We are a group of people from the community attempting to improve the involvement of the community in the training of Clinical Psychologists at the University of Manchester. We have a range of experiences of using or being interested in psychological therapies, and have been working together to make the training of Clinical Psychologists more responsive to the needs and wants of the community it serves.

The group is part of a pilot project funded by NHS Northwest (formerly the Greater Manchester Strategic Health Authority).

We believe that better services start with better training. We are hoping to improve the training of clinical psychologists by better involving the community in how the training at the University of Manchester is planned and delivered.

By doing this, we hope that Clinical Psychologists will provide better services to their local communities. We have been meeting for some years now and other people and organisations are involved. There is a wider database of people who can now be involved in helping to change the way the course trains Clinical Psychologists.
Experts by experience!

The CLG are a diverse group of people. We are members of the community who are interested in bringing a community perspective to psychology training.

Bridging the gap

The Community Liaison Group (CLG) are currently involved in a range of activities such as working with professionals and encouraging greater involvement with the community. We have organised meetings and conferences aimed at giving people opportunities to familiarise themselves with what the CLG is whilst accommodating views and expectations people may have.

The Community Liaison Group have valid input into all aspects of the trainee psychologist’s three year course. i.e. through teaching and by holding discussions with their tutors on the content of their course and playing an active role in the selection of new trainees by sitting on the interview panel and engaging in decisions on who is accepted on the course.

Integration with the university staff gives CLG members the same equity as paid staff. This includes contributing to the structure of the curriculum and also involvement in a broad area of activities within the Department of Psychology at the University of Manchester and use of university facilities such as the John Rylands Library.

...........achieving collaboration

Within the group are people who have used psychology services, carers and psychologists themselves.

We endeavour to bridge the gap between professionals and the community so that the public gets what it says it wants and needs from psychology input.

We are involved at the very start of the trainee psychologist’s career and give input into all aspects of their practice. We are also on the curriculum committee giving voice to what we think the trainees should be learning.

We are a visible presence at the University of Manchester, liaising with the course team to improve psychology practice for the good of service users. To date we have had ongoing involvement in the selection of trainees, have given lectures to trainees, have peer reviewed lectures - ensuring that lecturers deliver their teaching with a community perspective in mind. We have also helped to set up a course similar to ours at Lancaster University. In the future we hope to take our expertise into wider fields, for instance, training psychiatrists, nursing and social work staff.

Our next venture is to try and set up a social enterprise in order that we may recruit still more members of the community to help us in our quest to improve services for all.
A week in the life of a carer - CLG Member

1: Sunday
We bring our son home from his rehab unit on leave for day for family celebration meal. Suddenly aware he’s not around. In pouring rain, barefoot and no glasses he’s taken keys to granddad’s car and disappeared. 5 hours later the car is found abandoned many miles from home.

At midnight I get a call from a woman in city where car was found to say she has my son dripping wet on her doorstep. Eventually police bring him back to the unit but I’m left wondering for how long. What happened and what will be the repercussions?

2: Monday
Departmental review day at Manchester University so set off from home with a heavy heart. Can I focus on anything but what is going round and round in my head – why? what if? what now? Am asked to give a short presentation on new developments in mental health. If only they really knew what we go through! Am asked to facilitate feedback from two workshops. Fine - it’ll stop that sinking, powerless feeling for a short while.

Am put up in hotel overnight and get a chance to have dinner with my daughter who’s just started working in London. Where are siblings in all of this – how can they begin to make sense of it all? Her elder brother was at university when this madness began.

3: Tuesday
Visit new place fortunately not fifty miles down motorway like some places he’s been. Go through eight locked doors to find him. He asks if he can come home with me now. Think the cause and effect bit is missing at the moment. Ask to meet consultant as we’re off on holiday for five weeks very soon.

4: Wednesday
Very early start - overnight trip to London for two different projects I’m working on. Today it’s a DH research project looking at how to improve assessment of carers needs in mental health. If only they really knew what we go through! Am asked to facilitate feedback from two workshops. Fine - it’ll stop that sinking, powerless feeling for a short while.

