Using Attachment Theory within Mental Health Community Services to improve Patient Outcomes and reduce Service Utilisation Costs

A thesis submitted to The University of Manchester for the degree of Doctor in Clinical Psychology ClinPsyD in the Faculty of Medical and Human Sciences

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The University of Manchester

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Thesis Abstract

This thesis follows the paper-based format and papers one and two have been prepared for submission to Attachment and Human Development and the British Journal of Clinical Psychology, respectively. The relevant submission guidelines are included in the appendices (Appendix A and B).

Attachment theory (Bowlby, 1977a) has prompted a wealth of empirical research in its contribution to adult attachment patterns and subsequent psychopathology in mental health (Holmes, 2001; Wallin, 2007). More recently, attachment theory has been proposed as a suitable framework by which to inform the organisation, design and delivery of mental health services (Goodwin, 2003; Seager et al., 2007) but it is unclear what this would look like in practice. Adopting an attachment-informed service model has key implications for individual and service outcomes and the two papers presented in this thesis aim to contribute to research in this area, followed by a critical review of the research, its relevance and future implications.

Paper one is a narrative overview of the literature discussing the practice implications of services adopting an attachment-informed framework, and describes how this might be conceptualised in front-line service delivery. Articles reviewed described the influence of attachment theory in predominantly inpatient, secure forensic and/or psychiatric rehabilitation services, and its application within more generic community mental health services was explored.

Paper two aimed to investigate the importance of individual attachment and service attachment to client psychopathology, quality of life, service utilisation and service costs in community-based mental health services.

The final section, the Critical Review, critiqued the literature review and aimed to place the research within a wider context. This section considers the findings from the research and the limitations of the study, while also highlighting important issues for services, with implications for clinical practice and future research.

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Section One: Literature Review

Using Attachment Theory to inform the design and delivery of mental health services: A review of the literature

Paper One Word Count: 6784

Using Attachment Theory to inform the design and delivery of mental health services: A review of the literature

Abstract

Objective: To describe the design and deilvery of an attachment-informed mental health service.

Background: Authors from several different therapeutic schools have proposed that attachment theory provides a helpful framework to inform the design and delivery of mental health services.

Method: A narrative overview synthensised the literature describing attachment-informed mental health services. Literature was retrieved from searches of computerised databases, reference lists and by directly contacting authors in the field.

Results: Key themes were extracted from the literature which were organised to reflect the experience of a service user moving through the service system: service policy and evaluation; referrals; assessment and formulation; intervention; support for staff; support for carers; moving on; and potential service benefits.

Conclusion: Both service users and mental health workers have 'attachment needs'. Attachment theory could therefore provide a useful framework to inform the design and delivery of mental health services. The resource implications for services are discussed, as are recommendations for future research.

Introduction

In recent years there has been a wealth of interest, and empirical research, in applying John Bowlby's theory of attachment (1969, 1973, 1980) to relationships in adulthood and particularly, mental health problems in adulthood (Holmes, 1994, 2001; Wallin, 2007). Bowlby's theory conceptualised the "*propensity of human beings to make strong affectional bonds to particular others*" (Bowlby, 1977a, p.201) and drew from psychoanalysis, ethology, cognitive psychology and developmental psychology to explain the "*many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise*" (Bowlby, 1977a, p.201). The theory describes how a person's early experiences of receiving care from significant others creates mental representations about the self in relation to other people, and these 'internal working models' create expectations about how others will behave towards them in social relationships. Internal working models are believed to be generally unconscious and may influence thoughts, feelings and behaviour with emotionally significant people, including mental health workers.

Bowlby (1969, 1977a) described the role of the care-giver in facilitating secure attachments. The role involves: a) providing a secure base from which safe exploration can develop; b) being available and flexible; c) being sensitive and responsive to emotional distress; and d) intervening judiciously when needed. If these conditions are met, the individual develops a secure attachment style. This is associated with a positive self-image, a capacity to manage distress, comfort with autonomy and in forming relationships with others (Bowlby, 1969). Conversely, if caregivers are

insensitive or unresponsive to distress, the individual either escalates levels of distress to get their attachment needs met (insecure ambivalent or anxious attachment), or if individuals' emotions are consistently ineffective in eliciting contingent responses in caregivers, they learn to de-escalate their attachment system, which is associated with a dismissive approach to affect and an avoidance of close relationships (insecure avoidant or dismissing attachment) (Shaver & Mikulincer, 2002). There is also a fourth type of attachment pattern classified as 'disorganised', which is linked to severe maltreatment or neglect in childhood, where the caregiver is both a source of attachment and threat (Main & Soloman, 1990). These individuals are conceptualised as having high levels of anxiety and avoidance co-existing, or a break down in attachment organisation (Fraley & Shaver, 2000); however, when disorganised attachment is conceptualised as a mixture of anxious and avoidant attachment, rather than a breakdown of attachment, it can help to explain some of the contradictory findings in the attachment literature. Attachment disorganisation has prevalence rates of 80% in children exposed to parental maltreatment or drug abuse (van Ijzendoorn, 1995).

Bowlby (1977a) conceptualised attachment behaviour as "*any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser*" (Bowlby, 1977a, p.203). Attachment behaviour may include crying and calling to elicit care, following, clinging and protesting at being left with strangers. Attachment behaviours manifest most obviously when a person is ill, afraid or distressed. Bowlby proposed that although attachment behaviours diminish steadily with age, in terms of frequency

and intensity, these behaviours persist through the life course and reflect a person's age, gender and current circumstances. He also made the distinction between attachment and dependence behaviours. Dependence behaviours are indiscriminate, rather than being motivated by a need to maintain proximity to a particular person, whereas attachment implies an enduring bond and associated engagement of emotion to that person. Bowlby (1977a) stated that attachment behaviour, which is essential for survival, should be viewed as a positive behavioural concept and should not be confused with dependence which is often viewed with disapproval and criticism.

Bowlby (1977b) went on to decribe how attachment theory can inform individual psychotherapy and during the past three decades attachment theorists have expanded and refined the clinical implications of the theory. These authors have argued that attachment styles influence the development of adult psychopathology and psychotherapy outcomes (Shorey & Snyder, 2006; Surcinelli, Rossi, Montebarocci, & Baldaro, 2010), and attachment theory can inform the goals of therapy and the process of achieving these, most notably the importance of developing a secure base, the therapueutic relationship and providing a corrective emotional experience (Holmes, 2001; Wallin, 2007).

More recently, attachment theory has also been proposed as a suitable framework by which to inform the design and delivery of mental health services (Goodwin, 2003). Significantly, a national advisory group on mental health, safety and well-being for the Department of Health (Seager et al., 2007) suggested how policy-makers could improve the therapeutic quality of mental health services in the UK. The national

advisory group agreed that rather than continuing with recommendations for specific brands of psychological therapies or theoretical models, commissioners and policy-makers should recognise that it is the non-specifics of therapy which underpin good psychological care. The group members, who were experts representing a wide range of different psychological approaches, agreed that it is secure attachments and relationships that create mental health and well-being and that this needs to be reflected by creating 'psychological mindedness' within mental health services. The working group derived a summary of the five universal psychological principles that all services should subscribe and adhere to; of most relevance here, principle 2 states that "*A psychologically-informed generic policy framework is badly needed to promote psychologically safe mental health services (over and above the growing guidance on specific psychological treatments)*", while principle 3 states that "*Attachment theory provides a universal evidence-base that has not yet been harnessed*" (Seager et al., 2007, p.1).

Despite these laudable aims there has been little, if any, change in the way that mental health services are commissioned and delivered. A recent independent enquiry into acute and crisis mental healthcare reported some worrying findings from the service user experience (Mind, 2011). The authors concluded that "*mental health services have lost touch with basic humane principles when dealing with people in crisis – as shown by dirty wards, lack of human contact, a lack of respect often bordering on rudeness by staff, and a reliance on force. This does not produce the relationships and conditions that help people recover.*" (Mind, 2011, p.6). The report suggested that action is urgently needed to ensure that mental health care is built on humane values,

but that this will require organisational commitment and a rethinking of 'professional boundaries' so that staff can interact naturally with clients without losing their professionalism. The reference to human contact, and sensitive, flexible responses to individual distress, also reflects key principles of attachment theory and highlights the need for services to be more attachment-informed.

There may be a number of barriers to developing attachment-informed mental health services including both attitudinal barriers and economic restraints (Goodwin, 2003; Marrone, 1998). There also seems to be a lack of clarity and synthesis in the literature about what an attachment-informed service is, and how it is designed and delivered in practice. Without such a synthesis of work from different theoretical schools and perspectives, services have no clear guidance about how to make the necessary changes in practice. Having clear guidelines would make it easier for services to use attachment theory in the way recommended by the working group and echoed in the Mind report, and thus overcome an initial barrier to implementation. The aim of this review is therefore to describe an attachment-informed mental health service in terms of both design and delivery. It is also anticipated that this summary will promote evidence-based research to evaluate the utility of using attachment theory in the philosopy, design and delivery of mental health services, and the review concludes by making specific recommendations for future research.

Method

The first author identified texts describing the application of attachment theory to the design and delivery of mental health services using PsychInfo, MEDLINE, Web of

Knowledge, COPAC, CINAHL and Science Direct entering the search terms 'attachment OR Bowlby' AND 'services OR teams OR organisations OR institutions OR oriented OR service delivery' AND 'mental health OR psycholo*'. Terms were entered for searching in the titles and abstracts of articles. The author included all English language papers, books or chapters in edited books, published or in press between 1960 and 2012, which described the use of attachment theory in designing and delivering mental health services.

The author included articles that specifically described the application of attachment theory in the design and delivery of mental health services for adults or adolescents, including articles that described the application of attachment theory in forensic mental health services. Articles were excluded if the focus was on the application of attachment theory to individual psychotherapy only, to children or parenting interventions, looked after children and/or fostering, couples therapy or family therapy, or in the application of attachment theory to understanding the development of mental health problems or response to treatment. Relevant papers cited in the reference list of papers from the initial search were followed up and incorporated if they met the inclusion criteria, and the author also contacted experts in the field for further relevant publications.

A narrative overview was used to elicit key themes within the papers. The first author used a data extraction form to summarise each paper and carried out a thematic analysis to identify key themes within the papers (Miles & Huberman, 1994). The themes were then verified by other authors for reliability and validity.

Overview of papers

Six relevant articles were identified through the initial search after removing duplicates and the author identified a further three relevant manuscripts through the references for citations in those papers. The author was able to access another five articles after contacting experts in the field for further information, giving a total number of 14 manuscripts for the review. The majority of reviewed papers were published journal articles, although there was also an unpublished book chapter from an edited book in press, and a chapter from a book on attachment theory and forensic mental health services. The oldest papers were Adshead's (1998) paper 'Psychiatric staff as attachment figures - Understanding management problems in psychiatric services in the light of attachment theory', which focussed on attachments with psychiatric staff within forensic mental health services, and Moore and colleagues' (1998) paper 'A new perspective on youth care programs: Using attachment theory to guide interventions for troubled youth', which described the application of an attachment framework in an adolescent service.

Gwen Adshead had made the most significant contribution to the literature (n=4), followed by Martin Seager (n=3) and Phil Rich (n=2). All papers discussed the clinical implications and practical application of attachment theory in mental health services (n=14), with six papers from forensic mental health settings, two papers from institutional mental health care, one paper from psychiatric services, one paper from psychiatric rehabilitation services and one paper from assertive outreach services. There were also theoretical papers discussing the application of the theory to general

adult mental health services (n=2) and the development of a measure of attachment to adult mental health services (n=1).

Eight major key themes were identified in the literature reviewed, with four subthemes: service policy and evaluation; referrals; assessment and formulation; intervention (*creating a secure base, availability and flexibility, sensitivity and responsiveness, providing corrective emotional experiences*); support for staff; support for carers; moving on; and potential service benefits. Table 1 (Appendix C) shows the manuscripts included in this review with a summary of the key themes described in each. The main body of the review will describe the themes in more detail and this will be followed by a final section discussing and integrating key themes, including future research implications.

Key Themes

Service Policy and Evaluation

A total of seven papers highlighted that an attachment perspective needs to be pervasive throughout the treatment environment, so that all staff understand, subscribe to and enact an attachment-informed approach in their interactions with service users (Berry & Drake, 2010; Goodwin, Holmes, Cochrane, & Mason, 2003; Moore, Moretti, & Holland, 1998; Rich, 2006a; Schuengel & van Ijzendoorn, 2001; Seager, 2006; in press). Seager (in press) discussed reconceptualising mental health services as a professional family, so that the attachment needs of both staff and service users are highlighted and addressed. Extending the metaphor of the professional family to the wider system, Seager (2006) argued that in order for

frontline services to be more attachment-informed, the state should model effective care-giving by allowing freedom for services to be creative and make decisions at a local level, but offer support and backing when needed. Authors also suggested that an attachment-informed service would need to develop the means to assess and evaluate mental health services on their ability to meet attachment needs (Berry & Drake, 2010; Seager, in press) and Goodwin and colleagues (2003) developed a measure of attachment in mental health services to aid such evaluation.

Referrals

Two papers discuss using attachment theory to inform decisions about referral processes (Schuengel & van Ijzendoorn, 2001; Seager, 2006). Seager (2006) suggested that referral systems could be improved by conceptualising the referring agent and the receiving service as a parental system working together to meet the needs of the service user. He questioned the current ethos of many services' referral criteria, which remain highly diagnostic and service-centred; for example, deciding whether someone fits into the existing service framework or qualifies for treatment on the basis of diagnosis. Instead, he recommended adapting service delivery to meet the needs of the individual, in the same way that an effective care-giver is flexible and responsive in meeting needs.

Schuengel and van Ijzendoorn (2001) also commented on referral processes. They proposed that attachment theory should inform decisions about the appropriateness of inpatient services for clients because attachment-informed services can place demands on staffing and resources. They discussed how being admitted into inpatient

services is hard for patients as they can be cut off from attachment relationships in the community and services therefore need to decide whether the person can cope with the transition. Additionally, because the stressors associated with inpatient treatment might exceed the cognitive and behavioural coping abilities of the patient, service resources and staffing needs to be adequate to provide at least one relationship that is stable enough to develop into an attachment relationship. They suggested that if the staff-client ratio in the setting is too large, if the staff turnover is too high, or if the client is likely to be transferred many times, inpatient placements are likely to be detrimental to the establishment of new attachments and should be avoided.

