has set aside his or her professional view of what is wrong with the client, works together as an equal partner with the client to co-construct a detailed view of what the person's preferred future would look like. Every bit of understanding is checked with the client in an effort to ensure the whole process is making sense. The therapist becomes the learner and the client becomes the teacher – teaching the therapist how things work in their world. The therapist is relieved of their expert stance of having to know all the answers, and takes on an even more intense role as a good listener.

A sound knowledge base of academic theories of behaviour change is still helpful to the therapist (so those years of hard professional training have not been wasted). Principles of reinforcement are applicable, for example, and these can be explained to the person, so that both client and therapist can use the information in a productive way. In common with more traditional therapies, SFBT focuses on concrete observable measures of forward movement and sets targets which are measurable and make sense to the client. Principles of reinforcement make sense as part of the process, because people will do things that they find rewarding. The therapist and client together work out what is rewarding and how to get rewarding things to happen more often. SFBT also requires both the therapist and the client to have some degree of memory and ability to attend during appointments. I would add at this point however that I have been quite surprised at the common understandings reached and progress made between myself and people with limited verbal language. The difficulties in establishing a relationship and setting goals for work with people who have autism are most often my problems, not theirs.

The research base
The literature on SFBT spans more than two decades now, beginning with de Shazer and colleagues' first paper in 1986 (de Shazer et al., 1986). Since that time, much has been published in the areas of family therapy, couples therapy, mental health work education, social work, rehabilitation of offenders and in physical health (see O'Connell, 2003, for examples). Literature has been published on SFBT for children as well as adults, and a little has been written about using the approach with people who have learning disabilities (Rhodes, 2000; Stoddart et al 2001; Smith, 2005; Bliss, 2005). SFBT has not, however been researched extensively with people who have autism though a tiny start is being made (Bliss & Edmonds, in press).

Because SFBT is very much individually based, no particular adaptations are necessary to the philosophy of the approach when working with people who have autism. Creativity is essential in terms of techniques to agree and remember goals, to assess progress, and to have discussions. Thankfully, because SFBT is an expert-expert proposition, I, as a therapist, do not bear sole responsibility for the creativity. A happy realisation in my solution-focused work with people who have autism is that they are massively creative people who patiently help me to understand and work with them.

Very preliminary outcomes
Preliminary results of using SFBT to varying degrees with clients are very encouraging indeed. As we explore coping skills and identify strengths which are already being used by the individual, very often they begin to sit up straighter and give better eye contact. We might spend time practising how to imagine a future without the problems, and we spend some time using visual cues to help the person identify how they are feeling. We also practise identifying what the person will do, or what others will do with the person when they move one point up on a scale, often of 0–10 but sometimes having only two points, depending upon what makes sense to the person. This concrete way of defining what needs to happen in order for things to get better appears to make sense to many, though of course not all, people with autism

Individuals have commented that they feel the therapist is really listening to them and this encourages them to try hard to help the therapist understand what things are like in their world. One individual in particular

noted that other therapists 'only half listened' to what he was saying, and 'filled in the other half with what they thought was going on'. This individual especially liked the extra time taken to explore his interests and how the skills necessary to pursue his interests could also be used to achieve some of his wishes for the future.

SFBT has also encouraged people to think in terms of how they will know when they are finished with therapy. We work at identifying what the individual will see, hear or feel when they have accomplished enough in therapy. We also wonder what comments others will make that will tell us we have worked well together. These are unusual and difficult questions to answer but clients and carers usually rise to the challenge.

I also have noticed that individuals do not need or want to see a therapist every week, as is often the practice with other therapies. When given the option to choose the length of time between appointments, it is often between two and six weeks. This means, from a pragmatic point of view, that I can see more individuals less frequently and still see positive outcomes.

People with autism and I hope to produce some case studies and more detailed evaluations of how SFBT helps people with Asperger's syndrome and high-functioning autism, as well as their carers, as we become more practised in using the therapy. Ideally, we would be able to secure funding for substantial research into the application of SFBT principles with this population. At a minimum, there appear to be aspects of SFBT which help clients to establish respectful relationships with therapists, and which help therapists to see their clients as wonderful collections of competencies, creativity and strength. This seems to make for a happy and helpful relationship all around.

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Developing specialist services for adults with Asperger's syndrome in Liverpool

Paul Skirrow & Joanna Farrington

Although awareness of the prevalence of Asperger's syndrome has increased, people with the condition often have difficulty accessing services. This paper describes the development of a service in Liverpool designed specifically for people with Asperger's syndrome.

SINCE LORNA WING first coined the term 'Asperger's syndrome' over 25 years ago (Wing, 1981), an increasing number of children and adults in the UK are being diagnosed with this, or other 'autistic spectrum disorders' (ASDs) almost every day (Fombonne, 2006). Despite the growing acknowledgement of the unique needs of this client group, services designed to meet these needs have not always been so quick to adapt (Powell, 2002). This paper describes the development of one such service, the Liverpool Asperger Team, together with some of the lessons learned over the five years since its foundation.

Falling through the gaps

The majority of governmental policy documents, including *Fair Access to Care Services* (DH, 2003), the *National Service Framework for Mental Health* (DH, 1999) and the *Mental Health Policy Implementation Guide: Community mental health teams* (DH, 2002) avoid defining services on the basis of diagnostic labels. However, the reality of NHS treatment is that services are frequently allocated on the basis of psychiatric diagnosis and, as long as they do not have a 'severe and enduring mental illness' or a (global) learning disability, adults with Asperger's syndrome frequently find themselves unable to access community service:

> Autism spectrum disorders constantly fall through the gap between mental health and learning disability services for most people at the medium or higher functioning part of the autistic spectrum (Barnard et al., 2001).

In a survey undertaken by the National Autistic Society, involving the families of over 450 adults with autistic spectrum difficulties, Barnard et al. (2001) found that nearly 70 per cent of parents felt that their children with an ASD would be 'incapable of living independently'. Furthermore, of the adults defined as having Asperger's syndrome or 'high functioning' autism, only 12 per cent were in paid employment and nearly a quarter (24 per cent) had no meaningful activity outside the home. Perhaps not surprisingly on the basis of this pattern, nearly one third of the sample reported experiencing mental health problems but, despite this, only 16 per cent reported being offered an assessment under the 1990 NHS and Community Care Act and only 45 per cent of the adults who did receive an assessment reported actually receiving the services specified in the assessment.

Interestingly, nearly half of Barnard et al.'s population were not diagnosed until after the age of 16, making them ineligible for support from their local education authority or from many child and adolescent mental health services. Indeed, diagnostic services are often provided with children in mind, making it difficult to gain a conclusive diagnosis as the individual gets older (e.g. Stirling & Prior, 1999). While the 2004 National Service Framework for Children, Young People and Maternity Services (DH, 2004) provides a specific policy exemplar for children with autism, Asperger's syndrome has been explicitly excluded from policy documents for adults, such as *Valuing People* (DH, 2001).

Meeting the need in Liverpool

The issue of adults with Asperger's syndrome was raised in Liverpool as early as 1999, when the learning disabilities directorate was receiving an increasing number of referrals for adults with ASDs who had minimal, if any, global learning disabilities. Similarly, although depression, anxiety and 'challenging behaviour' were often common, many of these individuals did not fit the criteria for 'severe and enduring mental illness' that would allow them access to generic mental health services. However, it was clear that these individuals still had a number of health and social care needs that were not being addressed. On the basis of this, the (then) head of mental health services initiated a number of cross-agency meetings, inviting representatives from the Learning Disabilities Directorate, Liverpool Primary Care Trusts and Liverpool City Council to discuss the issue. These meetings were later for-

malised into the local 'Asperger Syndrome Steering Group', which included representatives from the voluntary sector, together with adults with Asperger's syndrome and their carers.