Am put up in hotel overnight and get a chance to have dinner with my daughter who’s just started working in London. Where are siblings in all of this – how can they begin to make sense of it all? Her elder brother was at university when this madness began.

5: Thursday
DH National Steering Group – how do I keep my cool when all around me everyone looks so composed and in control. Wonder what their real lives are like? Am sitting between two psychiatrists – a rose between two thorns or a victim between two protagonists? I try believe the system can get better and I’m here to add my perspective so that I can make a difference but sometimes it’s hard when their words don’t match my reality.

6: Friday
Meet the new RMO (now RC) … try not to think of my little joke IMO - Irresponsible Medical Officer and am pleasantly surprised. He really wants to find out my views and perspective, believes in a balance of biological, psychological and sociological approaches. He listens and agrees when I say we should be reducing meds to NICE max guidelines and looks forward to working with me when I return from holiday.

7: Saturday
Frantically wash, iron, pack and finish off some of my paperwork. Being a freelance consultant and trainer has its swings and roundabouts but being able to take a five week break in France is certainly an up. On the way to the ferry we call and see my son. He looks incredibly well - as good as we’ve seen him in years. He’s started work on a children’s book and has done some amazing drawings that show a huge amount of concentration. At least we’re leaving him on a high – that is until he says on our way out “So can I come with you to France?”
What’s News?

An Example of Good Practice

The University of Manchester’s Beacon Project has held the Community Liaison Group up as an example of best practice. The Beacon Project is trying to improve the engagement between the university and its local community. Linda Steen, Clinical Director of Clinical Psychology Doctorate Programme at the University of Manchester said “I’m really pleased that someone has recognised the success of the group and now hope that along with other similar groups linked by the Beacon Project, we can strengthen the community’s voice within the University”.

CLG Interview Executives

Members of the CLG have been involved in recruiting and interviewing senior executives in Manchester’s Mental Health and Social Care Trust. Miguel Hayward, a member of the group and someone who sat on the interview panel said:

“This was a very innovative way of gaining confidence building and work based experience. This gave me the opportunity to get involved in other areas outside the university’s department of psychology.”

Community Members Evaluate Lecturers

People with experience of mental health problems and people from ethnic minority groups have been evaluating lectures to ensure they reflect the reality of people’s lives and that in addition to lecturing about the individual they also take account of the wider community within which the individual lives. There is currently a need to better involve other groups, for example young people’s perspectives on mental health and those with neurological conditions.

“I learned about the journey and experiences of several service users which was a really powerful experience. This has made me think and reflect upon my own clinical experience and ways that I can work more collaboratively with clients.”

If you have experience of using services or care for someone who does, maybe you would like to influence psychologists for the future?

If you would like to get involved please see contact details at the end of the newsletter.
What I do in the CLG?

Linda Steen...

Who am I?

Hello, I’m Linda Steen and I have worked on the clinical psychology training programme at the University of Manchester since 1994. My job involves working closely with the students on the programme and with qualified clinical psychologists in the North West to make sure our students get the best training possible to prepare them for working with service users and carers once they qualify.

How did I get interested in working with the community?

My own training in clinical psychology back in the late 1970s taught me that I should always listen to the service users I work with, treating everyone as individuals, each with their own needs. My first job as a clinical psychologist working in Rochdale with adults in primary care clinics gave me the chance to put this into practice but I always felt there was a better way to get to know the community I worked in than just sitting in a clinic.

In the early 1980s, I got my first opportunity to work with the wider community in helping to set up and run a Well Woman Clinic. This was well before GP practices set these up as a matter of course and was a voluntary evening clinic, which was held in a portakabin, and run by women for women to promote positive approaches to health. What was particularly enlightening about this project was the chance I got to go out of the clinic to meet women in their own communities and homes and find out what they really wanted. Most importantly, it helped to show me that you didn’t have to have a professional qualification to know how best to help others; in fact usually the best help was provided by people who had been through the same situation rather than having read about something in a text book. This definitely helped me to become better at my job as I could now see more clearly what service users really wanted.