The differing views expressed by Seager (2006) and Schuengel and van Ijzendoorn (2001) about inclusion and exclusion criteria in referral systems seem to be in opposition to each other, yet both opinions apply concepts of attachment thinking to promote the well-being of the service user at the centre of the referral process. Whether services should be more or less inclusive may depend upon the service being referred to, and the capacity they have to meet the needs of the patient.

Assessment and Formulation

All of the papers reviewed highlighted the need to consider attachment issues during routine assessment and formulation (Adshead, 1998, 2001, 2002; Adshead et al., 2005; Barber et al., 2006; Berry & Drake, 2010; Goodwin et al., 2003; Moore et al., 1998; Rich, 2006a, 2006b; Schuengel & van Ijzendoorn, 2001; Seager, 2006, 2011, in press), and highlighted different methods of assessing attachment, through clinical interview and/or with self-report attachment measures. The Adult Attachment Interview (AAI)

(Main & Goldwyn, 1984) is a semi-structured interview that assesses adult attachment patterns by the coherence of the individual's narrative in describing their memories of being parented. Papers have highlighted the potential benefits of the AAI to assess attachment (Adshead, 1998; Berry & Drake, 2010), but it is also recognised that the measure is time consuming to administer and requires training, which places considerable demands on service resources (Berry & Drake, 2010). Berry and Drake (2010) suggested alternative self-report measures of individual attachment that are easier to administer and more amenable to routine assessment. These include the Relationship Questionnaire (Bartholomew & Horowitz, 1991); the Revised Adult Attachment Scale (Collins, 1996); the Experiences of Close Relationships Scale-Revised (Fraley, Waller, & Brennan, 2000); the Client Attachment to Therapist Scale (Mallinckrodt, Gantt, & Coble, 1995); and the Psychosis Attachment Measure (Berry, Barrowclough, & Wearden, 2006, 2008). There is evidence to suggest that people with avoidant attachment styles may be particularly difficult to engage in treatment, so Berry and Drake (2010) highlight the importance of identifying people with high levels of avoidant attachment and providing staff with additional support and supervision in working with them (Berry & Drake, 2010).

Seager (2006) discussed the need to develop an assessment protocol for assessing the quality of current attachment relationships. He suggested the development of a tool that would measure the accessibility of each service user's attachment objects, including partners, family, friends and professional attachments, and the perceived quality of each attachment object. In a paper describing an attachment-informed

youth care service, Moore and colleagues (1998) also suggested that it is important to assess patients' attachment histories, including parental attachment patterns.

Adshead and colleagues (2005) argued that attachment assessments can be supplemented by paying attention to clinicians' own feelings and behaviours towards the client. They described examples of staff experiencing very negative countertransference reactions to patients, which are usually accompanied by feelings of rejection towards them. They reported that these reactions can be aroused in response to resistance in the client that leaves staff feeling stupid and worthless (Adshead, Charles, & Pyszora, 2005). Adshead (2002) also particularly recommended monitoring attachment behaviour in new patients when first admitted to a long-stay institution, as during this period, they will often draw on past attachment behavioural strategies to manage their sense of threat or fear.

Several papers suggest that assessing attachment styles helps to inform formulations by providing an understanding of the psychological function of challenging behaviour (Adshead, 1998; 2002; Berry & Drake, 2010; Rich, 2006a, 2006b; Seager, in press), and risky behaviour (Adshead, 1998; 2002; Moore et al., 1998). For example, deliberate self-harm, suicide, aggression and violence can be understood as attachment behaviours that are triggered by threats to attachment relationships, such as the loss of an attachment figure like a key nurse (Adshead, 1998), or the threat of discharge (Seager, in press). Anxiety and distress may be expressed as anger towards care-givers or staff, which Adshead (1998) suggests may reflect the client's perceptions of failed care-giving by attachment figures. Anger can be understood as the result of anxiety,

lowered threat perception and a failure to regulate arousal (Adshead, 2002). Understanding the functions of problematic behaviours is considered important as it helps to develop staff empathy as well as provide insight into ways of reducing risk.

Intervention

The themes related to intervening with clients in an attachment-informed service were organised to reflect the qualities and functions of a care-giver who is likely to promote secure attachments: providing a secure base; availability and flexibility; sensitivity and responsiveness; and providing corrective emotional experiences.

Create Secure Base

Nine of the papers reviewed discussed the importance of establishing a secure base as a pre-requisite to intervening successfully with clients (Adshead, 1998; 2002; Adshead et al., 2005; Barber et al., 2006; Berry & Drake, 2010; Goodwin et al., 2003; Moore et al., 1998; Rich, 2006a; Schuengel & van Ijzendoorn, 2001). As the secure base is a core concept within attachment theory, it is unsurprising that this is reflected in the literature describing attachment within mental health services. In a study that described the development of a measure of service attachment (Goodwin et al., 2003), focus groups with service users elicited themes about their experiences of attachment relationships with mental health services. One of the main themes that was elicited was 'secure base' which was defined as feeling safe within the environment and being looked after. Within mental health services the secure base concept has been conceptualised as a feeling of physical safety, for example in terms of ward environments or ward atmosphere (Adshead, 1998), or as intrapsychic/psychological

safety, through a sense of belonging with a team or service (Adshead, 2002; Moore et al., 1998).

Barber and colleagues (2006) described a staged approach to establishing a secure base, which encompasses many tasks discussed within other themes here, however, they assert that a whole systems approach is crucial. This includes shared ownership of the attachment model of care; validation, respect and support for staff; comprehensive assessment which includes information on attachment; identifying a core team; and developing in-depth knowledge about the client. Developing meaningful relationships with staff is a key factor in creating a secure base to improve people's attachment security, and has been shown to aid the recovery process regardless of the type of therapy offered (Seager, 2006). Berry and Drake (2010) recommend that during a client's time with a service, staff should be encouraged to engage in one-to-one activities with clients to facilitate the development of secure staff-client relationships.

In terms of maintaining a secure base, three authors discuss the need for boundaries within client-staff relationships (Adshead, 2002; Rich, 2006a; Schuengel & van Ijzendoorn, 2001) and recommend that staff, who represent attachment figures for their clients, receive training to avoid becoming over-involved or in a conflicted relationship with their clients (Schuengel & van Ijzendoorn, 2001). Adshead (2002) reported that creating and maintaining boundaries is particularly important in forensic settings, as it helps clients to express unregulated feelings in a safe way. Rich (2006a)

suggested that appropriate boundaries can be maintained by creating a therapeutic structure that provides order and consistency, and defines roles and expectations.

Availability and Flexibility

According to Bowlby (1977a), a secure base needs to be established with a primary attachment figure and that attachment figure then has to be available consistently over time. Within the context of a mental health service, most authors (n=11) equate this to providing continuity of care, through building a consistent relationship between the same staff member or team and service user over time (Adshead, 1998; 2001; Berry & Drake, 2010; Goodwin et al., 2003; Moore et al., 1998; Rich, 2006a, 2006b; Schuengel & van Ijzendoorn, 2001; Seager, 2006; 2011, in press). Suggestions include assigning dedicated key-workers to work with each client (Goodwin et al., 2003; Moore et al., 1998; Schuengel & van Ijzendoorn, 2001), and minimising the number of other staff involved in each client's care (Adshead, 2001; Berry & Drake, 2010; Moore et al., 1998; Rich, 2006b).

In terms of ensuring continuity of care, it is recognised that it is important for services to maintain stability of staff teams (Schuengel & van Ijzendoorn, 2001). Recommendations for promoting stability include avoiding unnecessary reorganisation in services and ensuring staff retention by creating a positive working environment with good support mechanisms in place and good pay (Berry & Drake, 2010; Schuengel & van Ijzendoorn, 2001). These papers further highlight the importance of recognising and acknowledging clients' attachments to all staff within the system, including non-qualified staff, such as cleaners, receptionists and cooks (Berry & Drake, 2010).

Services should also therefore avoid unnecessary changes in non-clinical staff and endeavour to retain stability in these workforces through good working conditions. Berry and Drake (2010) additionally highlight that patients may develop attachments to service activities and structures such as ward-based activities, and highlight the importance of routine in promoting continuity of care.

In terms of flexibility and availability, Seager (2006) advocates that services should offer a more diverse range of treatment options including briefer sessions, telephone contacts, written contacts and on-demand services, rather than structured doses of therapy sessions reflective of a medical model. He also recommends offering psychological support outside normal working hours, as it is particularly at those times that vulnerable people are most in need of help and most at risk (Seager, in press). Moore and colleagues (1998) similarly recommend that staff modify the structure of treatment programmes, depending on the needs of the situation, and through negotiation with service users themselves.

Sensitivity and Responsiveness

Bowlby (1977a) described how a care-giver needs to be sensitive and responsive in responding to emotional needs and this is also reflected in the literature applying the theory to service delivery. Six papers discussed the importance of staff's ability to provide sensitive appropriate responses to distress in their clients (Adshead, 1998; Goodwin et al., 2003; Moore et al., 1998; Rich, 2006a, 2006b; Seager, in press) and that this is achieved through good professional listening, emotional containment, and showing care and concern for service users (Goodwin et al., 2003). The importance of

this theme was borne out in Goodwin and colleagues' (2003) paper with focus groups of service users, which revealed the value they ascribed to services in providing human contact and comfort, giving them a feeling of being attended to and listened to. Seager (in press) further suggested that staff should adapt their therapeutic style to the client's attachment style to facilitate attunement. Attunement is an affect-regulatory process which involves modifying or regulating an individual's emotions by reflecting it back, through appropriate facial expression and tone of voice; for example, emphasising softly expressed sad feelings, soothing excitement, or sharpening vagueness of tone (Holmes, 2010).

Provide Corrective Emotional Experiences

Attachment theorists argue that a key goal of psychotherapy is to provide a corrective emotional experience (Holmes, 2001; Wallin, 2007). Accordingly, the majority of papers highlight the high levels of insecure attachment in people with mental health problems and suggest that the role of services is to provide corrective emotional experiences that challenge and modify people's insecure internal working models. Eight papers discussed how this can be achieved within the context of mental health services and these highlight the importance of providing new opportunities for success and self-efficacy, as well as changing the person's negative perceptions of others (Adshead, 1998; 2002; Adshead et al., 2005; Moore et al., 1998; Rich, 2006a, 2006b; Schuengel & van Ijzendoorn, 2001; Seager, in press).

More specifically, Moore and colleagues (1998) suggested that staff can encourage new learning by focussing on clients' strengths and encouraging collaboration with

clients: 'doing with' rather than 'doing to'. Similarly, Rich (2006a) stated that it is important to show confidence in clients and to recognise their worth and value. Adshead and colleagues (2005) discussed the need to encourage independence, while Seager (in press) also cautioned that clients' dependency on services should be de-stigmatised. This dilemma would reflect Bowlby's (1977a) assertion that attachment behaviour should be viewed as a positive behavioural concept, and should not be confused with dependence which is often viewed with disapproval and criticism. Berry and Drake (2010) discuss this conflict and describe the need for the care-giver to strike a fine balance between providing reassurance while also encouraging the person to gain independence, explore their environment and take risks.

In order to modify insecure internal working models of others, Rich (2006a) suggested that staff should provide non-contingent positive interaction with clients, rather than interacting only when there are problems, and they should assume the responsibility to initiate and persevere with efforts to connect with the client. Conflict within relationships with clients should be viewed as an opportunity and staff should be supported to embrace, rather than condemn, conflict because it means that some aspect of the client's internal working model is activated and available for investigation (Moore et al., 1998). Staff in services may need specific guidance in how to achieve these aims however, and this is explored below.

Support for Staff

Eight of the papers acknowledge that working in an attachment-informed service will inevitably test the internal resources of staff and clinicians, as many users of mental

health services have experienced poor attachment experiences and will act out, or project these difficulties, in staff relationships (Adshead, 1998, 2001, 2002; Adshead et al., 2005; Barber et al., 2006; Berry & Drake, 2010; Moore et al., 1998; Seager, in press). These papers consequently highlight the need to support staff in their work and authors list a number of different ways in which staff can be supported to manage attachment issues in their work. These include staff training, supervision and consultation (Adshead 2001; Adshead et al., 2005; Berry & Drake, 2010; Moore et al., 1998; Seager, in press), and staff group reflective practice (Barber et al., 2006; Berry & Drake, 2010). Suggestions for the content and focus of training, supervision, consultation and reflective practice groups have included understanding clients' attachment styles and needs, understanding attachment behaviours and maintaining boundaries (Schuengel & van Ijzendoorn, 2001), and how to become more effective caregivers (Berry & Drake, 2010). Some authors specifically discussed the need for staff to be aware of their own attachment style and their own attachment issues, which they might re-enact with clients or colleagues, or find mirrored in the clients they work with (Adshead, 1998, 2002; Berry & Drake, 2010). Adshead (2002) suggested that improving staff's own psychological security, through developing staff's ability to self-reflect, would subsequently improve clients' attachments experiences within services.

It is also important to manage staff's individual caseloads to ensure that they do not have too many people with high levels of attachment needs at any one time (Berry & Drake, 2010; Seager, in press). Differences in attachment styles between staff has implications for teams who work with complex presentations as there is often

disagreement about how best to manage difficult behaviours; Adshead (2002) emphasised the importance of avoiding these splits within teams by using the support mechanisms described above. Other authors have suggested that regular team building exercises may help to improve shared understanding about salient attachment issues within current client caseloads and may help to prevent disputes within the team (Berry & Drake, 2010; Moore et al., 1998). Adshead (1998) also recommended more managerial and financial support for staff as the lack of either can reduce service capacity to respond sensitively and appropriately to clients' needs.

Support for Informal Carers

One paper mentioned the need for support for informal carers and co-working with them to support systemic change in the client (Moore et al., 1998). Moore and colleagues described the use of a support group for family and carers, as well as individual therapy sessions, to help them recognise their role in maintaining maladaptive cycles with the client. These interventions enabled them to explore their own attachment styles and how they influenced their perceptions of, and relationships with, the client. Given the central role of family relationships in attachment theory, it is surprising that only one paper mentioned this theme and is a significant omission in the literature.