One of the first tasks of Liverpool's Asperger Steering Group was to commission a research project to assess the needs of adult with Asperger's syndrome in the local area (Knight & Porter, 2001). The research study, funded by Liverpool Health Authority, recommended the development of a managed care network, where linked groups of professionals and organisations from primary, secondary and tertiary care can work together in a coordinated way, designed to be unconstrained by professional or organisational boundaries (Knight & Porter, 2001). Key to this, the authors believed, was the development of an Asperger's syndrome-specific multidisciplinary team, which would take the coordinating role with in the network and
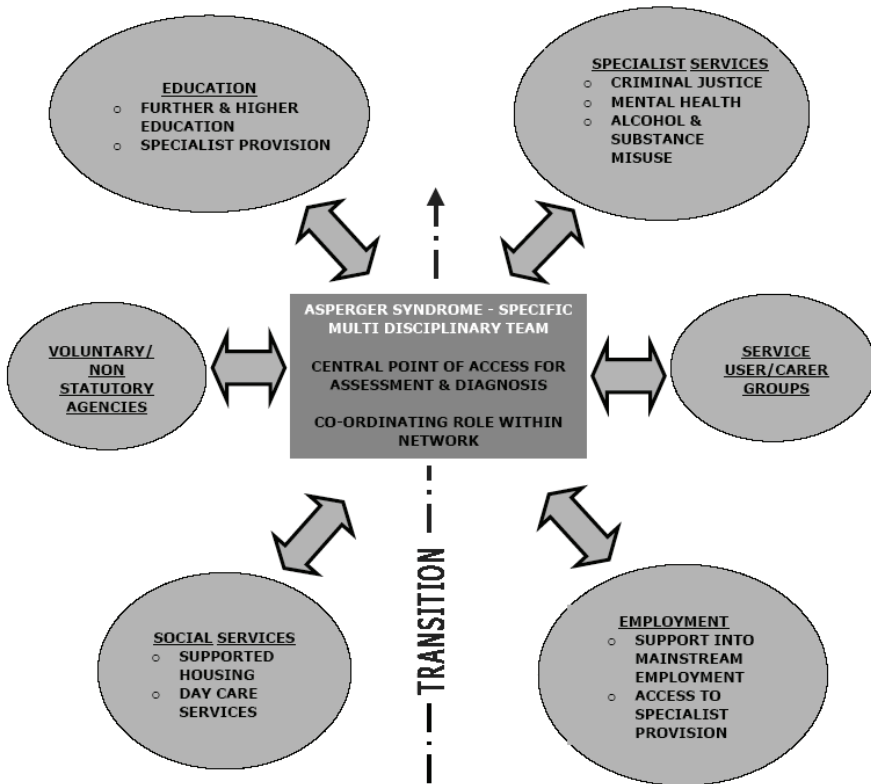
Figure 1: Liverpool's managed care network for adults with Asperger's syndrome
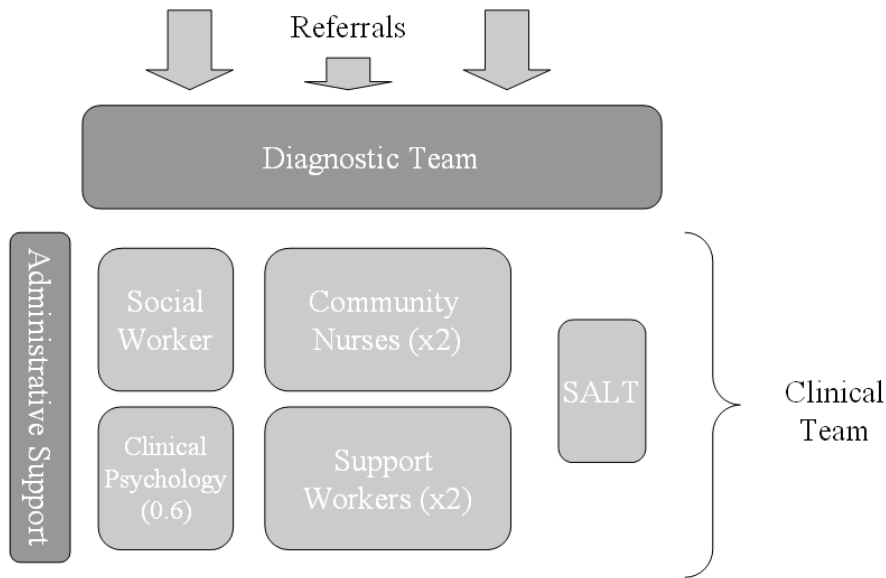
Figure 2: The current structure of the Liverpool Asperger Team

act as the central point of access to the network (Figure 1).

Following the recommendations of the research project, and further consultation meetings with the commissioners and representatives from the local authority, the structure and functions of a specialist team for adults with Asperger's syndrome were finalised by the middle of 2002. After a further period in which a number of professionals were trained in assessment and diagnosis of ASDs (specifically the Diagnostic Interview for Social and Communication Disorders (DISCO); Wing et al., 2002) and a manager was appointed, the team secured its funding from the Liverpool PCTs and the local authority and began to recruit to the specialist multidisciplinary team in early 2003. Some of the key roles of the team are described as part of the managed care network in Figure 1.

The Liverpool Asperger Team: Four years on

Since the formation of the Liverpool Asperger Team, nearly 500 individuals have been referred for assessment and intervention. Due to the high numbers of referrals, one of the most important roles of the team has been the assessment and diagnosis of Asperger's syndrome itself and signposting individuals to their appropriate services. Indeed, barely half the referrals made to the team have subsequently gone on to meet eligibility criteria for the service. Once the individual has been assessed and diagnosed as having Asperger's syndrome, is living within Liverpool and is over the age of 18, they then gain access to the 'core' clinical team, which includes specialist practitioners from nursing, social work, clinical psychology, speech and language therapy and specialist support workers (see Figure 2).

The vast majority of individuals served by the team are young males – over 35 per cent of referrals to the team have been for individuals aged 18–25 and, consistent with the reports of previous authors (Ehlers & Gillberg, 1993), the ratio of male to females referred to the team remains approximately 3:1. However, there is also diversity within this group: the team serves a number of adults over the age of 65, a number of parents with Asperger's syndrome and families where Asperger's syndrome spans several generations. Indeed, providing support services to meet the needs of such a diverse group is rarely straightforward.

The ongoing challenge

After nearly four years of working with adults with Asperger's syndrome, a number of key issues have emerged. Almost by definition, Asperger's syndrome affects individuals' ability to access those everyday community activities that involve human interaction and, as a result, the greatest challenge to services for adults with Asperger's syndrome is to maximise their inclusion into community activities. The typical mental health day service is frequently a busy, unstructured environment, where the person with Asperger's syndrome can often be extremely vulnerable to exploitation and abuse by other service users. Similarly, day services for adults with learning disabilities usually offer activities tailored to their clientele, which may be unlikely to stimulate many individuals with Asperger's syndrome. Indeed, the unstructured, large-scale service provision of day centres seems largely unsuitable for adults with autistic spectrum disorders in general and it is a constant challenge to provide needs-led, person-centred social care for this client group.

Many people served by the team have developed a strong 'Asperger identity' and a community network of people with Asperger's syndrome is slowly developing. Indeed, this sense of connection and community is cited by many as one of the most useful things in helping them to cope with the 'neurotypical' world, and it is hard to stress enough how important many individuals with Asperger's syndrome consider their diagnosis to be. While individualised, person-centred support packages, allowing individuals with Asperger's syndrome to access the wider community and to reduce barriers to social inclusion, remain the 'gold standard' of services, given the choice many of these individuals would prefer the company of other people with Asperger's syndrome in segregated settings to forced integration into the 'neurotypical' world.

As with any diagnosis-based service, an ongoing challenge is frequently the interface with other diagnosis-driven services, where professional disagreements about the 'primary diagnosis' can lead to individuals being excluded from services. In Liverpool, as in other areas, the challenge has been to create and maintain good working relationships with local mental health and learning disabilities teams, based on a philosophy of working jointly rather than seeking a 'primary diagnosis'. Indeed, in Liverpool, where there are no consultant psychiatrist or inpatient beds allocated to adults with Asperger's syndrome, local community psychiatrists have been forced to take 'RMO' responsibility for adults with Asperger's syndrome, facilitating joint working with 'dual diagnosis' clients.

Conclusions and implications

The Liverpool Asperger Team is a specialist service for adults with Asperger's syndrome and was set up in response to a specific, identified local need. Many individuals have received and continue to receive services which they would have been denied before its foundation. However, the authors would not wish 'specialist' diagnosis-driven services to be considered a panacea for adults with ASDs or indeed any other diagnosis. The goal is for person-centred, needs-led care for all service users of which diagnosis can only ever be the smallest, if significant, part.

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Autistic spectrum disorder and attachment: Where are we now?

Andrea Flood & Ewan P. Perry

This paper considers whether early developmental difficulties commonly associated with ASD are a significant influence on a child's primary attachment relationships. It focuses particularly on the Dynamic Maturational Model (Crittenden, 1995) of attachment and psychopathology.

T HE MENTION OF autism and attachment in the same utterance is still likely to bring to mind the controversy created by Bruno Bettelheim's popularisation of the hypothesis that autism is a psychogenic disorder resulting from disturbed attachments between autistic individuals and their cold, distant mothers (Bettelheim, 1967). Current thinking has, thankfully, moved on since then and this article's purpose is not to resurrect the debate. Rather, the aim is to think about how attachment relationships emerge and develop within the dyadic relationship between a child with autistic spectrum disorder (ASD) and their primary caregiver, as they would for any neurotypically developing child. This is considered of value given the growing evidence to suggest that, for this latter group of children at least, the development of primary attachment relationships has significant implications for both short and long-term psychological well-being (Green & Goldwyn, 2002; Rutter, 1995).

Although a neurobiological basis to ASD is now well established (Medical Research Council, 2001) it is widely recognised that there is significant heterogeneity in its presentation. Attempts to identify a single underlying deficit have proved inconclusive (for a review see Penn, 2006) and Goodman's (1989) proposal of autism as a syndrome of multiple primary deficits may account for the range in presentation commonly observed. However, the evidence base of additional fac-

tors associated with the divergence in presentations and what this suggests with regard to interventions remains at a very early stage. What is well established in the research with neurotypical children is that when a child's early emotional needs remain unmet, or they experience a punitive relationship, this has direct consequences for neurobiological development and the ability as an adult to cope with arousal and distress (Gerhardt, 2004). The authors therefore argue that it is both theoretically and clinically relevant to consider whether early developmental difficulties commonly associated with ASD are a significant influence on a child's primary attachment relationships. In particular, consideration is given to whether the assumptions implicit in one model of attachment and psychopathology, the Dynamic-Maturational Model (DMM: Crittenden, 1995), hold true for children with ASD, in addition to identifying some of the challenges presented by research in this area.