This definitely gave me a taste for community-based work, especially as I could see the positive impact of this work on the lives of people who wouldn’t normally want to ‘bother their doctors’ with small things. After that, I went on to work on several similar projects, which often involved me giving talks to community and school groups about how to manage stress and use psychology in their everyday lives.

How did this lead to setting up the Community Liaison Group?

When I got my current job at the university, I was keen to make sure our students received teaching about and exposure to this kind of community and service user work. The clinical psychology programme was already doing a lot of good things to teach students about service user and carer perspectives but we recognised that we could do a lot more so I was very pleased when the opportunity arose to set up the Community Liaison Group (CLG) together with five other people – two clinical psychologists: Mark Sampson and Jude Moss, a student clinical psychologist: Rory Allott and two members of a user organisation, Having A Voice: Graham Stierl (who is now the Chair of the CLG) and Carol Lovett. We were very fortunate to receive funding from the Greater Manchester Strategic Health Authority (now called NHS North West) to help us do this. This was just what we needed to take our ideas forward.
Nine years of hard work

It has taken us almost nine years to get to the point we’re at. We now have a fantastic team of eight service users, carers and community members on the CLG who are involved in all aspects of running the training programme, including:

• sitting on interview panels for selecting students
• delivering teaching
• advising students and lecturers on how best to incorporate a community perspective in their work
• serving as full members of programme committees

We all agree that by doing things slowly and surely, this has helped us to make sure we’re getting it right and that everyone who needs to be, is on board with the work. We still have some way to go to involve more members of the community but we’re definitely getting there.

Looking back

When I trained as a clinical psychologist in the 1970s, some of the teaching we received involved us going to hospital wards for our lectures so that we could meet patients and find out what ‘symptoms’ they were experiencing. Although it was a good idea for students to meet with people who they were going to work with, this wasn’t organised in a helpful way and we felt as if the patient was just a ‘specimen’ to be examined rather than a real person. Also there seemed to be no acknowledgement that this could be upsetting for the patient, or indeed for us.

Looking forward

We have come a long way since then and I hope that the work we’re doing now is compassionate, always bearing in mind the question: is this what I’d want for a member of my own family? Breaking down ‘them and us’ barriers is what we’re aiming to do and, as I found with my work in the Well Woman Clinic all those years ago, the best way to do this is to involve the people at the receiving end of our services to help us to understand their needs. It may sound like a cliché but they really are the experts of their experience.

I’m delighted that this first edition of the Newsletter has been published. The articles in this edition represent over nine years of community liaison work on the Manchester clinical psychology training programme and I’m very proud to have been involved with this work from the start. I look forward to continuing this work for many years to come. We still have much to learn and to do but we have a great team of community members and now hope to recruit many more to take this work forward.

Linda Steen

Clinical Director of the Clinical Psychology Programme, University of Manchester

A SELF DESCRIPTION

Hello, my name is Hedera. I am a divorced, forty-something mother of two. Although my sons are now young adults I still consider motherhood to be the most important role in my life.

I have various hobbies. Included in these are creative cookery, reading and creative writing.

I am a serious student with the Open University and to date have gained pass certificates in the following subjects: understanding health and social care, understanding health, mental health and distress, social work and the law and starting with psychology.

I am a member of the Community Liaison Group based at the University of Manchester and enjoy an active social life during my spare time.

One other thing, I was also diagnosed with a severe mental illness – does that change your opinion of me?