Moving On

Applying attachment theory to clinical practice within services highlights the importance of endings and transition. Eight papers considered the importance of endings and transitions and discussed the obligation to acknowledge their impact, to

plan for discharge and changes carefully (Adshead, 1998, 2002; Adshead et al., 2005; Barber et al., 2006; Berry & Drake, 2010; Goodwin et al., 2003; Seager, 2006, in press). Abrupt terminations of therapy or service support could be prevented by graded discharge or outreach work (Seager, in press) and by ensuring on-going professional and lay support for the client (Barber et al., 2006). Issues of endings and transitions were highlighted as being especially significant for clients who may have suffered multiple losses in the past (Adshead et al., 2005).

Potential Service Benefits

One paper (Moore et al., 1998) reported the benefits of using attachment theory as a framework for the delivery of services. The authors described the impact of adopting an attachment-informed model in their service and reported several benefits over time. These included increased capacity for referrals and a number of reductions in staffing and training costs, staff absenteeism, staff injury, staff turnover, and a reduction in violence. The authors do not state how long it took for these benefits to be realised but it may take time for changes to practice to be operationalised and embedded within service delivery. Services might therefore need to consider the long-term benefits of implementing an attachment-informed service model. Considering the continual obligation for commissioners to develop effective services that provide value for money, an attachment-informed service model may also need to demonstrate the potential to recoup any extra initial investment in the long-term, and possibly contribute to reducing service costs over time.

Discussion

The above review contains articles from a number of different authors and incorporates ideas about applying attachment theory in mental health settings for adults or adolescents, most predominantly although not exclusively, within forensic and/or inpatient services. There were consistent themes across the articles reviewed, which were organised into a framework that would reflect the experience of a service user moving through the system: from referral to discharge. The eight major key themes identified were: service policy and evaluation; referrals; assessment and formulation; intervention (*creating a secure base, availability and flexibility, sensitivity and responsiveness, providing corrective emotional experiences*); support for staff; support for carers; moving on; and potential service benefits.

There was some consensus that in order to develop an attachment-informed mental health service there was a need to create an over-arching framework that could support and facilitate the integration of the model, and allow evaluation of the service's ability to meet attachment needs. Attachment theory could influence the way in which referral processes are conceptualised, and can help services decide whether they are able to meet the attachment needs of the person being referred. There is agreement about the importance of considering attachment history and experiences within assessment and formulation, which can help to understand presenting behaviours, predict engagement and response to staff.

The themes extracted from the articles reviewed, which related to intervening with clients in an attachment-informed way, echoed the components of care-giving that

promotes secure attachment, as described by Bowlby (1977a). The importance of providing a secure base was a recurrent theme in the literature, reflecting its central role in Bowlby's (1969; 1973; 1980) theory. Creating a secure base for clients generates a sense of belonging and a feeling of being looked after by services, and developing meaningful relationships with staff is a key factor in facilitating this. However, within these relationships there is a need to manage boundaries so that staff do not become over-involved or in a conflicted relationship with clients. Boundaries can be maintained by creating a therapeutic structure that provides order and consistency, and defines roles and expectations.

There is consensus that services must be more available and flexible by providing continuity of care to meet the attachment needs of clients, and authors agreed that this is derived through maintaining consistent relationships with dedicated keyworkers and allowing trust to be developed over time. Continuity of care is dependent on many factors, however, and ensuring the stability of the staff team through creating a positive working environment is a key factor, which may also have resource implications for services.

The requirement for caregivers to be sensitive and responsive was reflected in the articles reviewed and when applied to mental health services, necessitates that staff provide emotional containment for distress through empathic listening, warmth and attunement. Clients benefit from relationships which provide new opportunities for learning alternative ways of relating and responding to others. There is agreement that the staff-client relationship can be used therapeutically to provide corrective

emotional experiences that help to modify existing internal working models. By showing confidence in clients, focussing on their strengths and recognising their value and worth, staff can challenge previously developed mental representations that clients have about themselves, which can then encourage them to gain independence.

The articles reviewed also shared the opinion that adopting an attachment-informed framework would have implications for the support needs of staff, and training, supervision, consultation, reflective groups, caseload management and team building were highlighted as methods to address this. The attachment styles and needs of staff must also be considered within an attachment-informed service, as the model presupposes that all people in the system feel contained and supported. The support needs of carers was mentioned by only one article, which is surprising given the systemic focus inherent within the attachment model of thinking.

There was agreement in the evidence reviewed concerning the management of endings and transition, and it was agreed that this stage in the therapeutic process is especially difficult for people with attachment problems. It is vital to plan for transitions and endings in advance, acknowledging their impact with clients and preparing for the potential problems that discharge or absences can trigger. This could be prevented by graded discharge or outreach work, and through arranging on-going professional and lay support for the client.

The articles reviewed suggested that current service models and commissioning arrangements do not adequately support the development of attachment-informed

service models, which may require an initial additional investment over and above normal service costs. The evidence reviewed implied the need for extra resources in terms of workforce planning, staff training, formal and informal support for staff and carers, flexible service inclusion and delivery, and the development of appropriate attachment measures. Research is clearly needed to establish whether these costs would yield long-term savings, however studies have shown that investment in mental health services does lead to savings and improved quality of life for service users (Olfson, Gorman, & Pardes, 1995), and the current authors propose that initial investment in attachment-informed services may help to generate lower service costs long-term. One article did report resource savings and benefits over time and more research is needed to clarify the potential economic impact of using this model in the delivery of services.

Implications for Research

Although the above themes were consistent across several articles, there is a paucity of research supporting the concepts described. There is clearly a need for empirical studies to identify which components of the model described in this review are most important for therapeutic change and are most valued by service users. Very few papers also outline the adoption of attachment theory in outpatient or secondary care services. Given that many users of mental health services are supported long-term in the community, there is a need for more specific guidance on applying attachment theory to community based services as well as longitudinal research that evaluates the impact of using attachment theory in community mental health service models.

Limitations of the Review

The limitations of this review are in the relatively narrow scope of papers identified for review, which were primarily discussion papers. This review is therefore a theoretical overview of how an attachment-informed service might be conceptualised, rather than a synthesis of actual outcome data. While the papers included in this review provided interesting discussion about applying attachment theory in mental health service delivery, many of the papers did not explicitly describe how to do this in practice and this specificity was often missing. However, for the current review the authors attempted to specify examples of attachment-informed practice by more explicitly framing authors' suggestions within attachment theory. The process of thematic analysis is also reflexive and subjective in nature, and will be biased by the author's own influences and beliefs. The author is a trainee clinical psychologist who has an interest in applying attachment theory therapeutically within service models and so the extraction of themes may have been influenced by that interest. The other authors are also clinical psychologists who have clinical and research interests in applying attachment theory to practice.

Conclusion

In conclusion, this paper is the first known review that draws on the available literature to conceptualise an attachment-informed mental health service model. Attachment theory can be used to inform the journey of the service user through the service and may be able to lead to benefits for staff and clients, as well as reduce service costs in the longer-term. There is a lack of empirical research that evaluates the impact of adopting an attachment-informed service model and this is an important area for

future research. The present review describes implications for the design and delivery of clinical practice to guide mental health services in applying attachment theory, and it is the hope that its findings will promote future research to validate the utility of this theory in mental health service delivery.

Section Two: Research Paper

Adult attachment and service attachment: associations with psychopathology, quality of life, health service utilisation and costs in community mental health services

Paper Two Word Count: 4890

(Exc. abstract, tables and references)

Adult attachment and service attachment: associations with psychopathology, quality of life, health service utilisation and costs in community mental health services

Abstract

Objectives: To investigate the importance of individual attachment and service attachment to client psychopathology, quality of life, service utilisation and service costs in community-based mental health services.

Methods: In a sample of 25 participants, we used a cross-sectional design to look at associations between insecure attachment, service attachment, psychopathology, and service use and costs. Significant associations were entered into hierarchical regression models to clarify their unique contribution to service utilisation.

Results: Insecure attachment was associated with higher symptomotology and risk, lower functioning and well-being and higher service utilisation and service costs. Anxious attachment was related to higher service utilisation independent of symptom severity and predicted 14% of the variance in service use. Service attachment was not significantly associated with any main study variables.

Conclusions: It is important to assess clients' attachment in community mental health services, as they may help to explain differences in health service utilisation. Insecure attachment styles may exacerbate clients' experience of symptoms, increase risk, impair functioning and well-being and increase demands on service resources.

Practitioner Points

Positive Clinical Implications

- People with insecure attachment reported higher levels of symptoms and risk and lower functioning and well-being than people who have more secure attachment.
- People with insecure attachment styles use services more and for longer, and incur higher service costs than people who have more secure attachment.

Limitations

- The small sample size in the present study meant that associations with moderate effect sizes were not significant.
- The study's cross-sectional design limits the conclusions that can be inferred about the direction of causal relationships between attachment and other variables.

Introduction

Attachment theory (Bowlby, 1969) has informed a large body of research into the role of adult attachment in the aetiology of psychological problems and their maintenance (Wallin, 2007). Bowlby conceptualised the "*propensity of human beings to make strong affectional bonds to particular others*" (Bowlby, 1977a, p.201) and drew from psychoanalysis, ethology, cognitive psychology and developmental psychology to explain "*many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation*

and loss give rise" (Bowlby, 1977a, p.201). The theory describes how a person's early experiences of receiving care from significant others creates mental representations about the self in relation to other people, and these 'internal working models' create expectations about how others will behave towards them in social relationships. Internal working models are believed to be generally unconscious and may influence thoughts, feelings and behaviour with emotionally significant people, including mental health workers.

To facilitate secure attachments, Bowlby (1969, 1977a) described how the care-giver provides a secure base from which safe exploration can develop, and is available, sensitive and responsive to emotional distress. If these conditions are met the individual develops a secure attachment style, and this is associated with a positive self-image, a capacity to manage distress, comfort with autonomy and in forming relationships with others. Conversely, if caregivers are insensitive or unresponsive to distress, the individual either escalates levels of distress to get their attachment needs met (insecure ambivalent or anxious attachment), or if individuals' emotions are consistently ineffective in eliciting contingent responses in caregivers, they learn to de-escalate their attachment system, which is associated with a dismissive approach to affect and an avoidance of close relationships (insecure avoidant or dismissing attachment) (Shaver & Mikulincer, 2002).

Advocates of the theory claim that attachment relationships throughout adulthood provide individuals with a 'secure base' from which they can grow and develop (Ainsworth, Blehar, Waters, & Wall, 1978), and the concept of 'secure' versus

‘insecure’ attachments continues to affect interpersonal relationships and functioning in adulthood (Goodwin, 2003). Insecure attachment styles are overrepresented in psychiatric populations and there is evidence from both cross-sectional and longitudinal studies that insecure attachments can increase vulnerability to the development and maintenance of mental health problems (Dozier, Stovall, & Albus, 1999; Goodwin, 2003). There is also evidence from studies of mental health patients that insecure attachments are associated with more severe symptoms (Berry, Barrowclough, & Weardon, 2008; Ponizovsky, Nechamkin, & Rosca, 2007), poorer interpersonal functioning (Berry et al., 2008) and poorer quality of life (Caron, Lecomte, Stip, & Renaud, 2005; Couture, Lecomte, & Leclerc, 2007).

Associations between insecure attachment and poorer outcomes are likely to have implications for under-resourced health services. There is evidence from research involving patients in primary care GP services that insecure attachment anxiety is associated with higher health symptom reporting, more primary care visits and higher service costs, regardless of symptom severity (Ciechanowski, Walker, Katon, & Russo, 2002). However, the authors found the reverse effects for people with avoidant attachment. These patients were lower symptom reporters and users of health services. Ciechanowski et al (2002) argue that people with avoidant attachment characteristically do not focus on negative affect and are self-reliant, so are therefore less likely to report problems and seek help even when needed. This problem may be particularly significant in samples of people with severe and enduring mental health problems, who have been shown to have higher levels of avoidant attachment and

poor engagement with services (Berry et al., 2008; Dozier et al., 1999). Associations between insecure attachment patterns, service use and service costs have not, however, been investigated in samples of people with complex mental health needs, such as those under the care of community mental health teams, who typically present with multiple care needs for several years (Department of Health, 2002a).

Theorists have considered how mental health services can contribute to the development of secure attachment relationships (Goodwin, 2003; Goodwin et al., 2003; Holmes, 1993; Marrone, 1998). Significantly, these ideas were supported by a national advisory group on mental health, safety and well-being for the Department of Health (Seager et al., 2007); they argued that attachment theory provides the soundest evidence-base on which to design and measure mental health services. The working group members, who were experts representing a wide range of different psychological approaches, agreed that it is secure attachments and relationships that create mental health and well-being and that this needs to be reflected by creating 'psychological mindedness' within mental health services. If services can meet people's attachment needs in this way, it might then follow that service utilisation and costs could be reduced. Goodwin et al (2003) developed a measure of attachment to services and found positive associations between the measure and two self-ratings: how much people felt they had improved as a result of coming into contact with the service, and how helpful they felt the service had been to them. Additionally, the authors found significant differences on overall service attachment between service areas, with consistently lower scores for inpatient populations than community mental

health teams, psychological therapy and day centre services (Goodwin, Holmes et al. 2003). There is some evidence to suggest that people with insecure adult attachment styles report poorer attachment to services (Blackburn, Berry, & Cohen, 2010). However, in theory it is possible that if services are more attuned to the needs of insecurely attached clients via attachment-informed models they can be better engaged. Equally, it could be hypothesised that if people are securely attached to their service, this relationship could act in a similar way to the therapeutic alliance within individual therapy. The therapeutic alliance has been found to be more strongly associated with a reduction in client symptomatology than cognitive techniques (Webb et al., 2011; Webb et al., 2012), and this association might also be possible in client-service attachment relationships, with more securely attached people having fewer symptoms and problems than less securely attached people.

The current study aims to investigate associations between individual attachment, service attachment, psychopathology, quality of life, service utilisation and service costs. We measured psychopathology using the CORE-OM which is a measure of global distress. The measure has four subscales and enabled us to investigate associations between attachment and symptoms, functioning, risk and well-being.