Over the last two decades the number of studies looking at attachment and autism has slowly grown. A recent meta-analysis (Rutgers et al., 2004) identified one study that used the Strange Situation Procedure (SSP: Ainsworth et al., 1978) in its standard form, and nine that used it in a modified form, to categorise autistic children and non-autistic controls as securely or insecurely attached. Although 53 per cent of autistic children were classified as securely attached, this was significantly lower than the figure for children without autism. Another recent study from the same group (van Ijzendoorn et al., 2007) used an unmodified SSP, allowing a direct comparison with a control group of typically developing children. They investigated the relationship between parental sensitivity and attachment in groups of children with ASD and groups

with learning disabilities, language delay and typical development. Parents of children with ASD and parents of children without ASD were found to be equally sensitive, but the children with autism showed more attachment disorganisation and were less involved in interactions with their parents. Moreover, a significant interaction effect was found between parental sensitivity (high or low) and ASD (children with or without a diagnosis) on scores of attachment security. Only in children without ASD did increased parental sensitivity predict higher attachment security.

So, although there is evidence that some children with ASD experience secure attachment relationships, there also appears to be ways in which attachment relationships differ for these children compared to prototypically developing children. This, of course, may not be considered surprising, given that ASD is defined by difficulties with social interaction and communication. In addition, it is the authors' clinical experience that parents of children with ASD often report differences much earlier than actual diagnosis, with descriptions of their child as being particularly passive in infancy or, at the other extreme, overaroused and difficult to sooth. These early perceptions of temperament may be important, given that there is some evidence to support temperament as having a mediating role in the security of early attachment relationships (Thompson et al., 1988).

Crittenden's Dynamic-Maturational Model of Attachment proposes that prototypical maturational processes in children involve an interaction between a child's genetic inheritance and the dynamic experience of the caregiver and child relationship. The sensitivity of the caregiver within the context of this dyadic caregiver-child relationship is a key factor in predicting the emotional well-being of the child (and, later, adult). However, although the caregiver plays a significant role in this process, the young child is not considered a passive recipient of their caregiver's behaviour. Young infants exhibit attachment behaviours, such as crying, looking and reaching in order to attract the attention of their caregiver and maximise

the likelihood that their caregiver will protect and comfort them. The baby is therefore seen as organising their responses in order to 'shape up' their caregiver's behaviour and minimise psychological risk to themselves.

The DMM model predicts that different types of parental behaviour will lead to different patterns of responses by their babies. For example, when a baby has a sensitive, responsive caregiver they quickly learn that their own behaviour results in a predictable, contingent response by this person. When the caregiver attunes their response to their baby's distress, the baby learns that sharing their feelings with another person leaves them feeling comforted and that their arousal reduces. The theory proposes that when parental responses are either absent or overly intrusive in response to the behaviours exhibited by babies, then either inhibition or exaggeration of affective states occurs.

This model of attachment appears to be based on some key assumptions about the innate ability of a young baby. These include the ability to attend to and recognise increased arousal in other people and the adaptability to either inhibit or exaggerate emotional expression in response to this experience. Given that difficulties in interpersonal experience are a core feature in ASD, it is interesting to consider whether these early skills are present or not. This is a particular methodological challenge, given that ASD is not clearly recognisable until 18 months at the earliest and even then most children are not diagnosed until they are older.

Retrospective analysis of videotape has provided some very limited evidence that differences in social functioning are observable at one year, with children later diagnosed with ASD showed reduced 'looking at people' behaviour (Osterling & Dawson, 1994). The area that perhaps received the most focus in relation to early social deficits has been joint attention. Naber et al. (2007) focused on very young children with ASD, finding that young children with ASD (mean age 30 months) showed fewer joint attention behaviours than typically developing children of the same age. Interestingly,

this study also used the 'strange situation' to assess attachment, finding that joint attention behaviours were more common in securely attached typically developing children than in non-securely attached typically developing children.

These studies, of course, do not provide conclusive proof of deficits in these areas; however, they do provide some indication that by the age of two, children with ASD have begun to show atypical patterns of interpersonal exchanges when compared with typically developing children. Perhaps the key to understanding whether these patterns have implications for early attachment experiences lies in a greater understanding of when neurodevelopmental divergence occurs in the trajectories of these two groups of children. Hobson (1993a, 1993b) argues that differences in interpersonal experiences occur very early on, suggesting that a deficit in the capacity for inter-subjective engagement is in fact the core deficit seen in autism. In normative development, young children have an innate capacity to relate to and understand people in what is described as a 'special way' (Hobson, 1993b). Reciprocal relationships between people are experienced as qualitatively different to the relationships that exist between people and things. In order to understand the nature of these relationships, it is necessary to have an affective experience of them. It is this ability to experience other people in an affective capacity that is considered to be impaired in ASD.

With reference to the ability of young children to inhibit or exaggerate their arousal in response to caregivers' behaviours, although not a core diagnostic feature, difficulties with affect regulation appear to be commonly observed in children with ASD. Konstantareas and Stewart (2006) found evidence that, when faced with a mildly frustrating situation, children with ASD are more likely to employ strategies rated by others as less adaptive than a group of typically developing children. Sigman and Capps (1997) observe that by the second year of life children with ASD are often over-aroused and overactive, being difficult to calm at bedtime.

This provides tentative support for further exploration in this area, particularly in respect of whether children with ASD are able to modify their arousal in response to subtle forms of social feedback from their primary caregivers.

Whilst babies with early social communication difficulties may have parents who are very sensitive, the authors speculate that following the emergence of non-neurotypical patterns of development, young children with ASD themselves may be less adept in organising their own attachment behaviour in response to their parents' style. This hypothesis may account for van Ijzendoorn et al.'s findings that parental sensitivity did not impact on attachment security in children with ASD. Similarly, babies with ASD who have parents with mixed patterns may be less able to shape up their parents' behaviour by attuning to the variability in parenting style and adapting appropriately. The DMM proposes that parental perception of young babies as challenging or less responsive can then impact on their continued pattern of interaction. Or, indeed, it seems possible that parents may become inconsistent in their approaches with a child whom they experience as difficult to connect with, trying a whole range of styles in order to facilitate engagement between themselves and their child. In this way, baby and caregiver enter a maintenance cycle of mutually unsatisfying interaction.

There is, however, another layer of complexity to the problem that is summarised well by Hobson (1993a), who offers a note of caution when thinking about the experience of interpersonal relationships, and therefore attachment, for children with ASD. The majority of current research in this field has involved comparing attachment behaviours in children with and without ASD and noting the similarities and differences. However, to say that a child with ASD behaves similarly to a child without ASD is very different to saying the children have similar internal working models of relationships. The meaning or function of a similar behaviour may be different in each case. The converse is also true: dif-

ferences in outcomes on standard measures of attachment used with different populations do not necessarily allow us to draw conclusions about differences in internal working models. As long as attachment is assessed using behavioural criteria, there is no easy way to resolve this conundrum.

One of the purposes of this article is to encourage continued interest in this field. Besides the theoretical challenges identified above, there are pragmatic obstacles that need to be addressed in future research. One such obstacle is the use of a modified SSP in nearly all attachment research on children with ASD. Rutgers et al. (2004) point out that separations are either shortened or reduced to one instead of two due to the difficulties children with ASD have with unexpected separations and unfamiliar situations. One approach (e.g. van Ijzendoorn et al., 2007) has been to simply leave the SSP unmodified, though there are still potential issues with the contrived nature of this method for children with ASD. Another promising approach has been suggested by Rutgers et al. (2007) in a study using the Attachment Q-Sort (AQS), which is based on naturalistic observations of child-parent interactions. Clinicians and researchers in the field of ASD were asked to define an AQS criterion sort for children with ASD, which was found to correlate 0.93 with the original criterion sort based on an ideally secure typical child was. Only four items differed more than two scale points when comparing the criterion sorts; these items referred to physical proximity to the attachment figure. Securely attached children with ASD (at least in the eyes of those who are experienced in the field) therefore show a very similar range of behaviours to a securely attached prototypical child, and the AQS may prove useful in future research.

Another problem relates to the concept of sensitivity in parenting, and whether observed signifiers of a caregiver's sensitivity are the same for children with and without ASD. In terms of attachment, sensitive parenting for a typically developing child requires recognition of the child's arousal level and the effective use of interpersonal strategies to help soothe that arousal. In contrast, sensitive parenting for a child with ASD who is less able to respond to interpersonal strategies might involve careful changes to the environment or the provision of an activity that helps the child self-soothe. A mismatch may occur when parents of children with ASD choose, perhaps instinctively, an interpersonal approach to soothing, though it is of course hard to predict how a particular caregiver will respond to a particular child. Such a mismatch, if it does occur, may be another reason for the lack of association found between parental sensitivity and attachment security in van Ijzendoorn et al.'s study discussed above. Research aimed at identifying what constitutes sensitive parenting for children with ASD may be a first step in uncovering an association between parenting style and attachment security in children with ASD.