Community Member
Community Artwork

All images created by Tom
The partitioning of mind and body ushers in a separation between the so-called mental and physical health which has bedevilled the mental health field for the last century. Even the stigma attached to mental illness stems in part from this misguided split. But not to worry in the last few decades this split has finally begun to be overcome due to breathtaking progress made by modern integrative neuroscience. The real problem that has plagued the mental health field isn’t the partitioning of body and mind but rather a crudely mechanical outlook which reduces the mind to biology. What is modern integrative neuroscience touted as a great leap forward? Its basic outlook is evident in its name: Neuropsychology. The focus in on the brain and consequently mental illness is to be understood essentially in biological terms, as diseases of the brain. Accordingly, mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experiences into physical events, the brain undergoes changes in cellular structure and function. Get at those changes and you have the key to understanding and treating mental illness. As a general approach, there isn’t anything new about this: “insanity is brain disease” as already a basic tenet of psychology in the nineteenth century and, more broadly, the treatment of mental disorders as physiological illnesses has been the traditional stand point of the psychiatric profession since its origins. Indeed the belief in this position is so fundamental that it has been enshrined in the requirements that psychiatrists have medical degrees, but there is a big problem with its approach for most mental illnesses, it’s impossible to find a physiological cause. So it would appear that most people with mental illness have normal brains, and it needs to be added, peoples whose brains aren’t normal are suffering from neurological disorders – not mental illnesses. Again this isn’t news. The problems with treating mental illness as a brain disease were already evident at the beginning of the 20th century, and gave rise to radically different approaches to psychology, notably Freudian psychoanalysis. A century has gone by, one in which all sorts of technological marvels are being developed and yet as important as these discoveries have been for neurology, they have made virtually no difference to the treatment of mental illness. Though the brain provides the physiological potential for the mind, the realisation of that potential can only take place through the individual’s interaction with other human beings i.e. through society. To reduce the mind to the brain is to blot out the fundamental role of society in mental development. And if the mental health field keeps sticking to this misguided reductionism, despite its long-standing failure to produce results, this must mean that there is a powerful resistance to examining this social factor.

For In The Final Analysis Our Biologies are not our Biographies

I remain as always, your friend in recovery,
Rowland Urey.
A Clinical Psychology Trainee’s Perspective

Neuropsychology plays an important part in helping people accept and live with mental health problems. My assistant psychology experience included a lot of neuropsychology where I picked up a solid grounding in the basics. This introductory understanding facilitated an accumulation of knowledge through both lectures and practical experience on placement. I have been aware throughout our neuropsychology teaching that people who have no previous experience in this area appear to struggle in understanding its practice and application. I wonder if this uncertainty around ‘all things neuro’ creates avoidance and a ‘what’s the point’ attitude.

There is much research available identifying where neuropsychology has a role. The long term effects of chronic mental illness have frequently been discussed with neurological changes and cognitive impairments suggested. Neuropsychology has also established itself in health psychology, older adult services and learning disabilities. With these complex clients, who need structured rehabilitation plans it would be necessary to identify cognitive strengths and weaknesses to maximise the effectiveness of input from healthcare professionals which in turn would increase the chance of successful rehabilitation.

In my short time working in psychology I have already used neuropsychology in learning disabilities, older adult services, child psychology, health psychology, psychosis and personality assessment, demonstrating how applicable it is to many areas of mental health care. I believe that I would not have been able to fulfil the requirements of my psychologist role in all of these disciplines if I was unable to use neuropsychological tests and theories to provide information, support and successful interventions. I have also learned that prior to the identification of cognitive difficulties in a person, it is easy for care professionals to label clients negatively, as manipulative, defiant, difficult, and challenging - words we have all heard within our working lives and which have inadvertent affects on quality of care. Neuropsychology assessment and profiles can facilitate staff’s understanding of factors that may create difficulties for clients in their daily lives and therefore create effective care / management plans.

I do feel that it is important to include neuropsychology teaching on the training course. I would suggest that to create the best opportunities for beginners to fully engage in neuropsychology training, teaching must be planned with consistent practical approaches e.g. workshops, which build on past lectures learning outcomes. If its benefits are not identified and taught to trainees then there is a risk that future clients will not receive the quality of care they are entitled to. Also, without neuropsychology training, trainees will be unable to make a fully informed decision as to their preferred area of work. We have to generalise before we can specialise and the question may remain; ‘neuropsych…..what’s the point?’

A Professional’s Perspective

What is clinical neuropsychology?