We predicted a negative correlation between clients' attachment to the service and their symptoms and risk, with less securely attached people having more symptoms and higher levels of risk, and positive correlations with functioning, well-being and quality of life, with more securely attached people having better functioning, well-being and quality of life. We also predicted a positive correlation between individual

attachment and symptoms and risk, with more insecurely attached people having more symptoms and higher risk, and negative correlations with functioning, well-being and quality of life, with more insecurely attached people having worse functioning, well-being and quality of life. In terms of service use and costs, we hypothesised negative correlations between service attachment and service use and costs, with lower service use and costs for clients who are more securely attached to the service. We also predicted positive correlations between individual attachment and service use and costs, with higher service use and costs for people with more insecure attachment. Finally, we hypothesised negative correlations between clients' individual attachment and their attachment to the service, with more insecurely attached clients reporting lower attachment to their service.

Methodology

Design

A cross-sectional design was used to look at associations between insecure attachment, attachment to services, psychopathology (symptoms, risk, functioning and well-being), quality of life, and service use and costs.

Setting and participants

Participants were recruited from community-based mental health services in the North West of England, with adult clients aged 18-64 years. Community-based services included community mental health teams (CMHT: n=14) and specialist services: Early Intervention Teams (EIT: n=7); Mentally Disordered Offenders (MDO: n=1); and Review and Recovery (R&R: n=3). Inclusion criteria were informed consent and at least three

months time in the service, to ensure a sufficient duration of service-patient relationships. The study excluded patients who staff believed were too acutely unwell to complete questionnaires or interviews, and patients who did not speak English as the validity and reliability of translated versions of questionnaires and interviews had not been assessed. Thirty four patients were identified by teams and approached to participate in the study; three were identified as being unsuitable due to acute mental health problems, and a further six declined to participate, leaving a total of 25 participants that completed the interviews (73% uptake).

Measures

• Service Attachment Questionnaire (SAQ; Goodwin et al., 2003). The SAQ (Appendix D) is a 25-item self-report measure assessing the security of the attachment relationship between service user and multiple members of staff. The SAQ is different from traditional individual attachment measures and could be considered a measure of 'transitional' attachment figures. Higher scores indicate a greater sense of security in the attachment relationship between the service user and the team. The measure has demonstrated good levels of internal and test-retest reliability (Goodwin et al., 2003); Chronbach's alpha in the present study was .93.

• Psychosis Attachment Measure (PAM; Berry, Barrowclough, & Wearden, 2006). The PAM (Appendix E) is a 16-item self-report questionnaire used to measure the adult attachment dimensions of anxiety and avoidance. Higher scores on the PAM indicate a more insecure attachment on each dimension. It has been shown to have good

psychometric properties in samples of people with a diagnosis of psychosis (Berry et al., 2008); alphas in the present study were .84 for anxiety and .83 for avoidance.

• Clinical Outcomes in Routine Evaluation: Outcome Measure (CORE-OM; Evans et al., 2000). The CORE-OM is a 34-item questionnaire designed to measure global psychopathology. The measure consists of the following four subscales: problems/symptoms (12 items); risk (6 items); functioning (including general functioning, functioning in close relationships, and functioning in social relationships: 12 items); and subjective well-being (4 items). Higher scores on each subscale indicate higher levels of distress in each area. Alpha's in the present study were .91 for problems/symptoms, .86 for risk, .91 for functioning, and .88 for well-being.

• EuroQol (EQ-5D; EuroQol Group, 1990). The EQ-5D (Appendix F) is a standardised self-report questionnaire that assesses quality of life in terms of five health outcomes: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. It is applicable to a wide range of health conditions and treatments. Participant raw scores on the EQ-5D produced a five-figure health status profile, which was transformed into a single index score of health status using published UK time trade-off weighted value sets (EuroQol Group, 1990). The resulting EQ-5D single index scores range from 1 (perfect health) to 0, with scores below 0 indicating health states worse than death.

• Economic Patient Questionnaire (EPQ). The EPQ (Appendix G) is an adapted health economic questionnaire that retrospectively gathers continuous and descriptive data about service utilisation over the previous 3 months. Variables were computed for

‘total number of service use contacts’ and ‘total hours of service use’ using data derived from inpatient use, outpatient use, and primary/community care service use. The variable ‘service costs’ was computed using hours of service use and cost data on medication/prescriptions, health-care travel, private health care and extra costs due to mental health reasons. Service costs were calculated using published unit costs of health and social care provided by the Personal Social Services Research Unit (Curtis, 2011).

Procedure

Following ethical approval, the research protocol was disseminated to community-service team managers in one NHS trust. Potential participants were randomly selected by team managers, by identifying every third name from current caseloads within each team. Potential participants were then approached by their care coordinators and invited to participate in the study via patient information sheets (Appendix H). If clients were interested in participating in the study the researcher arranged to meet with them to take informed consent (Appendix I), and then arranged a follow-up meeting to complete the set of questionnaires on service premises. The set of questionnaires comprised the measures SAQ, PAM, CORE-OM, EQ-5D and EPQ. The researcher collected demographic and service use information for the EPQ from participant disclosure during interviews and case-note review.

Data Analysis

Descriptive statistics were obtained and skewness and kurtosis were calculated in order to check the variables were normally distributed. The variables ‘times used

services' and 'service costs' were positively skewed so log transformations were performed and were successful. The CORE-OM risk variable was also positively skewed due to most people being low risk, however, a range of transformations were performed on the data and were unsuccessful. Associations between continuous variables were assessed using Pearson's correlations and associations between categorical and continuous variables were assessed using independent t-tests. Non-parametric equivalents were used in analyses involving the CORE-OM risk subscale. Post-hoc analyses, using partial correlations, hierarchical multiple regression and ANCOVA, were carried out on significant associations to clarify the contribution of significant independent variables to dependent variables.

Results

Sample characteristics and preliminary analysis

The characteristics of the sample are summarised in Table 1, and descriptive statistics for the main study variables are summarised in Table 2. Preliminary data analysis was carried out to examine the relevance of demographic and team variables to the main study variables. Age was significantly negatively correlated with attachment to services (r=-.566, p=.003); with younger people reporting a greater attachment to their service than older people. The relevance of participants' team on service attachment was explored, however due to low frequencies in two groups (R&R and MDO), we excluded them from the analysis and compared group differences between CMHT's and EIT's. We found a significant group difference for service attachment; (t (19) -2.34, p=.03), with higher attachment to the service in EIT's (n=7, M = 62.71, SD = 14.41) than in CMHT's (n=14, M = 44.07, SD = 18.35).

Table 1: Demographic and socio-economic characteristics of study sample

	Mean	SD
Age	37.92	11.44
	N	**%**
Gender		
Male	16	64
Female	9	36
Team / Service		
Community Mental Health Team (CMHT)	14	56
Early Intervention Team (EIT)	7	28
Review and Recovery (R&R)	3	12
Mentally Disordered Offenders (MDO)	1	4
Employment Status		
Employed	3	12
Retired	2	8
Housework	1	4
Seeking work	3	12
Other (Sickness/disability)	16	64
Higher Education		
Yes	19	76
No	6	24
Degree or professional qualification		
Yes	10	40
No	15	60

Ethnicity		
White British	23	92
South Asian	2	8
Marital Status		
Married	6	24
Single	13	52
Living with partner	3	12
Divorced / separated	3	12

Table 2: Descriptive statistics for variables

Variable (Measure)	N	Min	Max	Mean	SD
Anxious attachment (PAM)	25	0	18	8.44	5.69
Avoidant attachment (PAM)	25	0	19	8.92	5.48
Service attachment (SAQ)	25	14	75	47.64	18.46
Symptoms (CORE-OM P)	25	2	45	21.12	12.49
Risk (CORE-OM R)	25	0	13	1.96	3.90
Functioning (CORE-OM F)	25	0	38	16.72	11.41
Well-being (CORE-OM W)	25	0	16	6.56	5.23
Quality of Life (EQ-5D) *Single Index score*	25	-.181	1	.481	.374
Times service use (EPQ) *Geometric mean* (Lg10)*	25	6	49	14.4*	n/a
Hours service use (EPQ)	25	1.25	34.5	12.15	9.20
Service use costs (EPQ) *Geometric mean* (Lg10)*	25	£148.55	£4310	870*	n/a

Given that the age demographic is generally younger in EIT's than CMHT's, where the service model provides care across the lifespan, we carried out further analysis to assess the relationship between team and service attachment when controlling for age, which also revealed a significant association with service attachment. We carried out an ANCOVA, with service attachment as the dependent variable, team as the grouping variable and age as the covariate. There was not a significant effect of team on service attachment after controlling for the effect of age (F (2, 18) 1.14, p=.300).

Attachment and clinical variables

We predicted negative correlations between clients' attachment to the service and their symptoms and risk, and positive correlations with functioning, well-being and quality of life. Contrary to predictions, service attachment was not significantly correlated with symptoms (r=-.022, p=.918), risk (r =.153, p=.465), functioning (r=-.043, p=.837), well-being (r=-.083, p=.694), or quality of life (r=.152, p=.468).

We predicted that there would be positive correlations between individual attachment and symptoms and risk, and negative correlations with functioning, well-being and quality of life. As predicted, anxious attachment was significantly positively correlated with symptoms (r=.617, p=.001) and risk (r=.631, p=.001) and negatively correlated[1] with functioning (r=.657, p=.000) and well-being (r=.646, p=.000). However, there was no significant association between attachment anxiety and quality of life (r=-.207,

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[1] The CORE-OM is problem scored: the higher the score, the more problems the respondent is reporting. Therefore, for functioning and well-being subscales, higher scores reflect lower functioning and well-being.

p=.321). As predicted, avoidant attachment was significantly correlated with lower functioning (*r*=.457, *p*=.022), but not with symptoms (*r*=.355, *p*=.102), risk (*r*=.331, *p*=.106), well-being (*r*=.304, *p*=.139), or quality of life (*r*=-.281, *p*=.174).

Attachment and service use and costs

We predicted negative correlations between service attachment and service use and costs, with lower service use and costs for clients who are more securely attached to the service, and positive correlations between individual attachment and service use and costs, with higher service use and costs for people with more insecure attachment. Contrary to predictions, attachment to services was not significantly correlated with times of service use (*r*=.113, *p*=.590), hours of service use (*r*=.051, *p*=.808) or service costs (*r*=-.096, *p*=.649). As predicted, there were significant positive correlations between anxious attachment and times of service use (*r*=.539, *p*=.005), hours of service use (*r*=.621, *p*=.001) and service costs (*r*=.414, *p*=.040). Avoidant attachment was also significantly positively correlated with times of service use (*r*=.449, *p*=.024) and hours of service use (*r*=.489, *p*=.013), but the association between avoidant attachment and service costs was slightly weaker and did not meet significance in this small sample (*r*=.293, *p*=.155).

As there were positive correlations between individual attachment and symptoms (anxious *r*=.617, *p*=.001; avoidant *r*=.355, *p*=.102), it is possible that people with insecure attachments may use services more simply because they are more symptomatic. Analysis confirmed that the association between symptoms and service

use was significant (r=.540, p=.005). We therefore used partial correlations to assess whether significant associations between attachment and service use and costs were maintained when controlling for symptoms. Anxious attachment was not significantly correlated with service costs (r=.250, p=.238), but was still significantly correlated with times of service use (r=.440, p=.031) and hours of service use (r=.436, p=.033) after controlling for symptoms. Avoidant attachment was not significantly correlated with times of service use (r=.331, p=.114) or hours of service use (r=.389, p=.060) after controlling for symptoms, although these results were approaching significance and may reach significant levels in a larger sample.

For the remaining significant associations between anxious attachment and service use after controlling for symptoms, hierarchical multiple regression analyses were performed to determine the unique variance that anxious attachment contributed to both service use variables. The first regression used 'times of service use' as the criterion variable and symptoms as the control variable, with symptoms entered in the first block and anxious attachment entered into the second block. Model 1 was significant and symptoms accounted for 29% of the variance in times of service use (F (1, 23) = 9.46, p=.005; adjusted R^2 = .26, R^2 change = .29). The inclusion of anxiety as a predictor into model 2 resulted in a significant model and an additional 14% of the variance being explained (F (2, 22) = 8.26, p=.002); adjusted R^2 = .38, R^2 change = .14). Symptoms and anxious attachment were both significant predictors, showing they were significantly related to times of service use (Table 3).

Table 3: Regression analysis for associations with times of service use.

Predictor variables	B	*t*	*p*	95% CI
Symptoms (CORE-OM P)	.25	1.22	.236	-.003 - .013
Anxious attachment (PAM)	.47	2.30	.031	.002 - .038

The second regression used 'hours of service use' as the criterion variable and symptoms as the control variable, with symptoms entered in the first block and anxious attachment entered into the second block. Model 1 was significant and symptoms accounted for 29% of the variance in times of service use (F (1, 23) = 9.37, p=.006; adjusted R^2 = .26, R^2 change = .29). The inclusion of anxiety as a predictor into model 2 resulted in a significant model and an additional 14% of the variance being explained (F (2, 22) = 8.11, p=.002); adjusted R^2 = .37, R^2 change = .14). Symptoms and anxious attachment were both significant predictors, showing they were significantly related to hours of service use (Table 4).

Table 4: Regression analysis for associations with hours of service use.

Predictor variables	B	*t*	*p*	95% CI
Symptoms (CORE-OM P)	.25	1.22	.236	-.130 - .498
Anxious attachment (PAM)	.47	2.28	.033	.065 - 1.44

Individual attachment with service attachment

We hypothesised that there would be negative correlations between clients' individual attachment and service attachment. Individual attachment was not significantly

correlated with service attachment: anxious attachment (r=.159, p=.449) and avoidant attachment (r=.371, p=.068). The association with avoidant attachment was approaching significance; however, the effect was not in the direction expected, with people with more attachment avoidance reporting greater attachment to the service.

Discussion

The current study builds on previous work by assessing associations between attachment and different domains of psychopathology in people with severe and enduring mental health problems, and is unique in exploring the relevance of attachment to service utilisation and costs in mental health. We found predicted associations between insecure attachment and psychopathology. More specifically, people with attachment anxiety reported higher levels of symptoms and risk, and lower levels of interpersonal functioning and well-being, while people with attachment avoidance reported lower levels of interpersonal functioning. Although there were no significant associations between avoidant attachment and symptoms, risk and well-being, the effects were in the expected direction and may have reached significance in a larger sample.