So what, besides food for thought, does the literature on ASD and attachment have to offer those working with children and adults with ASD on a daily basis? It is important to note that to accept that attachment may be different for those with ASD is not to draw a causal link or to implicate parenting style in the pathogenesis of the presentation. We would argue, however, that the evidence base, although underdeveloped, supports an assessment framework that goes further than diagnosis of ASD and simplistic explanations of symptomatology as being direct correlates of underpinning deficits, to a developmental formulation that recognises the potential impact of social communication difficulties on a child's earliest relationships and the dynamic interplay that may result.

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Still ignored and still ineligible? The development of a strategic development group to meet the needs of adults with autism in Cumbria

David Wheatcroft & Marion Jones

A variety of reports have identified the problems for adults with autistic spectrum disorders in accessing appropriate services. This paper describes the response to these reports in Cumbria, and assesses how far service developments have succeeded in improving the local situation.

RECENT RESEARCH (Baird et al., 2006) has suggested that around 1 in 100 children will meet the diagnostic requirements for autistic spectrum disorder (ASD), with marked implications for the organisation and delivery of adult services. In addition greater awareness, together with better access to diagnostic services, has further increased the number of adults who receive a diagnosis. Therefore the total number of adults with the condition has increased and will continue to increase over the coming years. Whilst the needs of individuals with autism and additional learning disabilities are well recognised (Jordan, 2003) and service provision is reasonably well defined, the provision of services for people with autism who do not have a learning disability is often lacking (Wheatcroft, 2005).

Whilst it is difficult to offer a definitive indicator of the number of adults with ASD, the National Autistic Society (NAS) has estimated that around 500,000 adults within the UK will have the condition. Within Cumbria, attempts have been made to estimate the number of adults with autism; an audit from 2006 indicates that there are in the region of 148 known adults with autism based on a population of 590,000 people. As is usually the case in the UK, there are currently no specialist clinical or support services available to adults with autism, although specialist residential provision is offered via independent provision in the learning disability service. Therefore, as the NAS 2001 report *Ignored or Ineligible* (Barnard et al., 2001) concludes:

> statutory agencies are failing adults with autism and Asperger syndrome. The majority of individuals and their families are excluded from the care system. They are either ignored or discriminated against through rigid eligibility criteria, often established through ignorance of autism spectrum disorder. In particular the critical period of transition from adolescence into adulthood is breaking down and parents are picking up the pieces.

Barnard et al. go on to make a number of specific recommendations for consideration at national and local level, including the co-ordination of diagnostic services, health and social services, education, housing, transport, benefits and employment, advocacy and forensic services, and the training of all relevant practitioners. The guidance offered was identified as relevant both across and between agencies, with a need for dedicated funding streams. In the follow-up document *Taking Responsibility* (Powell, 2002), further recommendations are made relating to the provision of services for adults with autism, particularly those with Asperger's syndrome. One of the main recommendations made by Powell was the call for the setting up multi-

disciplinary planning groups to address the following:

■ an Asperger's syndrome audit;
■ a register;
■ a training strategy;
■ a support pathway for services;
■ a support pathway for diagnostic assessment;
■ an information resource;
■ service provision;
■ quality assurance;
■ commissioning.

In order to respond to the growing numbers of individuals with autism, and as a response to the guidance offered by Barnard et al. (2001) and Powell (2002), in 2002 the Cumbria County Council select committee on support services for individuals with autism undertook a process of enquiry and set out a manifesto to build a 'cradle to grave autistic spectrum disorder service, with parity of access, across the county'. To work towards achieving this, two specific developments occurred, namely the commissioning of an autism development officer post and the setting up of two strategic development groups (one for children and one for adults) aimed at addressing the current deficits within services and identifying an appropriate pathway for service interventions in the future. This paper is intended to share our experiences of the adult development group and report our achievements to date.

For us, one of the key features in setting up the group has been to ensure that there is representation of appropriate personnel. So the group membership has been made up of representatives from a range of external agencies, including Connexions, Job Centre Plus, further and higher education, independent housing providers, the police and the criminal justice system as well as representatives from health and social services covering both mental health and learning disability services. Where possible, individuals with commissioning responsibility from health and social services have also been invited to attend the meetings. In an attempt to ensure that the views of individuals with autism are appropriately represented, a number of service users have been invited to attend the

meetings. To date, however, service user representation has been low.

A second element in securing appropriate membership of the group has been determined by the frequency of the meetings. A main meeting takes place quarterly and a number of subgroup meetings take place on a more frequent basis. In order to comply with local governance arrangements, the group has clearly defined terms of reference and operational objectives and is accountable to the relevant commissioning authorities. The ultimate aim of the development group is to produce a strategy or series of strategies aimed at improving the lives and quality of services offered to adult individuals with autism.

What has been achieved within the group?
To date the group has covered a number of salient issues. Significant work has taken place around the development of a training strategy. A training subgroup has developed a detailed one-day autism training package, which has now been delivered to several hundred people from all over the county covering a diverse range of occupational backgrounds. The development of a training strategy has been important but has not been without its difficulties, with the responsibility for training falling on one or two members of staff. There have been a number of issues in relation to resources, resource management and the delivery of training. These difficulties have not been insurmountable and have been resolved, at least in part, through the development of facilitators' training. Although we have failed to achieve this, we would strongly recommend that training is coordinated and recorded through a central point of contact.

To date, there is no national service framework which sets out the needs of people on the autistic spectrum and the available guidance offered for how services should meet the needs of people with ASD (e.g Powell, 2002) is often unclear and sometimes contradictory. Furthermore, the long-standing dichotomous division between services for adults has been reinforced by the ensuing debate about whether the needs of people

with ASD are best met within adult mental health or learning disability teams. In order to address these issues, a subgroup of key stakeholders from mental health and learning disability services were invited to attend a focus group in order to identify the most appropriate way of addressing this imbalance. Not surprisingly the issue of service provision was unresolved, but a commitment was made by all parties to work towards an agreed strategy in the future.

Locally, as elsewhere, it was identified that there is not an appropriate pathway for the initial diagnosis of ASD and the development group have been proactive in leading discussions about the provision of an appropriate and local service for diagnosis to take place. It is acknowledged, however, that diagnosis is only the first step of a process which, for many people, will involve many years of intervention and therefore the group has also formed subgroups looking at the assessment of need and the provision of support services. In this regard, members of the group have been able to exploit existing relationships with other forums, for example in relation to housing, education, employment and criminal justice.

What has been achieved beyond the group?

In response to the initial select committee report, Cumbria County Council (2007) has now undertaken a scrutiny review of services provided to adults with ASD. The scrutiny report has indirectly provided a benchmark against which the aims and objectives of the development group can be evaluated; it highlights that there are still significant gaps within services and makes a number of specific recommendations about the ways in which local services should meet those needs in future.

Conclusion: Still ignored and still ineligible?

As this was the title of our paper, it is only fair to reflect on this in our concluding comments.

Ignored? Probably less but this has demanded a level of commitment and lobbying on our part; without individuals who champion the cause of those on the autistic spectrum there will continue to be a degree of neglect of those who have autism within our services.

Ineligible? Probably less, but people with ASD are still only being offered short-term, pragmatic, clinically focused interventions without appropriate clinical support.

If Barnard and colleagues were to complete a follow-up report we suspect it would need to be called *Still Ignored and Still Ineligible*, but within our own resources we shall continue to work towards the development of our own services to meet the needs of adults with ASD to be recognised and included.

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Division of Clinical Psychology – HIV and Sexual Health Faculty

How can we deliver the NICE Guidelines regarding sexual health and behaviour change models into our services? Reflections from the experience of Sheffield Sexual Health Services

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Valerie and Gill do not consider themselves to be experts on this subject area, rather professionals who have had experience of teaching and training other health professionals in MI over the last eight years. They are happy to meet with others and share their experiences.

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National Autistic Society accreditation: A clinical psychology perspective

Rachel Brown

In the context of developing autism-specific services in Oldham, accreditation from the National Autistic Society was sought. This process of service development, and the contribution of clinical psychology to it, is described.

I N THE LATE 1990s a multidisciplinary meeting was held in Oldham to discuss the pressures being placed on the learning disability service by the increasing numbers of children being diagnosed with autism moving into adult services. Increases in the prevalence of autistic spectrum disorder (ASD) inevitably meant an increased demand for services. The service decided to pursue National Autistic Society accreditation as it was felt that this process provided the necessary support and motivation for the Oldham Learning Disability Service to develop locally provided autism-specific services.

In 2006 Oldham Learning Disability Service (now under the umbrella of adult and community services) was one of the first statutory services to achieve National Autistic Society accreditation for its supported living scheme, outreach bases and respite services. It is committed to ensuring that people with a formal diagnosis of ASD, or who respond best to autism-specific approaches, receive a local service that is person centred and autism specific.