Neuropsychology is about understanding the relationship between the brain and behaviour. Clinical neuropsychology concerns itself with conditions that are affecting the brain and as a result of this are having a direct impact on a person’s physical and mental health and wellbeing.

Physical and mental conditions caused by a disturbance in the workings of the brain will by their very nature affect the functions of the brain. This includes mental (cognitive) skills such as memory, attention and concentration, problem-solving and reasoning, visual perception and language.

Impairments in cognitive skills such as memory or concentration can have a very significant impact on a person’s ability to manage their daily life, develop and maintain social relationships and hold down jobs. The impairments can therefore have a direct effect on a persons behaviour towards others, and their interaction with their environment.

Clinical neuropsychology is about helping an individual and his or her family or carers understand the nature of this brain – behaviour relationship, and find ways to adjust to, and compensate, for those difficulties.

Continued overleaf
What does clinical neuropsychology do?

Clinical neuropsychology is involved in measuring cognitive strengths and weaknesses, rehabilitation of cognitive difficulties, provision of psychological therapies and interventions, family work and supporting a person to get back to work. It is involved in the diagnostic process of both physical and mental health conditions, including helping to identify whether some conditions are caused by a physical disorder of the brain or triggered by psychological factors such as trauma or other adverse life events.

Clinical neuropsychology contributes to the decision making process for persons undergoing surgery for conditions such as epilepsy and Parkinson’s disease, both from a mental health and cognitive perspective.

So what is the point of clinical neuropsychology in mental health?

A distinction is often drawn between mental and physical health, as if they were two separate entities. In reality, a person’s mental health and emotional well being is affected by a wide range of factors that also includes their physical health. The opposite, of physical health being influenced by mental health, is of course also the case. To separate them out in such an arbitrary way does not do justice to the interlinking nature of physical and mental health and wellbeing.

Consider for example a person with a primarily physical health condition such as head injury, epilepsy, stroke or brain tumour. As well as cognitive impairments, anxiety, depression and post-traumatic stress disorder often accompany this physical condition, triggered by the life changing and traumatic nature of the illness.

Alternately, consider a person with an existing mental health condition such as psychosis or depression, also experiencing a physical condition affecting the brain. The additional effect of cognitive impairment and emotional distress, can have a detrimental effect on the pre-existing mental health condition and the overall adjustment process.

The value of clinical neuropsychology is in identifying and disentangling the various factors that are influencing a person’s clinical presentation, and the impact of their difficulties on themselves and others, be this from a physical or mental health perspective.

There are four reasons why this is important:

► Firstly it ensures that the individual and other health professionals involved in their treatment have a good understanding of the various factors that are contributing to a person’s clinical presentation. This is part of the diagnostic process which may include identifying whether a person’s presenting problems are due to a pre-existing mental health condition, a new mental health condition, a dementia or other neurological condition, or a brain injury.

► Secondly, it helps to ensure that a person receives the most appropriate treatment for their condition and also that the most appropriate care plan is put in place. A person could for example be wrongly treated for depression, if the underlying reason for their loss of interest in their environment or inactivity is a cognitive problem caused by a previous brain injury, and where the cognitive problem has not been identified. The opposite can also happen, in that mental health issues are not identified in persons who experience cognitive problems and emotional distress following illness and injury.

► Thirdly, cognitive impairments are part of many mental health conditions, examples are schizophrenia and depression and understanding the impact of the condition on cognitive function can form an important part of the overall treatment and management plan.

► Fourthly, identifying the relative contribution of emotional and cognitive factors within a primarily physical or mental health condition allows a person to develop a more thorough understanding of their condition. This can be helpful in the ongoing process of adaptation and self management of persistent difficulties.

The point of clinical neuropsychology

Within mental health it is one of clarification of brain behaviour relationship for individuals, their families, carers and other health professionals, so that treatments, care plans and other interventions can be appropriately tailored to individual needs.