Associations between insecure attachment and symptoms and insecure attachment and poorer functioning are consistent with previous research with patients with severe enduring mental health problems (Berry et al., 2008). To our knowledge no previous studies have investigated associations between insecure attachment and risk, nor insecure attachment and well-being, in samples with severe mental health problems, but there is evidence of associations between insecure attachment and risk in samples

of primary care patients (Ahrens, Ciechanowski, & Katon, 2012) and evidence of associations between insecure attachment and well-being in non-clinical samples of young adults (Moore & Leung, 2002). Although insecure attachment styles may be functional in terms of reducing the likelihood of caregiver maltreatment and infant distress, they are hypothesised to increase vulnerability to psychopathology and lead to worse outcomes following the onset of psychological difficulties (Belsky & Nezworski, 1988). Attachment anxiety is hypothesised to create lower thresholds for dealing with stress and hypersensitivity to signs of rejection which can manifest in behaviours to elicit care, including suicidal ideation and deliberate self-harm (Bowlby, 1977a). Attachment avoidance is associated with an overt compulsive self-reliance and a minimisation of affect, but in the face of extreme stress, it is possible that these defences breakdown and the individual lacks alternative adaptive methods of coping with distress, such as seeking support from others.

In contrast to previous research (Caron et al., 2005; Couture et al., 2007), quality of life was not significantly associated with anxious or avoidant attachment in this study. However, associations were in the expected direction, with more insecure people reporting poorer quality of life. As highlighted above, the lack of significant findings in our study may be a result of the small sample size and consequent loss of power.

As predicted, insecure attachment was also associated with higher service utilisation and costs, and the relationship with service utilisation remained significant for anxious attachment when symptoms were controlled. We found that avoidant attachment was also associated with higher service utilisation and although the relationship did

not remain significant after controlling for the influence of symptoms in this sample, the associations may be significant in a larger sample. Our finding that anxious attachment was associated with higher service utilisation and costs was consistent with previous research that looked at general health use within primary care (Ciechanowski, Walker et al., 2002). People with anxious attachment tend to seek reassurance and be over-reliant on others to meet their needs (Bowlby, 1977a) and this interpersonal style may therefore also manifest in patient and health professional relationships.

Our finding that avoidant attachment was also associated with higher service use contrasts with previous research in primary care, which found that people with avoidant attachment were lower symptom reporters and users of general health services (Ciechanowski, Walker et al., 2002). The conflicting findings of our study and the study by Ciechanowski and colleagues may be associated with the different samples. It is possible that the avoidant people in Ciechanowskis's primary care sample were able to function relatively well without services. However, people with avoidant attachment may not function as well when faced with the stress associated with severe and enduring mental health problems, but yet may not be able to engage well with and make use of the supports provided by mental health services (Berry et al., 2008). It is possible that these people therefore have high levels of unmet need and frequently present to services in crisis.

Contrary to our hypothesis, attachment to services was not associated with any clinical variables, or with service utilisation and costs in this sample. Nor was it significantly

associated with insecure attachment; however the relationship between avoidant attachment and service attachment was approaching significance and could be an important effect in a larger sample. The effect was in the opposite direction than expected though, with avoidant people reporting higher service attachment. This too may reflect the propensity of people with avoidant attachment to make less demands of others with a preference to cope alone (Bowlby, 1977a), and could manifest within services as apparent satisfaction with service input, but if couched within attachment theory this may not accurately reflect their true support needs. Additionally, our finding that avoidant attachment was also associated with poorer functioning may explain the near significance with service attachment, as previous research (Catty et al., 2011) has found that service attachment was associated with poorer functioning in community services; Catty and colleagues (2011) described how people who were the most disabled, in terms of their support needs, valued their relationship with their service more highly.

Finally, both age and team were significantly associated with service attachment, with younger people and clients from Early Intervention Teams (EIT's) both reporting greater service attachment. The age demographic of clients within EIT's is, however, generally younger, and associations between team and attachment were not borne out in further analysis. The mean attachment to community services score in the present study was 47.64, which was significantly lower than those reported in previous studies: 77.04 in psychiatric rehabilitation services (Blackburn et al., 2010) and 72.81 in a mixed mental health service sample (Goodwin et al., 2003).

Limitations

In terms of assessing service attachment, a major limitation of this study was in the recruitment procedure, which relied upon care coordinators approaching clients that had been identified through random selection. Given that the study focused on attachment relationships between staff teams and clients, there may have been some unwillingness on the part of care coordinators to approach clients with a known history of problematic relationships with themselves or the service. Equally, clients who gave informed consent to participate in the study were self-selecting, which may have caused an over-representation of participants who were unhappy with the service, or likely to complain about dissatisfaction with the service. Future research looking at service attachment should aim to use a more representative sample and consider alternative ways of recruitment than the procedure used within this study.

Another major limitation was the small sample size. A power calculation showed that with 25 participants, the study had 80% power to detect a correlation effect of 0.55 or more at the 5% level of significance, which in terms of magnitude is a large effect size (Cohen, 1988). We did find several associations which met this criterion but a number of associations had moderate effect sizes that would have reached significance in a larger sample. Future research should aim to increase power by using a larger sample.

The use of a cross-sectional design also limits the conclusions that can be inferred about the direction of causal relationships between attachment and other variables. It is possible that psychopathology or patterns of service use lead to insecure

attachments, or that the associations are bi-directional or can be explained by a third unmeasured variable. Future research should therefore use longitudinal designs to clarify the direction of associations between attachment, psychopathology and service use and costs. Furthermore, participants' subjective reports of psychopathology, quality of life, service use and attachment, may be biased due to inaccuracies in recall or social desirability bias. The reliance on self-report data also introduces the problem of common method variance (Furnham & Henderson, 1982).

Clinical Implications

Associations between insecure attachment and psychopathology, including symptoms, risk, functioning and well-being, highlight the importance of services assessing and meeting clients' attachment needs (Berry & Drake, 2010; Goodwin, 2003; Seager et al., 2007). The finding that people with insecure attachment use services more, and incur higher service costs, has obvious financial implications for health services and gives an economic argument for using attachment theory to inform service organisation and delivery. The implementation of an attachment-oriented service model may incur extra investment in the short-term but, given the high number of people with insecure attachment in mental health services, this initial outlay is likely to save more money in the long-term (Moore, Moretti, & Holland, 1998).

According to attachment theory, services should work with people with insecure attachments by providing consistent staff-client relationships and responding sensitively and flexibly to distress, for instance by minimising changes in staff teams and providing out of hours services (Berry & Drake, 2010). For people with high

attachment anxiety, services should focus on regulating affect and containing distress, and by careful planning for endings and transition between services. For people with high attachment avoidance, services should focus on improving engagement by creative and flexible service delivery, including telephone contacts and assertive outreach (Seager, 2006; Seager, 2011).

This study did not find support for the relevance of service attachment in community mental health services to psychopathology, service use or costs. Younger people reported a greater service attachment, as did participants from Early Intervention Teams, but these associations were inter-related and did not offer any meaningful explanations of the factors that contribute to people's attachment to services. Additionally, respondents reported lower overall attachments to their community mental health team than previously reported within inpatient and psychiatric rehabilitation services. Whether this finding is due to real fundamental differences in mental health service delivery models is unclear however, and further research is needed to investigate the importance of service attachments in community mental health.

Conclusion

Despite its limitations, this study is unique in assessing associations between attachment and service use and costs in people with severe and enduring mental health problems. Attachment theory can explain differences in the way that people use services and help to predict individual service costs. Further research is needed to

clarify the utility of adopting an attachment-informed service model in community mental health so that potential benefits can be empirically assessed.

Section Three: Critical Review

Word Count - 7194

Critical Review

Introduction

This study is a valuable contribution to the attachment and community mental health services literature, by assessing associations between attachment and different domains of psychopathology in people with severe and enduring mental health problems. This study is unique in also examining the relationship between insecure attachment and service utilisation and costs in community mental health services. Prior research into insecure attachment and service attachment in mental health services has tended to focus on clients within inpatient, secure forensic and/or psychiatric rehabilitation settings, and no research has considered the economic impact of clients' attachment on their mental health service use. Following a review of the literature, no published studies to date have investigated associations between insecure attachment or service attachment and psychopathology (symptoms, risk, functioning, well-being and quality of life) in a community mental health sample. Articles identified in the literature review applied attachment theory predominantly within inpatient mental health settings; problematic attachment issues within these populations are likely to be more severe and present more difficulties for care and risk management (Adshead, 1998; Schuengel & van Ijzendoorn, 2001), and these difficulties may have prompted the bulk of attachment research to be carried out with these populations.

The lack of previous attachment research in community mental health settings is surprising, given that this service model has become the foundation of the mental health secondary care system in the UK and has an integral role to play in supporting service users and families in community settings (Department of Health, 2002a, p.6). Community-based mental health teams work with people still living in their own homes and can focus on specific areas such as recovery, or on specific conditions such as psychosis. Generic community mental health teams offer services for a wide range of problems, including people with time-limited disorders who are referred back to their GP when their condition has improved, as well as people with severe and enduring mental health problems who typically present with multiple care needs for several years (Department of Health, 2002a).

Severe and enduring mental health problems and personality disorders have consistently been linked with histories of interpersonal traumas, such as physical, sexual and emotional abuse, neglect, abandonment and loss of attachments (Seager, Orbach, et al., 2007). People with these histories frequently experience difficulties in interpersonal relationships, including their ability to engage in therapeutic relationships (Berry & Drake, 2010), and insecure attachments are associated with more severe symptoms (Berry, Barrowclough, et al., 2008; Ponizovsky, Nechamkin, et al., 2007), worse interpersonal functioning (Berry et al., 2008), higher risk (Ahrens, Ciechanowski, et al., 2012), lower well being (Moore & Leung, 2002) and lower quality of life (Caron, Lecomte, et al., 2005; Couture, Lecomte, et al., 2007). The present study provided further evidence that insecure attachments are associated with more severe

psychopathology, and also found important associations between insecure attachment and higher mental health service use and costs. People with anxious attachments reported higher service use and costs, and people with avoidant attachment reported higher service use. In the case of anxious attachment, higher service use was still maintained after controlling for symptom severity.

Methodological Considerations

A number of methodological issues merit discussion. The main limitation of the literature review was in the fairly narrow scope of articles identified for review, which were primarily discussion papers. This necessitated a theoretical overview of how an attachment-informed service might be conceptualised in practice, rather than a synthesis of actual outcome data which would have been preferable. Additionally, while the articles provided interesting discussion and debate about how to apply attachment theory in mental health service delivery, many of the papers did not explicitly describe how to do this in practice and this specificity was noticeably absent for inclusion in the review. The authors were careful not to impose their own interpretations on the literature but attempted to make vague recommendations more specific by more explicitly framing them within the attachment theory evidence-base. There is a need for more systematic and empirically robust published research that examines the role of attachment theory in mental health service design and delivery in all service settings. Until such research exists, the recommendations and implications reported in the literature review should be interpreted with caution.

A major limitation of the present study was in the recruitment procedure, which asked care coordinators to approach potential participants. As the study was looking at attachment relationships between staff teams and clients, care coordinators may have been reluctant to approach clients with whom they had had difficult or new relationships, which might have lead to an over-estimation of service attachment in the study. However, this is unlikely as the study found a much lower service attachment mean than has been reported in previous studies with inpatients, which implies an under-estimation of service attachment in this study sample. The service context in which this study took place is significant and may have affected staff's ability to cooperate, recruitment to the study, and participants' responses, particularly in relation to questions about service attachment. All community mental health services included in this study had recently undergone significant reorganisation as part of the Transforming Community Services Programme (Department of Health, 2009), which meant that some staff and service users were required to move teams as part of the changes. Assertive Outreach teams were disbanded, with the majority of their clients moved into CMHT's, and many long-term clients within CMHT's were moved into new Review and Recovery Teams. Many staff teams discussed with the lead researcher the negative impact that these changes had had not only on their clients, but also on staff members themselves. Many staff and clients had lost significant relationships, including staff-team relationships as well as staff-client relationships. While the present study did not set out to elicit participants' experiences of these changes, several did discuss the effect that the recent reorganisation had had on them. They too reported that the changes had had a significant impact on their sense of security

and stability, and given that this study was looking at attachment relationships in services, it will undoubtedly have influenced the study's process and findings.

A comparison of the means of insecure attachment and symptoms in this study with previous studies was not possible as previous studies either did not report individual insecure attachment means, or used different measures of symptomatology. Therefore, characteristics of the present sample were compared with previous studies. The mean age of participants was 38, which is comparable to previous studies (44: Berry et al., 2008; 39: Blackburn et al., 2010); all current participants came from community-based services, with the majority (56%) from generic community mental health teams (inpatient: Berry et al., 2008; psychiatric rehabilitation: Blackburn et al., 2010); there was under-representation from women (36%) in the sample, although this was also comparable to previous studies (32%: Berry et al., 2008; 21%: Blackburn et al., 2010); 88% of the sample were not employed, compared to 100% of the sample in Berry et al's study (2008); the majority of participants (92%) were of white British origin, which is comparable to 92% in Berry et al's study (2008) and 87% in Blackburn et al's (2010) study; and 64% were single or separated, compared to 88% in Berry et al's (2008) study.

Another limitation of the present study was the small sample size which resulted in low statistical power to detect potentially important factors, and this raises the possibility of type 2 error. The original number of participants needed for the sample was confirmed using a power calculation, which found that with n=45 subjects, the study would have had 80% power to detect a correlation effect of 0.4 or more at the

5% level of significance. It was originally planned to recruit a minimum sample of 45 participants, however because recruitment was problematic, possibly due to the service context previously discussed, the researcher extended the recruitment area from one borough within the trust to all localities across the trust and extended the period of data collection. However, despite these contingencies, recruitment only reached a total of 25 completed interviews. A revised power calculation showed that with 25 subjects, the study had 80% power to detect a correlation effect of 0.55 or more at the 5% level of significance, which is considered a large effect size (Cohen, 1988). Although our study did find associations that reached this level, several other associations had more moderate effect sizes which may be significant in a larger sample. The large number of correlations raises the possibility of type one error however and, with the additional possibility of type 2 error, means that caution must be exercised here and these results must remain preliminary.