The involvement of the clinical psychology services for adults with learning disabilities within Oldham plays a key part in the overall success of this ongoing initiative. The clinical psychologists' role is to provide input to direct care staff in a number of ways:
- leadership and project management;
- documentation and goal planning;
- clinical involvement;
- teaching.

As a direct result of this service development:
- service users with autism have benefited tremendously from having appropriate local autism-specific support. By supporting people with complex and challenging behaviours in autism-specific way there is a reduced need for expensive out-of-area placements. This local service also enables service users who have been placed out of area to return home.
- Families are very happy that their relatives have a nationally recognised and quality assured service.
- A large number of staff at all levels throughout the organisation have gained the skills necessary to work in an autism-specific way.

The accreditation process

The mission of the National Autistic Society accreditation programme is to improve the quality of provision for people with an autistic spectrum disorder. This is done by ensuring a unified standard of excellence in both policy and practice, by providing a systematic framework for continuous self-examination and development, and by ensuring that services registered with the programme are given guidance and support in order to meet the established criteria required for accredited status.

In order to achieve accreditation an organisation must provide evidence that it has a specialised knowledge and understanding of autism which consistently informs the organisation, the resources, management of the organisation, individual assessment, support plans for all service users and all aspects of practice. The evidence is evaluated using autism-specific criteria, which are applied to each area of the organisation.

This process requires commitment and seamless joint working across all levels of the

organisation. It is vital that all staff share a single vision of what locally provided autism-specific services will consist of, and that they also share determination that is possible to achieve accreditation. In Oldham a team of individuals from all levels of the organisation, including senior managers, communication therapists, clinical psychologists, drama therapists, locality coordinators, resource managers, senior care staff and direct care staff, were coopted on to various working parties to support the initiative. In Oldham the consultant clinical psychologist and a locality team manager co-championed and led the initiative and an autism-specific development worker was employed to oversee the several components of the accreditation process.

Internal and external training were essential to achieving accreditation. The service was committed to ensuring that all staff throughout the organisation were competent to deliver autism-specific services that met the needs of the people they support. It became mandatory for all staff to attend a one-day basic awareness course within three months of their employment. These courses were pitched at direct care staff level. They combined lecture, discussion and exercises. They were designed to be experiential, fun and memorable.

Staff teams working with people with ASD were also identified for further in-depth autism training involving monthly tutorial sessions. A number of staff accessed external training courses. In addition, several conferences, with experts in the field of autism, were held in Oldham. A wealth of resources was purchased in order to establish an autism-specific library that was available to all staff.

Documentation needed to be devised to enable staff to construct person-centred plans in an autism-specific way. A tool called the Oldham Triad of Impairment Document was developed which enabled staff to consider how symptoms of autism affected the client they were supporting in both positive and negative ways. Staff were asked to reflect on how they could best provide support for that individual to help them function reasonably in a neurotypical world. Although time consuming, this process was extremely beneficial as it required a person's entire support network to work together and devise a person-centred, autism-specific goal plan. This plan was cross-referenced to all other documentation such as communication dictionaries, care plans and risk assessments. This ensured that an individual's support was consistent across all aspects of their life.

The accreditation team set rigorous standards in almost all aspects of Oldham learning disability service's support of adults with ASD. The topics covered were:
■ staff recruitment and induction;
■ professional development;
■ staff information resources;
■ consistent understanding of autism;
■ operational policies and records;
■ service development plan;
■ assessments;
■ reporting and recording;
■ individual plans;
■ continuity and consistency;
■ flexibility of thought to cope with change;
■ communication;
■ social understanding and ability;
■ behaviourial support;
■ family and support links;
■ transition.
In addition there were specialist standards for each individual being accredited:
■ living environment;
■ support methodology;
■ personal development (general and individual);
■ leisure;
■ vocation/occupation;
■ healthcare needs, promoting independence;
■ community participation.
The documentation, including the Triad of Impairment document, care plans, communication dictionaries, risk assessments and agreed standards, was not merely a paper-based exercise. The service needed to demonstrate that it was providing consistent evidence-based, autism-specific support to its service users. During the accreditation, the accreditors observed most of our service users being supported, to ensure that the documentation and goal plans were being put into practice.

As a result of embarking on the accreditation programme, Oldham Learning Disability Service has developed useful links with other services and providers throughout Oldham and beyond. Several working parties have evolved to plan and coordinate autism services across adult and child services.

The role of the clinical psychologist in achieving accreditation

The accreditation process required a 'whole service' approach. As with any service development, there must be several key players to keep up the momentum and provide clinical and managerial leadership. Clinical psychologists have the unique skills and qualities necessary to lead a service towards developing a robust autism-specific service. The accreditation process was long and at times arduous. It required individuals with organisational and project management skills and with 'finisher-completer' qualities.

In the Oldham accreditation process, the consultant clinical psychologist was instrumental in developing the Oldham Triad of Impairment document and supporting staff teams in the triad meetings to devise individualised autism-specific goal plans.

All the clinical psychologists within the service offered autism-specific clinical assessments and interventions. These interventions differ from generic learning disability clinical work as there is different emphasis on specific features of autism and the person-environment fit. Specific behavioural interventions were designed and implemented that considered an individual's motivation for change and understanding of the world in which they live.

The clinical psychologists were active members in the autism training pool and supported the training department in delivering all levels of autism awareness training as well as training devised around specific individuals for staff teams.

Conclusions

Oldham Learning Disability Service was successful in achieving accreditation across its residential, respite and outreach services. The process was comprehensive and required robust multidisciplinary and multi-agency commitment and support across all levels of the organis ation. Clinical psychology played a key role in ensuring the success of the initiative by providing autism-specific clinical assessments, interventions and training as well as leadership and project management skills.

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Diagnosis and undiagnosis of autistic spectrum disorders: If you want to get out of it, you've got to get into it

Dougal Julian Hare

Clinical psychologists often avoid involvement in the process of 'diagnosis'. However, this can lead to people erroneously receiving the ASD 'label' from psychiatry on the basis of inadequate information when 'diagnosis' based on a psychological formulation would be much more constructive.

THIS PAPER IS not about the process of diagnosis of autistic spectrum disorders (ASD) and the whys and wherefores of assessment instruments. Rather, I wish to discuss the current ambivalence about engagement in the process of assessment and diagnosis of ASD that is still expressed by many clinical psychologists (see Jones, 2006). In so doing, I will be making the case that clinical psychologists should regard involvement in the diagnosis of ASD, and its important corollary of undiagnosis, as central to our clinical practice with this group of people. As the situation is markedly different with regard to services for children with intellectual disabilities, and in keeping with other papers in this special issue of *Clinical Psychology Forum*, I will be focusing on work with adult service users.

Within the field of intellectual disabilities, clinical psychologists in the UK have had an awkward relationship with the issue of diagnosis, an issue that has come to define our profession's relationship with the dominant profession of psychiatry. This relationship is one that can be characterised as neither in nor out. On the one hand, clinical psychology has certainly taken the lead in promoting evidence-based practice, especially with regard to 'challenging behaviour' (Emerson, 2001) and there is also much interest in constructionist and critical psychology accounts of intellectual disability. On the other hand, we appear to be happy to be the providers of IQ scores so that psychiatry can make diagnoses of learning disability. Even in services where psychiatry is mercifully absent from the lives of people with intellectual disabilities, the inclusion and exclusion criteria are almost invariably based on simplistic psychiatric categories using IQ scores – diagnosis in absentia. A similar division of labour can be seen with regard to the emerging issue of so-called mental health problems in people with intellectual disabilities, with clinical psychologists seemingly happy to provide assessment data, for example unquestioningly using the PASS-AD tool as developed by psychiatry and pharmacology (Moss et al., 1998), so that psychiatrists can then make diagnoses which are then accepted by our profession and others. The current thinking about the validity or otherwise of both psychiatric nosology and the practice of psychiatric diagnosis (Bentall, 1990) is largely absent from the discussion of the 'mental health' of people with learning disabilities (Stenfert Kroese et al., 2001; Hare et al., 1999). I expect that many clinical psychologists will protest that this is a caricature of their practice, but how many would refuse to produce IQ scores or produce a PAS-ADD when asked to do so by psychiatry?

Against this ambivalent background, it is perhaps not surprising that many clinical psychologists in the field of intellectual disabilities remain uneasy about being involved in the diagnosis of autistic spectrum disorders, perhaps because it is easier to refuse to become involved with such work and to claim that it requires a level of competence and training that only psychiatrists have.

This ambivalence about both the diagnostic process and what is derogatorily referred to as 'labelling' people with autism (for a discussion of the utility of identifying autism, see Bennett et al., 2005, and Brown-Wright & Gumley, 2007) is all the more unusual given that ASDs are essentially behavioural disorders, defined on the basis of developmental impairments in social interaction, communication and symbolic representation (imagination). Whilst ASDs are evidently of organic aetiology (Rimland, 1964), to date no biological markers of any diagnostic utility have been identified. This is in contrast to many other developmental disorders, such as Down's syndrome and fragile X, for which unambiguous biological markers have been found. Moreover, the prognostic utility of identifying specific forms of developmental disorder has been clearly demonstrated, for example the identification of the nature and course of self-injurious behaviour in the Lesch-Nyan and Cornelia de Lange syndromes has enabled effective psychological formulations and interventions to be developed (Oliver et al., 2005). Such work, as falls under the rubric of functional diagnostics, is not feasible without engaging with the issues around diagnosis and the delineation and identification of syndromes (Dykens, 1995). But in order to be able to move to rational evidence-based practice, it is necessary to assess and diagnose conditions such as autism.