Dr. Elisabeth Berry
Consultant Clinical Neuropsychologist
Words Into Action:
The Community Trains NHS Clinical Psychologists

Members of the Community Liaison Group led an event to meet with Clinical Psychologist from the NHS and consider how they could better involve the community in the services where they worked. The aim was to ensure that trainees from the University, who were on placement with these Clinical Psychologists received support to ensure that they always consider the wider community within which their clients live. It is hoped that by taking such a community perspective, people can draw on their own resources within the community and ensure a full and long lived recovery.

It was also hoped that there would be increasing involvement of Trainees in projects that supported people using NHS services to become involved in developing and even providing services, recognising that people who have experienced distress often have the expertise to improve services and even help others.

The event was attended by around 50 people, which included a mix of psychologists, service users, carers, community groups and people from the Strategic Health Authority, who fund both the CLG and the Clinical Psychology course itself. The event was well received and will lead to real changes. One Clinical Psychologist noted “I will make more of community involvement and ensure I’m a more ‘humanistic’ and ‘personable’ psychologist”.

Graham Stierl said, “it was a brilliant four days and I really got a sense of what qualities the course was looking for, however after listening to both the candidates and the staff I thought there was rather too much of a focus on Cognitive Behaviour Therapy and not enough emphasis on how approachable candidates appeared”.

Local People Get Involved In Interviews

Every year the University of Manchester receives hundreds of applications for its Clinical Psychology course. Places are limited to around 20 people, so competition is tough. Applications are first sifted through by a team of NHS and University Clinical Psychologists, before around a hundred people are offered interviews, which take place over 4 days.

This year people from the Community sat on the interview panels and assessed how community centred the interview process was and in what ways they felt it needed changing. Jen Kilyon pointed out, “it is essential people who use services and their carers are involved at this early stage to ensure that the course use criteria for selecting people that prospective and current service users think important”.

Local People Get Involved In Interviews

Good Practice Spread Across the North West

The challenges of involving the community in the training of Clinical Psychologists have been many and the success of the CLG in overcoming those challenges has been immense.

They have worked with the University to develop a new role, the ‘Community Adviser’. This new role is recognised through an honorary contract which gives recognition to people from the community involved in developing the course and ensures they have access to University facilities and training to make their role successful.

They have overcome other barriers, such as how to make payments to people in recognition of their work without impacting on their disability benefits or tax status. Likewise, they have moved from an add-on to the University course to an integral part of it - attending meetings on a whole range of new course developments, such as E-Learning and reviewing the quality of lectures.

Members of the CLG have shared these lessons with NHS services and Universities across the North West at two Best Practice conferences held recently.
The Poets Corner: Straight from the People

Why I work For the CLG

I work for the CLG it is
Funny, We use Our Time For The Money.

Richard Hughes
University of Manchester

The Compliant Client

Drag your feet
Stare down at them
And shuffle when you walk.
And mumble when you talk.
Be ever so polite to your C.P.N
Reporting about you is favourable then. If they make a blunder
Don’t point it out.
These things they’re very sensitive about.
Blame every mistake on yourself.
Protection of their egos
Is good for your mental health
Or so you read in your file
While you think they’re stupid
All the while.
Individuality they have banned
A lack of spirit they demand.
So shuffle your feet
And humble your tone
And save your real viewpoint until you get home.

Ivy M Moore

Want to contribute to the newsletter?

We would like your artwork, poetry, articles and letters for future editions.

If you would like to contact us about your ideas or contributions then please use the email or write to the address below.

Here are some ways you might like to get involved:

1. Feedback to lecturers.
2. Contributing to the lectures.
3. Advising on research projects.
4. Feedback on trainees’ interviewing skills.
5. Having a say about the curriculum and more.

You may like to attend our open meeting in the New Year.

Email or write us for more details.

Every year there are lectures on Collaboration and Community Perspectives and Expectations.

If you are interested please contact us for details.

Designer: Miguel Hayworth
Editor: Jen Kilyon

Disability Statement

The Community Liaison Group is committed to accommodating accessibility needs to any individual with disabilities who need them.

If you would like this newsletter in other formats, please contact us, request a copy by audio tape or CD, Large Print A3, PDF by post or e-mail.

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