Another possible limitation to the study lies in the use of an attachment measure that did not assess secure or disorganised attachment. The present study assessed insecure attachment dimensions using the Psychosis Attachment Measure (PAM: Berry et al., 2006) which is a self-report measure originally designed for use with people with a diagnosis of psychosis, but can be applied with other psychiatric diagnoses. Research using the PAM has shown that attachment style was relatively stable over time in a prospective design which followed up an acute group and a stable group six months later (Berry et al., 2008). The PAM measures two underlying dimensions of attachment: anxiety versus avoidance in affective behavioural terms, or a model of self versus others in cognitive terms. However, there are psychometric advantages to

conceptualising attachment using the dimensional approach (Griffin & Bartholomew, 1994), and the use of multi-item scales with underlying dimensions of anxiety and avoidance have been found to be valid for investigating adult attachment with self-report questionnaires (Brennan, Clark, et al., 1998). Additionally, self-report measures have been shown to provide a reliable assessment of attachment style in patients with severe psychopathology (Picardi, Martinotti, et al., 2011).

The use of multiple subscales from one clinical outcome measure (CORE-OM: Evans, Mellor-Clark, et al., 2000) as separate variables may have limited the ability to generalise findings. The measure was not intended to provide clear separation of the subscales (problems/symptoms, risk, functioning and well-being) as they are often highly correlated (Evans, 2003). However, the authors published separate psychometrics for the four subscales as there is evidence of differential change on them over time and therapists sometimes track a certain domain for a patient over the course of therapy (Evans, 2003); importantly, replication of the factor structure with 2,277 cases from a clinical sample showed that the risk items were largely distinct from other items. The present study found significant correlations between anxious attachment and all four CORE-OM subscales, and between avoidant attachment and one subscale (functioning), however, the use of partial correlations to tease out the significance of one variable over another for anxious attachment was not useful due to multicollinearity. The significance of total global distress (total CORE-OM) was looked at in the analysis, and showed associations with anxious attachment but not with avoidant attachment. Using total global distress scores did not give as much detailed

information about the separate domains that contribute to global distress. Due to word restrictions, the global distress score was therefore omitted from the paper.

The study was unique in looking at insecure attachment from a health economic perspective and used an adaptation of the European Patient Questionnaire (EPQ), a non-standardised health economic questionnaire, to collect service utilisation and cost data. Given that service utilisation and costs were main study outcome variables, the researcher endeavoured to ensure accurate costings on the data collected for each participant. The analysis included only the direct costs of care, in line with international guidelines and UK policy (National Institute of Clinical Excellence (NICE), 2004), which were estimated from retrospective service use reported by participants, and multiplied by published national unit cost data standardised to 2010-2011 prices (Curtis, 2011). Service use data were collected for hospital inpatient and outpatient services, primary and community care and prescribed medications. Community care included day care facilities and contact with multidisciplinary mental healthcare professionals and teams, social workers and social support workers. If additional services were used, patients were asked to specify the name and location of the services. Additional data on the number of times each service was used, and the average length of each contact were also collected. National average unit cost data were used to control for differences in costs between care settings. The cost of medicines did not include the costs of dispensing or administration of the drugs, as it was assumed that these were included in the unit costs used for hospital inpatient and outpatient care, and primary and community care. The EPQ has been used within

many health economic studies and has been shown to provide reliable information for statistical analysis (Davies, Lewis, et al., 2007). However, the EPQ did not cover all current participants' resource use; the sample was drawn from community-based services and some will have been cared for under the Care Programme Approach (CPA: Department of Health, 1999), with resultant cost implications. The EPQ did not ask for separate information about CPA arrangements, which was not detected until costing of the data. Published unit costs are available for care packages for people with mental health problems (Curtis, 2011) with three levels of costs for care package categories: moderate, substantial and critical. This omission from the EPQ meant that separate care package costs could not be included in the total service costs variable, which may have caused an under-estimation of costs and influenced the results found in this study. Then again, it might be assumed that care package costs are included in the unit costs for community mental health team contacts, which might have moderated this omission.

The present study sampled participants from community-based mental health services, regardless of diagnosis, and did not therefore determine the diagnoses of participants. This might imply difficulties in generalising the results, however the authors argue that it may also be seen a strength; this broad inclusion criteria reflects 'real-life' caseloads in community mental health services and therefore provides the study with ecological validity. Improving the ecological validity of a study typically implies external validity as well, suggesting that the results from this study can be generalised to clinical

populations. The study was also strengthened by having one researcher across multiple sites, which improved consistency in collecting data.

The use of a cross-sectional design also limits the conclusions that can be inferred about causal relationships between attachment and other variables. It is possible that psychopathology or patterns of service use lead to insecure attachments, or that the associations are bi-directional or can be explained by a third unmeasured variable. Furthermore, participants' subjective reports of psychopathology, quality of life, service use and attachment may also be biased due to inaccuracies in recall or social desirability bias and the reliance on self-report data introduces the problem of common method variance (Furnham & Henderson, 1982). Mood and cognitive problems (memory, attention, concentration, and effects of medication) (Tarrier, 2005) and interviewer/interviewee relationships (Polgar & Thomas, 2000) can also influence participants' responses. Future research could employ longitudinal designs to clarify the direction of associations between attachment, psychopathology and service use and costs, and utilise mixed methodologies that integrate subjective and objective information to improve problems of bias.

The set of questionnaire measures were all read aloud to participants by the researcher to minimise any problems with reading, comprehension or attention. Although this was performed to assist participants with the process and ensure completion of the relevant information, participants may have felt reluctant to reveal information about themselves, or they may have understated/overstated symptoms

and problems to portray themselves in a more positive light (Briere, 1992). To mitigate against this, the researcher ensured that all participants fully understood that their responses were confidential and anonymous.

Context of Study

The rationale for the present study was initially prompted by a local trust policy document for organising and delivering psychological therapies for adults and older people (Pennine Care NHS Trust, 2008). The paper proposed a service model and strategy for the delivery of psychological therapies across the trust and described the core principles of the strategy, which were informed and supported by a document produced by a national advisory group on mental health, safety and well-being for the Department of Health (Seager, Orbach, et al., 2007). This document proposed attachment theory as a suitable framework by which to inform the design and delivery of mental health services, as it is secure attachments and relationships that create mental health and well-being, and that this needs to be reflected by creating 'psychological mindedness' within mental health services. The working group derived a summary of the '*Five Universal Psychological Principles*' that all services should subscribe and adhere to: of most relevance to this study, principle 2 states that "*A psychologically-informed generic policy framework is badly needed to promote psychologically safe mental health services (over and above the growing guidance on specific psychological treatments)*" while principle 3 states that "*Attachment theory provides a universal evidence-base that has not yet been harnessed*" (Seager, Orbach, et al., 2007, p.1). However, the importance of attachment theory is not universally

shared. Critics have suggested that it describes only some of the factors involved in healthy growth and development, and cannot provide a comprehensive account of the complex and subtle factors of development, or of psychopathology (Ryle & Kerr, 2002). In view of the gathering weight attributed to the usefulness of attachment theory in service models, the present study was developed to first define and conceptualise an attachment-informed service model, and then explore associations between individual- and service- attachment with psychopathology, to clarify its relevance and implications. However, the implementation of an attachment-informed mental health service model might also have resultant cost implications and so, given the current economic pressures facing the NHS, the study planned to evaluate the impact of insecure attachment in community mental health settings on service use and costs.

Crucially, the introduction of Payment by Results (Department of Health, 2002b) and the recent Spending Review (HM Treasury, 2010) have become a prominent part of the current political and economic agenda. A supporting economic document to 'No Health without Mental Health' (Department of Health, 2011) outlined the need for the NHS to find up to £20 billion in efficiency savings by 2014, reporting that "*mental ill health is the single largest cause of disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease*" (Department of Health, 2011, p.4). Estimated annual costs for different mental disorders across the lifespan in the UK were reported; depression £7.5 billion, anxiety £8.9 billion, schizophrenia £6.7 billion, dementia £17 billion, and medically unexplained symptoms (somatisation disorder) £18 billion; additionally, the costs of mental ill health are forecast to double over the next 20 years. The report suggested

that through improving the quality and efficiency of current services, innovative and preventative approaches could reduce costs by improving outcomes and increasing quality of life. The authors proposed that "*there is significant scope for the imaginative re-design of services which support people who live with a mental illness. Services can be safer, more timely, more personalised and increasingly cost-effective*" (Department of Health, 2011, p.18). It may be possible that the people who make commissioning decisions, about service configuration, design and delivery, might be more open to creative and innovative models of community mental health services at this time. However, the commissioning of mental health services is also a changing landscape.

The NHS in England is currently going through a period of significant change in the way that mental health and social care services are commissioned (Bennett, Appleton, & Jackson, 2011). The Coalition Government proposed a new clinical commissioning structure that will see GP commissioning consortia (GPCC) largely replace primary care trusts (PCTs) to take on the responsibility for commissioning the bulk of NHS primary and secondary mental health services by 2013. The GPCC will include representation from every GP practice in the local area and importantly, they will be expected to draw on expert advice from health and care professionals and work in partnership with local authorities to also involve patients and communities. It is recognised that some GPCC might lack the necessary expertise in commissioning services for people with long-term mental health problems so joint commissioning arrangements with local authorities will be allowed to offset this. Local authorities will lead the strategic co-ordination of commissioning between NHS, social care, public health and other local agencies

through new health and well-being boards; core membership of these boards will include all local GPCC, directors of social care agencies and public health agencies, and locally elected members. Health and well-being boards will decide how to make best use of the total resources in their local area to best deliver reductions in demand for health services. The NHS Commissioning Board will regulate and support the GPCC by publishing commissioning guidance and model care pathways, based on evidence-based quality standards developed by the National Institute for Health and Clinical Excellence (NICE) (Bennett et al., 2011). The Joint Commissioning Panel for Mental Health (JCP-MH) launched in April 2011, and has published the first four guides of its commissioning framework for Primary Mental Health Care, Dementia, Liaison Services, and CAMHS Transition Services. Each guide describes what a good service configuration looks like and collates scientific evidence, service user and carer experience, and best practice examples. Of relevance here, the JCP-MH is currently working on a commissioning framework guide for community mental health services which will be released in late 2012.

The overwhelming pace of recent changes has triggered a proliferation of accompanying supporting documents and guidelines, however the current NHS reforms to improve quality of care and control costs in mental health are nothing new (British Psychological Society, 2001). There is a long history of successive reforms that have set out to achieve the same aims, yet it has long been acknowledged that the NHS is unlikely to be allocated enough resources to achieve ideal service provision (Newdick, 1996). Unfortunately, it seems there has been little change in the way that mental health services are commissioned and delivered as a recent independent

enquiry into acute and crisis mental healthcare reported some worrying findings from service user experience (Mind, 2011). The report concluded that action is urgently needed to ensure that mental healthcare is built on humane values, but this will require organisational commitment and a rethinking of 'professional boundaries' so that staff can interact naturally with clients without losing their professionalism. In a direct recommendation to commissioners, the authors suggested that while there are common needs for care and safety, every person's crisis and needs are different, and service delivery must reflect this diversity of needs. Commissioners should not assume that one service model will fit all and they should encourage flexibility and creativity in services to provide personalised and community-specific solutions (Mind, 2011). The report's recommendations echo the basic tenets of attachment theory that stress the importance of genuine relationships between people that are based on respect, and in being sensitive and responsive to people's individual needs.

Goodwin (2003) has previously discussed the extent to which attachment theory had influenced the philosophy and organisation of mental health services and acknowledged that most service commissioning is concerned with political and economic factors. Yet currently there may be scope for creatively re-imagining services and attachment theory might prove some value, in terms of applying its concepts to staff-team and staff-patient relationships. However, Bennett and colleagues (2011) acknowledge that there will be risks to services in this time of transition, as the transfer of commissioning responsibilities is taking place within a highly challenging financial context. Therefore, how these ideas could be voiced within the new commissioning structure needs to be considered.

The involvement of clinical leadership in commissioning in England is still in development but has proved invaluable to developing services, as the information that clinicians hold can augment that of GP's (Bennett et al., 2011). The guidance recommends leadership from both primary care organisations and mental health trusts locally, to develop commissioning networks that facilitate the sharing of expertise; "*Psychiatrists and other senior mental health staff can advise on aspects of the care of people with severe and enduring mental illness as well as other areas, about which most GP's have generic, rather than specialist, knowledge.*" (Bennett et al., 2011, p.41). It seems crucial that senior clinicians representing the interests of patients with severe mental health problems are included in commissioning networks, and should ideally involve representation from psychological therapies, as well as psychiatry, for attachment issues to be seriously taken into account.

Implications of study findings for services

Perhaps the most important, and unique, findings in this study lend support to the argument that attachment theory can explain differences in the way that people use services (Goodwin, 2003; Seager, in press; Shorey & Snyder, 2006). In line with previous research that looked at general health use in primary care (Ciechanowski et al., 2002), the present study found that insecure attachment was related to higher mental health service utilisation and costs, and could still predict higher service use for people with anxious attachment over and above their level of symptoms. While we also found that anxious attachment was related to higher service costs, this was not

maintained after controlling for symptoms. However, service costs will rise exponentially with higher service use and this association may prove significance within a larger sample. These results are not surprising when couched within attachment theory, as anxiously attached people tend to seek reassurance and be over-reliant on others to meet their needs (Bowlby, 1977a). Within mental health services this interpersonal style is likely to influence relationships between staff and clients, with anxious people requesting and needing more, and multiple, service input than people who are more securely attached.

Our finding that avoidant attachment was also related to higher service use, contrasts with Ciechanowski et al's (2002) findings, which reported that people with avoidant attachment were consistently lower symptom reporters and users of general health services. This interesting result might be associated with the different samples. It is possible that in primary care settings, people with avoidant attachment can manage by simply not using services, however when they have severe and enduring mental health problems, their avoidant defences might not function as well. Previous research has found that avoidant attachment is associated with problems in therapeutic relationships (Berry et al., 2008), but other authors have reported from clinical examples that beneath the seeming self-reliance of avoidant people is a deep need to be looked after (Holmes, 2001). This could potentially manifest within services in a number of ways; people with avoidant attachment might appear to need low levels of support, and indeed express that directly to staff, however they may then re-present to services frequently in crisis because they have not addressed their true support needs. Equally, avoidant people might initially seem to require only short-term

interventions but then make little progress therapeutically, or in terms of their ability to function independently, and end up requiring long-term, low-level support; indeed, this scenario is familiar within mental health services where many clients can seem 'stuck'. Our findings raise important implications for community mental health services, in terms of commissioning arrangements, workforce planning and service organisation, and has particular relevance for NHS mental health services given the current need to save money (Department of Health, 2011). The incorporation of attachment theory concepts in community mental health services may help to reduce service costs over time and might be a useful addition to consider in service commissioning (Bennett et al., 2011).