Consideration of the importance of diagnosis leads to the less frequently discussed issue of undiagnosis of autism. At the same time that research is suggesting that autistic spectrum disorders are more prevalent than was thought to be the case only a decade ago (Fombonne et al, 2001), there are also concerns being raised that such diagnoses are being made too readily, often on the basis of limited assessments, in order to provide a label for people whose presentation is odd and bizarre and who do not respond to psychiatric interventions (e.g. anti-psychotic medication). As a corollary to the misdiagnosis of autism, there is therefore a need to appropriately undiagnose, which can be illustrated by briefly describing three instances when such a course of action was necessary.

Case 1

This concerns a young man in his early twenties with a history of psychiatric diagnoses (primarily 'schizophrenia') since early adolescence, who was resident on an inpatient psychiatric ward. As pharmacological treatment only resulted in a general tranquilisation and had no impact on his unusual behaviour, it was suggested that he might have Asperger's syndrome and this was subsequently diagnosed by a psychiatrist on the basis of a standardised assessment without involvement from other professions. Post-diagnosis involvement of clinical psychology, ostensibly to inform autism-specific management, revealed a pattern of behaviour and neuropsychological dysfunction strongly indicative of acquired localised brain injury and a subsequent history of probable head injury in early adolescence.

Case 2

A young man with a history of schizophrenia diagnoses was referred from an early intervention service for psychosis. This followed an unusual childhood during which he attended a special school. Prior to involvement from clinical psychology, he had received a diagnosis of autism on the basis of a standardised assessment procedure completed solely by psychiatry. The combination of 'learning disability', 'schizophrenia' and 'autism' was considered to explain his markedly odd presentation and experiences, despite his evident normal intellectual abilities and lack of specific response to a variety of neuroleptic medication. Interviews with both the young man and his family, together with a general neuropsychological assessment, cast doubt on the validity of all three diagnoses and strongly indicated temporal lobe epilepsy. Moreover, a CT scan had previously indicated structural abnormalities congruent with this assessment (this demonstrates the importance of neuropsychology for learning disability services).

Case 3

A young women in her mid-teens with a diagnosis of Asperger's syndrome was referred via CAMHS on account of self-harm and

depression. The diagnosis of Asperger's syndrome made when she was eight years old had been accepted by both her family and by educational and health services. This assessment was made without any involvement of psychologists or any other professionals and was based on a short psychiatric appointment. Again, her 'odd' presentation, which seems to have been the basis of the Asperger's syndrome diagnosis, lead to further neuro-psychological and neurological investigations in conjunction with psychiatry, which indicated that temporal lobe epilepsy had to be considered as the basis of both her 'odd' presentation and her current emotional distress. However, the family had by this time invested in the original diagnosis as the explanation for their daughter's problems and this diagnosis continued to be used in a pejorative manner by educational services.

Engaging with diagnostic issues

It might be argued that any such diagnostic work, including investigating potential mis-diagnosis, should be left to psychiatry. Leaving aside the point that just such an abrogation of involvement and acceptance of given diagnoses leads to the very problems described above, it is my contention, based on experience, that the centrality of diagnosis to psychiatric practice and the narrowness of the clinical evidence that will be considered by psychiatry makes it unlikely that misdiagnosis will be recognised. Rather, just as with 'schizophrenia', inappropriate diagnoses of autism will be defended on the basis of authority and so-called empirical treatment (Johnstone 1997). Clinical psychology's basis

as an applied science means that diagnoses such as autism should be considered as hypotheses to be tested against a wide range of evidence and, if found wanting, discarded in favour of other hypotheses that explain more of the variance in a person's presentation. This is a very different process from the categorical labelling of a person with autism and it is certainly not a call for an uncritical acceptance of psychiatric diagnoses as enshrined in DSM (Kutchins & Kirk, 1997). Rather, it is to recognise that all diagnoses should be fair game for clinical psychologists to test, autism being no exception, but in order to be able to do this, we must abandon our current ambivalent stance on the diagnostic process in intellectual disability services and engage more fully in assessment and diagnosis of people with suspected autistic spectrum disorders.

In conclusion, I would contend that as clinical psychologists, we need to stop hiding behind the self-serving excuse of 'I am not an expert?'* and should get our hands dirty and engage with diagnostic issues for the benefit of some of the most marginalised people using the health and social services.

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* 'A cry from the heart from carers whose aim is to find and relax in the care of true experts in the full knowledge that at last they can trust the advice given … to tell carers that they are the experts in the treatment of health matters is not what they wish to hear, destroying trust and shaking confidence in the ability and the intentions of the service' Tucker (2001).

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Clinical psychology and autistic spectrum disorders: Conclusions to special issue

Dougal Julian Hare & Paul Skirrow

NOW THAT providing appropriate support to people diagnosed with autistic spectrum disorders is endorsed across the board, there is a need for information on what works in terms of getting services up and running. Therefore, in selecting contributions, we have attempted to balance practical information and guidance about what works with a desire to think somewhat more widely about people described as having ASD. We hope that the articles that have been presented in this special issue of *Clinical Psychology Forum* have been useful and we hope that they will encourage work with this group of people in much the same way as clinical psychologists have successfully begun to work in other previously 'closed' fields such as psychosis. We hope that such work will contribute to the demystification of ASD. Equally, we hope that stifling orthodoxies do not develop and that clinical psychologists will continue, for the benefit of our clients, to ask the awkward questions as to the nature and aetiology of conditions such as ASD and how best to support those so diagnosed.

One development that might usefully follow from the collation of this collection of articles would be a more co-ordinated response by clinical psychology, as per psychiatry (Royal College of Psychiatrists, 2006), to the increasing demand for services for people with ASD, such that we might usefully direct the development of services. Given the potential contribution of clinical psychology, we would be doing a disservice to people with ASD and their supporters if we opted for the easy path of setting up services that merely addressed diagnosis and 'co-morbidity', without incorporating our unique strength of formulation using a biopsychosocial model, as well as the breadth and depth of psychological research available to us.

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DCP Update

As good as it gets: Why the government proposals for statutory regulation of applied psychology represent the best option for public protection and the future of the profession

David J. Murphy

Unless you have just returned from an extended vacation to Mars you will probably be aware that in late December 2007 the Department of Health (DH) published a consultation document outlining proposals for the statutory regulation of applied psychologists. The consultation document contains a draft of a statutory order to amend the 2001 Health Professions Order in order to create a new part of the Health Professions Council's register for applied psychologists. The consultation closed on 22 March.

Protected titles, protected public?

The DH propose to protect the seven specialist titles corresponding to the applied divisions of the Society: clinical psychologist, counselling psychologist, educational psychologist, forensic psychologist, health psychologist, occupational psychologist, and sports and exercise psychologist. The rationale for this is that these titles are commonly understood by service users and have validity in describing holders of distinct sets of competencies. It is hard to argue that this is unreasonable since we, the profession, rather than the DH, evolved these specialist titles.

What the DH do not propose, however, is to protect the term 'psychologist' itself. In contrast, the position of the British Psychological Society has been to insist that the generic title must be protected. On the face of it, protecting the term 'psychologist' does seem to offer greater public protection. Surely, one might reasonably suggest, not doing so risks leaving the public vulnerable to unqualified, unregulated practitioners? In practice, I would argue, the opposite is in fact the case. Protecting the title 'psychologist'

means defining competencies to register – standards of proficiency in the language of the Health Professions Council (HPC) – in such a way that they apply to everyone who is reasonably entitled to describe themselves as such. This means that the competencies can only be specified in the broadest of terms. Indeed the Society did undertake a consultation in August 2007 based on such a generic model of standards of proficiency. These standards included statements such as the ability to 'provide psychological advice about specific psychological processes and outcomes of psychological interactions, interventions/applications/psychological services and developments' and 'plan interventions/applications/psychological services, determining aims, objectives, criteria, theoretical frameworks and scope of interventions/applications/psychological services, assessing resources, requirements and constraints for the interventions/applications/psychological services and producing implementation plans for the interventions/applications/psychological services'. That's clear as mud then.