In terms of implications for the design, delivery and organisation of services, the review of the literature found that most attachment theorists agree that an attachment perspective should be pervasive throughout the whole treatment environment, with all staff understanding, subscribing to and enacting an attachment-informed approach with service users (Berry & Drake, 2010; Goodwin et al., 2003; Moore, Moretti, & Holland, 1998; Rich, 2006a; Schuengel & van Ijzendoorn, 2001; Seager, 2006; in press). Seager (2006) has much to say on the importance of creating a suitable service framework that allows the incorporation of ideas from attachment theory. He suggests that service culture and policy should be influenced and that this needed to evolve at national policy level to allow services the freedom to make decisions at a local level. Mental health services could be reconceptualised as a professional family, in ways that allow staff to 're-parent' service users with insecure attachment patterns (Seager, in press), and this approach could influence referral

systems by conceptualising the referring agent and the receiving service as a parental system working together to meet the needs of the service user.

Attachment theory could also influence models of mental health service delivery, in terms of offering flexible treatment options. Seager (2006) suggested briefer sessions, telephone contacts, written contacts and therapy 'on-demand', rather than structured doses of therapy sessions that seem more reflective of a medical model. Moore and colleagues (1998) similiarly recommended giving staff the freedom to modify the structure of treatment programmes. Their research described the real-life impact of adopting an attachment-informed model in their service and reported several cost benefits, including increased capacity for referrals and reductions in staffing and training costs, staff absenteeism, staff injury, staff turnover, and a reduction in violence (Moore et al., 1998). In conjunction with the results from the present study, these findings provide further evidence that by considering attachment in service delivery, mental health services may be able to reduce service costs and contribute towards efficiency savings over time.

Implications of study findings for practice

Equally important findings in this study support arguments that insecure attachment can explain differences in levels of psychopathology (Belsky & Nezworski, 1988); insecure attachment is hypothesised to increase vulnerability to psychopathology and lead to worse outcomes following the onset of psychological difficulties. Consistent with previous research, we found that anxious attachment is related to clinically significant differences in the experience of symptoms and distress (Berry et al., 2008;

Blackburn et al., 2010) and functioning (Berry et al., 2008) in clients with severe and enduring mental health problems. We also found that anxious attachment was associated with lower well-being in a severe and enduring mental health sample, which expands on similar findings with a non-clinical population (Moore & Leung, 2002). Importantly, we found that anxious attachment was related to higher risk in people with severe mental health problems in a community setting, which mirrors findings of increased health risk behaviours for anxiously attached people in a primary care setting (Ahrens et al., 2012). The risk items we used in the analysis for our study have been shown to be distinct from other clinical domains (Evans, 2003) which suggest a real finding that can explain differences in potentially risky behaviour in community mental health clients. Attachment anxiety is hypothesised to create lower thresholds for managing stress and interpersonal problem-solving, which can manifest in behaviours such as deliberate self-harm, suicidal ideation and somatisation, to elicit care from others (Bowlby, 1977a). Within mental health services, anxiously attached people may be more prone to communicate distress and act out in ways that require crisis intervention. Our findings indicate that such communications should be taken seriously however, as they may be more at risk of following through on threats. In view of the priority that all mental health services assign to reducing deliberate self-harm and suicide ideation, attachment theory may help to focus service response, which may in turn free up valuable resources to where they are most needed.

For people with avoidant attachment, we found lower reported levels of interpersonal functioning, but no significant associations with other clinical domains (symptoms, risk and well-being). The association with poorer functioning is consistent with other

research from severe and enduring mental health populations (Berry et al., 2008) and also bears out central tenets about avoidant patterns in attachment theory. The theory explains that avoidant attachment is associated with unconscious needs for love and support which are disclaimed and dismissed, to avoid being rejected and/or becoming reliant or relied upon by others. Yet people with attachment avoidance cannot maintain these defences indefinitely and may eventually crack under pressure, developing psychiatric problems (Bowlby, 1977a). In terms of how this might manifest within services, people with avoidant attachment may need to be more proactively engaged by services. Although they are likely to communicate their ability to self-manage and indeed, may appear to need minimum support, they may deteriorate quickly if personal circumstances change, requiring increased service input. If staff are aware of someone's attachment pattern they may be able to identify potential triggers in advance and monitor their situation more effectively.

The clinical implications of these findings support arguments that highlight the importance of services assessing and considering clients' attachment issues in their support plans (Berry & Drake, 2010; Goodwin, 2003; Seager, 2007) as it may help to explain individual differences in people's response to illness, engagement and treatment success. The review of the literature comprehensively described how services might work better with people with insecure attachments by adopting elements of the secure caregivers role (Bowlby, 1977a), which can map onto all areas of standard service provision.

Attachment theory describes the central role of a secure caregiver in facilitating secure attachments, which are to provide a secure base from which safe exploration can develop, to be available and flexible, to be sensitive and responsive to emotional distress and to intervene judiciously when needed (Bowlby, 1969). When applied within mental health service settings, these functions can create a more individual and personalised way of responding to the different attachment needs of clients. Assessing attachments in new clients can elicit transgenerational attachment patterns (Moore et al., 1998), which can provide useful information about how they are likely to relate to staff and other clients (Adshead, 2002). Seager (2006) suggested that services develop an assessment protocol with appropriate measures for assessing attachment that measure the accessibility of each client's attachment objects.

Understanding someone's attachment style can then help to inform their formulation, particuarly in understanding the psychological function of challenging behaviour (Adshead, 1998; 2002; Berry & Drake, 2010; ; Rich, 2006a, 2006b), and risky behaviour (Adshead, 1998; 2002; Moore et al., 1998; Seager, in press). Adshead (1998) discussed how deliberate self-harm, suicide, aggression and violence can be understood as attachment behaviours that are triggered by threats to attachment relationships, such as the loss of an attachment figure like a key nurse, or the threat of discharge (Seager, in press). Adshead (1998; 2002) and Moore and colleagues (1998) described it well, asserting that all behaviour has meaning and having an insight into a person's internal working models can provide useful information about the psychological function of their behaviour.

In terms of services intervening with clients in a more attachment-informed way, attachment theory describes the importance of providing a secure base through consistent, available and flexible staff-client relationships, providing appropriately sensitive responses to distress, and corrective emotional experiences. Most of the authors identified in the literature review discussed the importance of establishing a secure base as an initial requirement of intervening successfully with clients (Adshead, 1998; 2002; Adshead et al., 2005; Barber et al., 2006; Berry & Drake, 2010; Goodwin et al., 2003; Moore et al., 1998; Rich, 2006a; Schuengel & van Ijzendoorn, 2001). Within mental health services this has been conceptualised as a feeling of physical safety, in terms of ward environments and/or atmosphere (Adshead, 1998), or as intrapsychic/psychological safety, through a sense of belonging with a team or service (Adshead, 2002; Moore et al., 1998). The development of meaningful relationships with staff is a key factor in improving people's attachment styles (Seager, 2006) and Berry and Drake (2010) recommend that staff should be encouraged to engage in one-to-one activities with clients to facilitate the development of staff-client relationships.

Once a secure base is established with a primary attachment figure, that attachment figure then has to be available consistently over time (Bowlby, 1977a). Within mental health services this is akin to providing continuity of care, through building a consistent relationship between the same staff member and client (Adshead, 1998; Berry & Drake, 2010; Schuengel & van Ijzendoorn, 2001; Seager, 2011; in press). In light of the reported impact that the recent service reorganisation had had in this sample (Department of Health, 2009), it is useful to consider this in terms of attachment theory. Authors have discussed how policy decisions in services can result in ruptures

of attachment and containment (Adshead, 2001; Seager, 2006). It is crucial to maintain stability of staff to ensure continuity of care (Schuengel & van Ijzendoorn, 2001), by reducing staff movement (Seager, 2006) and avoiding unnecessary reorganisation (Berry & Drake, 2010). Equally, it is vital to monitor separations and losses for the client and avoid abrupt terminations of therapy and/or service support (Adshead, 2002; Seager, 2006).

A caregiver needs to be sensitive and responsive to distress and many authors emphasised the importance of staff's ability to provide this with their clients (Seager, in press), through using good professional listening, emotional containment, and showing care and concern (Goodwin et al., 2003). Seager (in press) suggested that staff could adapt their therapeutic style to the client's attachment style to facilitate attunement, which has been described by Holmes (2010) as an affect-regulatory process that modifies or regulates the clients' emotions through reflection.

The final component in developing more secure attachments is through providing corrective emotional experiences that challenge and modify people's existing internal working models (Rich, 2006b; Schuengel & van Ijzendoorn, 2001), and within the context of mental health services this can be achieved by providing new opportunities for success and self-efficacy, and by changing the client's negative perceptions of others (Adshead, 1998; Moore et al., 1998). It is important to show confidence in clients and to recognise their worth and value (Rich, 2006a); however, while staff should provide reassurance to their clients, they also need to encourage them to gain

independence, explore their environment and take risks (Berry & Drake, 2010). Furthermore, staff should be supported to view conflict with a client as an opportunity because it means that some aspect of the client's internal working model is activated and available for investigation (Moore et al., 1998).

It is crucial for services to acknowledge the impact of clients' insecure attachment patterns on staff and provide them with appropriate support in working within an attachment framework (Barber et al., 2006). This can be achieved using staff training, supervision and consultation (Adshead 2001; Adshead et al., 2005; Berry & Drake, 2010; Moore et al., 1998; Seager, in press), and staff group reflective practice (Barber et al., 2006; Berry & Drake, 2010). Supervision and training can focus on understanding clients' attachment styles and needs, understanding attachment behaviours and maintaining boundaries (Schuengel & van Ijzendoorn, 2001), and becoming more effective caregivers (Berry & Drake, 2010). More managerial and financial support for staff has also been suggested (Adshead, 1998) as the lack of either can reduce service capacity to respond sensitively and appropriately to clients' needs. Clinicians need good quality attachments to skilled supervisors and supportive managers, with access to a reflective space (Seager, 2006). Staff should also be aware of their own attachment style, as differences between staff can provoke disagreements about how best to manage difficult behaviours in clients (Adshead 1998, 2002; Berry & Drake, 2010). Adshead (2002) discussed the importance of avoiding these splits within teams and recommended utilising support mechanisms for staff previously described.

Implications of study findings for research

The present study did not find support for the relevance of service attachment in community mental health services to service utilisation, costs or psychopathology. Although younger people reported a greater service attachment, so did participants from Early Intervention Teams, and given that these associations were inter-related they did not provide any meaningful explanations of the factors that contribute to people's attachment to services. However, participants in this study reported lower overall attachments to their community mental health team than has been previously reported within inpatient and psychiatric rehabilitation services. Whether this finding is due to real fundamental differences in mental health service delivery models is unclear and, given the lack of literature and peer-reviewed evidence of applying attachment theory in community mental health services, further research is needed to investigate the importance of individual and service attachment in these settings. Alternative recruitment procedures should ideally be adopted too so that a larger and more representative sample can be drawn, to better inform the analysis and provide the study with more power to detect significant associations.

Future research could employ alternative methodologies to clarify longitudinal links between factors: for example, a prospective cohort study could provide more information about causal relationships between insecure attachment and psychopathology, service use and costs. It may also be beneficial to utilise mixed methodologies that integrate subjective and objective information, from both qualitative and quantitative data. Future research would also benefit from using a

range of measures of psychopathology to see if our findings can be replicated; although our findings did suggest that there were differences between the CORE-OM subscales, as evidenced by differences reported for avoidant attachment, it would nevertheless aid the analysis of associates if future research employed a range of distinct measures.

For future research that looks at evaluating the economic impact of attachment in community mental health services, it might be useful to use a more standardised service receipt inventory to assess service costs. Equally, it is crucial to include separate costs for case management and CPA arrangements in community mental health services for a fuller picture of service costs in these settings. Future clinical research that looks at insecure attachment in community services might also benefit from collecting information on participants' diagnoses, with historical information about their length of time with the service and any changes and transitions in care arrangements. Future research that utilises a mixed methodology would facilitate integration of important retrospective and prospective data.

Summary and Conclusions

Attachment theory is important to consider in working with clients with severe and enduring mental health problems. Many such clients are now cared for long-term within community mental health teams and present significant challenges for staff and services. The present study found that people with insecure attachments will

experience more severe psychopathology and incur higher service use and service costs. There is a growing movement by researchers and theorists to incorporate concepts from attachment theory in the organisation, design and delivery of mental health services, and our findings suggest that this may have the potential to contribute to important efficiency savings in the NHS over time.

These results are timely, given the present changes regarding service commissioning, as GPCC will be responsible for the bulk of service commissioning in primary care and mental health, and the requirement for them to provide quality services that reduce service demand and costs is a priority. The current authors argue the importance of considering relationships between staff, teams and patients in mental health service models and hope that clinical leadership, via representation from psychological therapies, will be included in commissioning networks so that commissioning frameworks currently being developed for community mental health services will reflect this.

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Appendix A: Instructions for authors: Attachment and Human Development

Papers will be considered providing that they have not previously been published or submitted simultaneously elsewhere for publication.

EMPIRICAL REPORTS

1) The paper should conform to APA standards, with a legible abstract (100-150 words), followed by sections that include an introduction, method, results, and discussion.

THEORY/REVIEW PAPERS

2) The paper should make an original, testable and/or useful extension/revision to theory and previous literature concerning attachment processes and human development.

CLINICAL CASE-STUDIES

3) Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

ALL SUBMISSIONS should include an abstract, and ordinarily be about 6,000 words in length, not exceeding 7500 words in total, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.

E-mail submissions to the Editor are preferred; please send an electronic copy of your manuscript to steeleh@newschool.edu .