It is, of course, a futile task to try to define applied psychology purely in generic terms; there is simply no such thing as a 'generic applied psychologist', and if there were, I for one would not want him or her working in my department, let alone providing psychological assessments and interventions for me or my family. Applied psychologists develop knowledge and skills relevant to the application of psychology within specific domains. Educational psychologists are experts in child learning and development, whilst occupational psychologists are experts in

psychological aspects of performance and selection in the workplace. There are many common skills, of course, but also distinct specialist competencies and knowledge. I believe the public are intelligent enough to know that someone advertising themselves simply as a 'psychologist' is not likely to have the expertise of a qualified educational psychologist or occupational psychologist. Indeed, it is perhaps illuminating that of persons using the term 'psychologist' on the Yellow Pages website, 83 per cent also use a specialist title, of whom the vast majority are both chartered and members of one of the seven applied divisions. Of those 17 per cent who use only the generic title 'psychologist', the vast majority (75 per cent) do in fact also have chartered status with the Society, although almost none are entitled to use a specialist title but nevertheless advertise a wide range of psychological services to the public.

The Society Presidential team has argued that statutory regulation needs to accommodate all those psychologists who have chartered status and are issued practising certificates, but who are not members of any applied Division. It is thought that the majority of these individuals would meet criteria for a specific domain but have simply not chosen to apply. These individuals would presumably then face no difficulty registering for their specialist title via HPC, particularly under grand-parenting arrangements. An estimated several hundred are believed not to meet the full range of competencies for any of the applied domains. Most of these are practising on the basis of a research qualification and supervised practice. It is likely that many would meet criteria for entry to the HPC register either immediately or with further training under grand-parenting arrangements. Obviously, the protection of specific rather than generic titles would restrict entry to the HPC register in the future to those who had undergone formal training in one of the specified domains. In my opinion, this enables the public to be clear about what they are getting.

Of course, in an ideal world, perhaps both the specialist titles and the generic term

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A reply from the Society President

David J. Murphy published a shorter version of this article as a letter in the April issue of The Psychologist. *Liz Campbell, the President of the Society, wrote the following reply.*

David's letter provides a useful opportunity to clarify some fundamental misunderstandings about the Society's position on statutory regulation.

Protection of the public has underpinned all decision making. The Representative Council agreed that the preferred title was 'psychologist' and that the alternative 'registered psychologist' would be acceptable. This title will be the least confusing to the public; will allow for any new/emerging areas of practice to be regulated and will stop unscrupulous practitioners using an alternative (as would be possible if purely the different adjectival titles were regulated; each domain will continue to be defined).

We have agreed that the D/12 level threshold standards of entry reflect the current standard for chartership; any reduction in this would be a reduction in current standards. The Society's Occupational Standards provide the underpinning generic standards of proficiency for psychologists.

There has been overwhelming support from subsystems and individual members for the Society's response to the current consultation on government legislation to bring in statutory regulation. I would like to personally reassure David that the Society has been engaging in detailed discussions with the Department of Health and the Health Professions Council for the last year.

See www.bps.org.uk/statreg for current information on the Society's work on statutory regulation.

'psychologist' could be protected. However, in order to protect a title in law, discrete competencies have to be defined; the title cannot be simultaneously defined in generic and specific terms. In other words you can't have your cake and eat it. Furthermore, protecting the term 'psychologist' would prevent academics and researchers using the title, it would similarly restrict those who use the title in other settings e.g. consumer psychologists, media psychologists etc, whom it is not appropriate to regulate for the purpose of public protection. It is perhaps also worth noting that certain commonly used titles such as 'doctor', 'nurse' and 'therapist' are not protected in law. Incidentally, protecting the term 'registered psychologist' probably represents the worst of both worlds, in that competencies would need to be defined generically and also the term 'psychologist' itself would not be protected.

In my view, the best solution for protecting the public is by protecting the domain specific titles, as proposed by the DH, which allows specific competencies to be defined for entry to the register and requires clear routes of training. Indeed, in my opinion, the HPC has got off to a promising start in creating robust standards of proficiency in collaboration with the profession despite the rather reticent response of the Society.

European psychologists
It has been suggested that regulating specific titles may cause difficulties for psychologists coming to the UK from other European countries since in most of these countries use the protected title is "psychologist" or its equivalent. This is a red herring. The issue with psychologists coming from other European countries is not just differences in title but differences in structure of training and the point at which individuals are eligible to use the title 'psychologist'. In many EU countries graduates of five-year undergraduate courses in psychology (e.g. Laurea, Diplôme) are permitted to use the protected title of 'psychologist'. These courses are typically very generic and the academic level attained is often classified by the international comparison body UK-NARIC as equivalent to

between honours and masters level. Moreover, the amount of training in an applied setting (e.g. clinical, forensic) undertaken by the point of registration may be very minimal. Psychologists with this type of training from another EU country applying for registration as a clinical psychologist in the UK will typically be required to undertake considerable further training before reaching the level required for chartered status. Thus, a difference in titles between the UK and continental Europe would, in fact, be an accurate reflection of the differences in the point at which registration and the eligibility to use a protected title occurs. To do anything other would actually obscure real differences in applied psychology training.

Other specialisms within psychology
Another issue which has been raised as potentially problematic is that of specialisms of psychology which are recognised in other countries but not associated with a specific title here. The example has been given of traffic psychologists, an emerging branch of applied psychology which is more developed in some other European countries than in the UK. Under the DH proposals, a traffic psychologist trained overseas or in the UK would be able to practise and use that title without HPC registration. If they wished to apply for registration as an occupational psychologist, they would have to demonstrate that they met the standards of proficiency for occupational psychology. Nevertheless, if in the future it was felt that the public needed protection from traffic psychologists, then a statutory order could be passed to add that title to the list of those registered by the HPC.

Clinical neuropsychologists are a unique case since, although in a few other countries it is possible to train solely in this area, in the UK we require psychologists to have first attained chartered status in either clinical or educational psychology and then undertake post-qualification training in clinical neuropsychology. The current DH proposals would essentially mirror the current state of affairs in the UK. In other words, in order to register with HPC, clinical neuropsycholo-

gists would have to demonstrate that they meet the standards of proficiency for clinical or educational psychology. Although it is yet to be agreed, the HPC is able to include post-registration qualifications such as clinical neuropsychology as annotations on the register (as it already does with training in supplementary prescribing for podiatrists, physiotherapists and radiographers). Of course, the current proposals do not offer protection to the title 'neuropsychologist', although prospective clients and employers would of course be able to see if a practitioner was HPC registered or not. Moreover, there is no reason why clinical neuropsychology could not become an entry level domain in the future if this route was supported within the profession within the UK.

PPC RIP

Many within the Society, quite understandably, cling on to the fond memory of the proposal for a Psychologists Professions Council (PPC). In my opinion the proposal for the PPC was, in many ways, very sound and well reasoned. Nevertheless, even if a new body

were to be set up, the fundamental issues outlined above would still remain. Regulating the title 'psychologist' means potentially catching in the regulatory net those who neither the DH nor the profession see as needing to be registered or else prevents many of those who legitimately use the title psychologist from doing so. It would also not solve the issue of protecting a generic title requiring generic standards of proficiency which are so broad as to be essentially meaningless.

Finally, and on a more pragmatic note, it is now abundantly clear that the PPC proposal is deceased, it is no more… In short, it is a dead proposal. The government white paper *Trust Assurance and Safety* published in February 2007 contained the following statement, written in bold type: 'the Government will not establish any new statutory regulators. Psychologists, psychotherapists and counselors will be regulated by the Health Professions Council.'

If that were not clear enough, in July 2007 the Government published a critique of the PPC proposal which ran to 18 pages which, regardless of whether or not you agree with its content, cannot be described as anything other than scathing. It was clear at this point that the PPC proposal should be allowed to rest in peace.

HPC AOK?

Whilst I have attempted to explain why, in my view, the DH current proposals are as good as it gets as a proposal for statutory regulation, I am not suggesting the HPC is entirely flawless. Many psychologists, myself included, have significant concerns over the procedures for grand-parenting professionals into the HPC register during the proposed three year grand-parenting period. Under these provisions practitioners do not need to meet the full standards of proficiency as long as they have been practising 'lawfully, safely and effectively' for three out of the past five years. They will be bound by the HPC code of conduct to practise only within their areas of competence.

I also have some concerns about the HPC processes for registration of overseas-trained health professionals. Whilst the HPC does

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Support for Clinical Psychologists Establishing IAPT Services

At the DCP Strategy meeting last month, it was decided to establish a DCP e-mail list for members involved with establishing IAPT services to keep in touch and exchange good practice. We will also post a set of FAQs regarding the impact of IAPT on clinical psychologists on the DCP website.

It was suggested that a series of quarterly CPD meetings could also be organised to support members in establishing IAPT services, particularly around governance, outcomes, and supervision management.

If you're interested in joining this list – please visit the DCP website (www.bps.org.uk/dcp) for further details, which will be posted soon.

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set specific requirements for adaptation periods for EEA (European Economic Area) migrants if needed (as it is required to do by EU Law), unlike the Society it does not do so for non-EEA migrants who simply receive a yes/no outcome (although applicants may use their record of assessment to guide further training and then reapply). Moreover, HPC does not oversee the compensatory training that EEA migrants undertake in the same way as the Society does. Essentially, an EEA migrant simply needs to find any HPC registered health professional from the same field, undertake a period of training under their supervision and HPC require only a letter of confirmation from the supervisor to enter them to the Register.

Under the current Statement of Equivalence in Clinical Psychology system both the plan of training and the proposed supervisors are approved at the outset and the specific outcomes are then reviewed by the Society upon completion. I believe this system offers better levels of quality assurance not only to the migrant themselves but also to the supervisor and the public. Finally, I have to admit I cringe when I look at the rogue's gallery of disciplinary hearings that are published on the HPC website prior to hearings, accompanied by all the lurid details of the allegations. Although as a Society we too have followed the 'name and shame' approach if an allegation has been proven, I'm sure many would have concerns about publishing such details prior to a hearing. Nevertheless, these are all concerns relate to HPC processes, they are not questions that are addressed in the DH consultation. In my view, the Society needs to be positively enaging with HPC and indeed engaging with the other 13 professions already regulated by the HPC to take these concerns forward.

BPS: Better Play Smart

The role of the British Psychological Society is critical at this time of major transition in the history of the profession. The Society needs to engage fully and positively with the Health Professions Council and the other professions represented therein. There are undoubtedly going to be difficult times ahead, for instance in relation to the grand-parenting period. Whilst it is necessary that the grand-parenting criteria for any statutory regulation system must preserve the rights of an individual to lawfully follow their profession, this must be balanced against the duty to protect the public and allow the public and employers to make informed decisions about the competencies a professional possesses. We need now, perhaps more than ever, our professional body to be able to listen to its members, communicate their views effectively and to engage collaboratively and constructively with the statutory regulatory body.

Conclusion

I believe that the current DH proposals at this point represent the best, realistic option to regulate the profession. Whilst, there are pros and cons to the protection of the title 'psychologist', I believe the DH proposal to regulate the seven specific titles rather than a generic title represents the only practical option and affords the best overall protection to the public. Whilst many psychologists, myself included, have some qualms about aspects of the Health Professions Council, I believe that now is the time for the profession to engage positively with the HPC and develop regulatory processes in partnership. Thus far, I believe that HPC's collaborative approach to developing the applied psychology standards of proficiency has been very encouraging in this regard. In short, this is as good as it gets and, whilst it may not be perfect, it could be a whole lot worse. It is now time to help make it work.

David Murphy is a Chartered Clinical and Health Psychologist and a Practitioner Full Member of the Division of Neuropsychology. He is Head of Psychology Services at Imperial College Healthcare NHS Trust. He is also the current Chair of the Board of Assessors in Clinical Psychology, a member of the Membership and Professional Training Board, past Chair of the Committee for Scrutiny of Individual Clinical Qualifications and a past member of the BPS Admissions Committee and the Committee for Training in Clinical Psychology.

This article was written entirely in a personal capacity.

Improving Access to Psychological Therapies conference

Lucy Horder

On 5 February 2008 the Group of Trainers in Clinical Psychology ran a successful conference that gave trainers the chance to engage with the Improving Access to Psychological Therapies (IAPT) agenda. Delegates were able to benefit from the experiences of a range of contributors, who offered diverse perspectives on the IAPT programme and trainers' roles in taking the agenda forward.

Graham Turpin and Roslyn Hope set the scene for the day by outlining the work that has been undertaken to date for developing national curricula and workforce specification for Low and High Intensity IAPT workers, in preparation for the first phase of funding for training and service provision being released in April 2008. Overall, the implementation plan envisages training around 8,000 new therapists over a six year period, with around 60% being High Intensity Workers, and 40% in Low Intensity roles. Around 3,600 of these will be trained in the first three years. The fast pace of implementation places immediate pressure on supervisory capacity and work is being undertaken to outline the competences expected of IAPT supervisors (funded by the IAPT programme and NHS Education for Scotland) and to develop supervision training for qualified staff. Other local initiatives to expand supervisory capacity by providing one-off 'top-up' programmes to qualified clinical psychologists were explored, and the group heard about some particularly interesting

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developments in this area from Malcolm Adams (East Anglia). Colleagues from the West Midlands also shared their experiences of dealing with capacity issues by developing a more joined-up supervisor database.

A key theme emerging over the course of the day related to the role that newly-qualified clinical psychologists will have to play in the IAPT programme, and their readiness to take on such roles at the point of qualification. Trainers took away the message that they will need to work on ensuring that DClinPsy programmes are delivering people who are CBT competent, and a mapping tool has been developed by Tony Roth and Steve Pilling to support this. Clearly training programmes across the country will vary, so the group also explored the option of offering an accredited CBT pathway through training – something which some programmes are already pursuing, and which will be supported by work on accreditation that is ongoing with the BABCP.

Colleagues from the West Midlands shared the benefit of their experience of having forged ahead with the IAPT training agenda, and outlined the factors that they feel have been key to their success: establishment of a core working group, building on existing local professional and service user and carer networks, and flexible approaches to University validation.

The day concluded with a question and answer session with David Clark, clinical advisor to the IAPT programme. David began reiterated the opportunity that is available to the profession to influence the future development of the mental health workforce, with newly-qualified clinical psychologists being well-placed to take on High Intensity Worker roles and, later, leadership roles within the new IAPT services. However, training programmes will need to be more explicit about their graduates' competence in CBT – having funded three years of training in clinical psychology, it is simply not tenable to expect the Department of Health to fund a further full year of High Intensity Worker training, and whilst this may be possible in years 1 to 3 of the IAPT programme, it will be highly unlikely if a second phase of

funding is secured for years 4 to 6. The group agreed that the most pressing priorities for programmes now are to begin work on mapping their curricula using Roth and Pilling's tool; to identify ways of collating a minimum dataset on particular placements; and ways of evaluating outcomes against the Cognitive Therapy Scale. A working group has been established to take this work forward.

To summarise, the next steps have been agreed as follows:

■ A small working group has already been established (Tony Roth, Helen Dent, Jan Oyebode, Gillian Hardy, Eugene Mullan) and is considering how training programmes can move towards mapping their curricula using Roth and Pilling's model to identify any gaps that need to be filled; collating a minimum dataset on particular placements; and evaluating outcomes against the Cognitive Therapy Scale.

■ The GTiCP should pursue the feasibility of establishing a secondarily accredited CBT pathway through training.

■ The group needs to think more creatively about how best to support supervisors to become BABCP accredited and/or eligible to provide CBT supervision.

■ HEIs need to continue to think about how they might respond to invitations to bid for both Low and High Intensity Worker training monies.

Independent Practitioner Forum

The Society's Professional Practice Board has set up an electronic forum for independent and private practitioners

If you are interested in joining, please send an e-mail to Nigel Atter at the Leicester office – **nigel.atter@bps.org.uk**

Nigel would also be interested in hearing your experiences of setting up in private practice

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Clinical Psychology Forum 2007: Index

Self-help

25 March

Clin psych says last session will be early May. She's talked to her dynamic supervisor. He says she's to start 'ending' now. Narrative supervisor says it might be fun not to mention it.

28 March

Pub with Graham. Asked why CP wants to talk about ending. N thinks it's 'cos she's a woman. Says they always want to talk.

29 March

Alison phoned to say I could come home but only if we talked!

29 March (later)

Pub with Graham and Nigel. Told N about Tim's reaction to move. Really upset that Hull FC are in play-off place. Southampton nowhere! Will Google trauma and football results.

1 April

Googled trauma. Lots of stuff about head injury. Googled depression and footie results instead. Odd site about mental health in footballers' wives. Something called *Journal of Epidemiology and Community Health* has report in 2003 about five-year study on death caused by heart attacks in North East England.

It says: 'Results achieved by the local professional football team are associated systematically with circulatory disease death rates over a five-year period in men, but not women.' Must tell Graham.
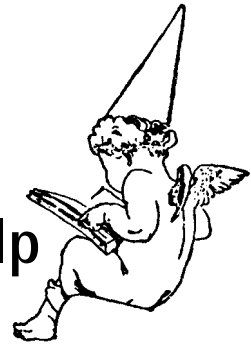
2 April

Call centre has a prize for most responses to cold calls this week. Will give away free bet on Grand National!

5 April

Won the free bet! Really excited about Grand National. Horse called L'Ami. Pub with Graham and Nigel to watch. N has money on Comply or Die. Told him about Googling heart attacks study. Says anyone supporting Newcastle, Leeds or Sunderland should know better. G not very sympathetic either. Thought I was worrying too much about Tim and the Southampton results. Says boys can survive anything – he did.

5 April (later)

Southampton won 2-0. L'Ami fell at second! Nigel getting LOTS of beer in. Seemed smug about Comply or Die.

9 April

Session with Clin Psych. Bit miserable. I thought it was about ending sessions with me. CP said it was 'cos she had 10 quid on Backbeat – fell at second! Asked her about Tim's vulnerability to football results. Unsympathetic – thought he should stop supporting losing teams! Then said she had referred me to a community mental health nurse when we move.

15 April

Not sure about seeing clin psych tomorrow. She might have asked me about seeing nurse. Didn't think they were qualified to see complicated cases like me.

16 April

CP says I'm not complicated. Hard to understand as she talks to TWO supervisors about me AND KEEPS NOTES! Asked her who she supported. Said it used to Newcastle United. Then switched to Sunderland but was giving Leeds a go now. Might tell her about *Journal of Epidemiology and Community Health* in last session.

Felix Q