Style guidelines
Description of the Journal's article style , Quick guide
Description of the Journal's reference style , Quick guide
Any consistent spelling style is acceptable. Use double quotation marks with single within if needed.
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Appendix B: Author Guidelines: British Journal of Clinical Psychology

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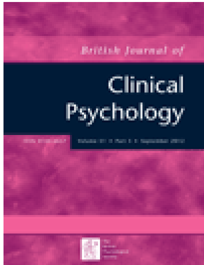

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Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing
All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements
• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.
• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.
• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
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• In normal circumstances, effect size should be incorporated.
• Authors are requested to avoid the use of sexist language.
• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments
These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000

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12. The Later Stages
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13. Early View
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Appendix C:

Table 1: Articles selected for literature review with summary of key themes

Reference	Client group	Focus of paper	Key Themes / Ideas
Adshead (1998)	Adult psychiatric inpatients	Clinical application with implications for services	Assessment and formulation; create secure base; availability and flexibility; sensitivity and responsiveness; provide corrective emotional experiences; support for staff; moving on.
Adshead (2001)	Adult inpatients (forensic)	Clinical application in mental health institutions	Assessment and formulation; availability and flexibility; support for staff.
Adshead (2002)	Adult inpatients (forensic)	Understanding management issues in forensic institutions	Assessment and formulation; create secure base; provide corrective emotional experiences; support for staff; moving on.
Adshead et al. (2005)	Adult high secure inpatients (forensic)	Planning discharge and transition	Create secure base; provide corrective emotional experiences; support for staff; moving on.
Barber et al. (2006)	Adult secure inpatients	Clinical application in secure mental health setting	Create secure base; support for staff; moving on.
Berry & Drake (2010)	Adult psychiatric rehabilitation	Theoretical paper with implications for practice	Service policy and evaluation; assessment and formulation; create secure base; availability and flexibility; support for staff; moving on.
Goodwin et al. (2003)	Adult mental health	Development of a service attachment measure	Service policy and evaluation; create secure base; availability and flexibility; sensitivity and responsiveness; moving on.
Moore et al. (1998)	Adolescents with challenging behaviour	Clinical application of attachment theory	Service policy and evaluation; assessment and formulation; create secure base; availability and flexibility; sensitivity and responsiveness; provide corrective emotional experiences; support for staff; support for carers; potential service benefits.

Rich (2006a)	Sexual offenders	Book: Application of attachment theory to treatment	Service policy and evaluation; assessment and formulation; create secure base; availability and flexibility; sensitivity and responsiveness; provide corrective emotional experiences.
Rich (2006b)	Forensic mental health	Application of attachment theory to clinical practice	Assessment and formulation; availability and flexibility; sensitivity and responsiveness; provide corrective emotional experiences.
Schuengel & van Ijzendoorn (2001)	Adult mental health institutions	Critical review of assumptions and implications	Service policy and evaluation; referrals; assessment and formulation; create secure base; availability and flexibility; provide corrective emotional experiences.
Seager (2006)	Adult mental health services	Theoretical paper: application of attachment theory to create psychological safety	Service policy and evaluation; referrals; availability and flexibility; moving on.
Seager (2011)	Adult outreach services for the homeless	Application of attachment theory in outreach work	Availability and flexibility
Seager (in press)	Adult mental health services	Book chapter: applying attachment theory to inform service delivery	Service policy and evaluation; assessment and formulation; availability and flexibility; sensitivity and responsiveness; provide corrective emotional experiences; support for staff; moving on.

Appendix D: Service Attachment Questionnaire (SAQ)

Below is a list of 25 statements about mental health services and the experiences people might have whilst receiving them. Please read each item and then respond to each one by indicating how close the statement is to **your own experience and feelings about the service you are currently in contact with**.

	Not at all	Sometimes	Quite Often	Always
1.I have somebody who listens attentatively to me	0	1	2	3
2.I have regular time with the same person that knows me and my problems	0	1	2	3
3.I feel under pressure to get better and be discharged	3	2	1	0
4.I have a feeling of being looked after	0	1	2	3
5. I have the feeling that I'll be accepted for who I am, whatever I say	0	1	2	3
6. I'm helped to realise that it's not just me - other people have similar problems	0	1	2	3
7. I don't feel listened to, or taken notice of	3	2	1	0
8. I get frustrated because I have to wait too long to see my key worker / therapist	3	2	1	0
9. I feel confident that support will be provided when I am discharged	0	1	2	3
10. I feel suffocated by the service rather than feeling safe	3	2	1	0
11. I can't relate to / get on with certain people in the service	3	2	1	0
12. It feels like there's a 'them and us' attitude from the staff	3	2	1	0
13. I feel that people in the service understand my needs and problems	0	1	2	3
14. I know that the same person is there for me consistently	0	1	2	3
15. I worry that I won't be better within the allocated time and will need longer	3	2	1	0
16. I feel safe within the service	0	1	2	3
17. I don't feel judged, just accepted	0	1	2	3
18. I feel patronized and stigmatized by the service	3	2	1	0
19. I don't feel that people really want to listen to what my problems are	3	2	1	0

	Not at all	Sometimes	Quite Often	Always
20. I worry that I'll be discharged without any follow-up from my key worker / therapist	3	2	1	0
21. I feel confident that if I need more time and help, over longer, that it will be given	0	1	2	3
22. I feel frustrated at my lack of freedom within the service	3	2	1	0
23. I feel I have a partnership with my key worker / therapist and that we work together	0	1	2	3
24. I have the feeling my key worker / therapist is really interested in me and wants to help	0	1	2	3
25. I am made to feel that I am a burden to the service and outstaying my welcome	3	2	1	0

Subscale 1: Being attended to (LISTENING)

1		7	13	19	Total:

Subscale 2: Being there – consistency and continuity (CONSISTENCY)

2		8	14	20	Total:

Subscale 3: Being given enough time – ending and leaving (ENDING)

3	9	15	21	25	Total:

Subscale 4: Safe environment (SAFETY)

4		10	16	22	Total:

Subscale 5: Relationships which enable helpful talking (TALKING)

5		11	17	23	Total:

Subscale 6: Human contact and comfort (COMFORT)

6		12	18	24	Total:

TOTAL:

Appendix E: Psychosis Attachment Measure (PAM)

We all differ in how we relate to other people. This questionnaire lists different thoughts, feelings and ways of behaving in relationships with others.

PART A

Thinking generally about how you relate to other key people in your life, please use a tick to show how much each statement is like you. Key people could include family members, friends, partner or mental health workers. There are no right or wrong answers.

	Not at all	A little	Quite a bit	Very much
1. I prefer not to let other people know my 'true' thoughts and feelings.	(..)	(..)	(..)	(..)
2. I find it easy to depend on other people for support with problems or difficult situations.	(..)	(..)	(..)	(..)
3. I tend to get upset, anxious or angry if other people are not there when I need them.	(..)	(..)	(..)	(..)
4. I usually discuss my problems and concerns with other people.	(..)	(..)	(..)	(..)
5. I worry that key people in my life won't be around in the future.	(..)	(..)	(..)	(..)
6. I ask other people to reassure me that they care about me.	(..)	(..)	(..)	(..)
7. If other people disapprove of something I do, I get very upset.	(..)	(..)	(..)	(..)
8. I find it difficult to accept help from other people when I have problems or difficulties.	(..)	(..)	(..)	(..)
9. It helps to turn to other people when I'm stressed.	(..)	(..)	(..)	(..)

	Not at all	A little	Quite a bit	Very much
10. I worry that if other people get to know me better, they won't like me.	(..)	(..)	(..)	(..)
11. When I'm feeling stressed, I prefer being on my own to being in the company of other people.	(..)	(..)	(..)	(..)
12. I worry a lot about my relationships with other people.	(..)	(..)	(..)	(..)
13. I try to cope with stressful situations on my own.	(..)	(..)	(..)	(..)
14. I worry that if I displease other people, they won't want to know me anymore.	(..)	(..)	(..)	(..)
15. I worry about having to cope with problems and difficult situations on my own.	(..)	(..)	(..)	(..)
16. I feel uncomfortable when other people want to get to know me better.	(..)	(..)	(..)	(..)

PART B

In answering the previous questions, what relationships were you thinking about?

____

(E.g. relationship with mother, father, sister, brother, husband, wife, friend, romantic partner, mental health workers etc)

Appendix F: EuroQol Questionnaire (EQ-5D)

ID Number:____ DOB______ Observation Period/Date______

By placing a tick in one box in each group below, please indicate which statement best describes your own health state today. Do not tick more than one box in each group.

Mobility

I have no problems walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

Self-care

I have no problems with self-care ☐

I have some problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

Usual activities (e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

Pain/Discomfort

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

Anxiety/Depression

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

Evaluation of own health

On a scale of 0-100, how good is your health today, where the worst state you can imagine is zero and the best state you can imagine is 100

It will help us to understand your answers better if you complete the following questions:

1. What is your age in years?

2. Are you: **Male** ☐ **Female** ☐

3. Are you:

a current smoker ☐

an ex-smoker ☐

a never smoker ☐

4. Which of the following best describes your main activity?

In employment or self employment	☐
Retired	☐
Housework	☐
Student	☐
Seeking work	☐
Other (please specify)	☐

	Yes	No
5. Did your education continue after the minimum school leaving age?	☐	☐

	Yes	No
6. Did you have a degree or equivalent professional qualification?	☐	☐

7. If you know your post code would you please write it here: ☐

Appendix G: European Patient Questionnaire (EPQ) V1: 04/01/11

Section A: SERVICE RECEIPT

1. Have you used any of these **inpatient hospital services** *during the last 3 months?*
Note 1: please enter '0' if service has not been used;
Note 2: where information CANNOT be determined, please enter 9999

Type of Inpatient Service (During last 3 months)	**Name of Hospital**	**Total number of admissions**	**Total number of inpatient days**
Acute psychiatric ward			
Psychiatric rehabilitation ward			
Long-stay psychiatric ward			
Emergency / crisis centre			
General medical ward			
Alcohol treatment ward			
Drug treatment ward			
Other *(specify)*			

2. Have you used any **hospital outpatient or day services** *during the last 3 months?*
Note 1: please enter '0' if service has not been used;
Note 2: where information CANNOT be determined, please enter 9999

Type of Outpatient Visit (during last 3 months)	**Name of Service**	**Total number of outpatient visits made**	**Total number of day attendances**
Psychiatric			
Hospital alcohol service			
Hospital substance use service			
Non-psychiatric *(specify)*			
Accident and Emergency			
Day hospital			
Other (please specify)			

3. Have you had any **other primary and community-care contacts** *during the last 3 months?*

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Do not use psychologist as a prompt and do not ask any additional questions if the client reports using a psychologist.*

Note 1: please enter '0' if service has not been used;
Note 2: where information CANNOT be determined, please enter 9999

Type of Contact	**Total number of contacts** (during last 3 months)	**Average time per contact** (hours)
GP, surgery visit		
GP, home visit		
Psychiatrist		
Psychologist		
Alcohol treatment or rehabilitation service		
Drug treatment or rehabilitation service		
District nurse		
Community psychiatric nurse / case manager		
Social worker		
Occupational therapist		
Voluntary counsellor		
Home help / care worker		
Other *(specify)*		
Other *(specify)*		

Section B: EXTRA COSTS

1. *During the last 3 months*, how much do you think you have spent on:
Note 1: please enter '0' if service has not been used;
Note 2: where information CANNOT be determined, please enter 9999

Description of Item	**Amount spent** (during last 3 months, £)
Prescribed, and over-the-counter, medications	☐ ☐ ☐ ☐
Travel costs *(e.g., parking fees to attend any hospital, GP or day-care appointments)*	☐ ☐ ☐ ☐
Private health care (include use of alternative therapies and practitioners)	☐ ☐ ☐ ☐

2. *During the last 3 months*, are there any other MAJOR (£50+) one-off expenses that you have had to meet? ☐
(No = 1, Yes = 2, Don't know = 9)

3 ***If Yes,*** please complete table below.

Item No.	*Description of Item*	**Amount spent** (during last 3 months, £)	**Incurred due to mental health problems?** *(No = 1, Yes = 2, Don't know = 9)*
1		☐ ☐ ☐ ☐	☐
2		☐ ☐ ☐ ☐	☐
3		☐ ☐ ☐ ☐	☐
4		☐ ☐ ☐ ☐	☐

Section C: YOUR EMPLOYMENT

C1. How you have been employed in the **last 3 months**?

*Please code the clients responses on the following list, **BUT DO NOT** read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

If participant does not report any paid employment or self employment go to C2.
If participant does report paid employment, go to C4.

Employment Status	(i)	Number of weeks spent in each category in the **last 3 months** (ii)	Tick one category that best describes your employment **now** (iii.)
a. Employee, full time (more than 30 hours/week)	Yes ☐ 1 No ☐ 2	☐☐	☐ 1
b. Employee, part time (less than 30 hours/week)	Yes ☐ 1 No ☐ 2	☐☐	☐ 2
c. Self-employed (paid work)	Yes ☐ 1 No ☐ 2	☐☐	☐ 3
d. Government-supported employment training	Yes ☐ 1 No ☐ 2	☐☐	☐ 4
e. Non government supported employment training or education	Yes ☐ 1 No ☐ 2	☐☐	☐ 5
f. Employee on sick leave because of mental health problems	Yes ☐ 1 No ☐ 2	☐☐	☐ 6
g. Employee on sick leave because of other health reasons	Yes ☐ 1 No ☐ 2	☐☐	☐ 7
h. Not in paid employment because of mental health problems	Yes ☐ 1 No ☐ 2	☐☐	☐ 8
i. Not in paid employment due to retirement	Yes ☐ 1 No ☐ 2	☐☐	☐ 9
j. Not in paid employment for other reasons	Yes ☐ 1 No ☐ 2	☐☐	☐ 10
k. Unpaid employment for a business owned by self, friend or relative	Yes ☐ 1 No ☐ 2	☐☐	☐ 10

Section C: YOUR EMPLOYMENT

C2. In the last 3 months, did you have a job or business you were away from?
If yes, go to C3.
If no go to C7

Yes ☐ 1

No ☐ 2

C3. If yes, why were you away from work?

Reason away from employment or business in the last 3 months	Tick one category that best describes the reason you were away
a. Holiday	☐ 1
b. Sickness	☐ 2
c. Studying/training	☐ 3
d. Maternity/paternity leave	☐ 4
e. Other (please specify)	☐ 5

C4. Please give details of all paid jobs or business you have had in the last 3 months

Type of paid job or business in the last 3 months	Hours per week	Wage after all deductions paid	Was this wage per week or per month
a.			Week ☐ 1 Month ☐ 2
b.			Week ☐ 1 Month ☐ 2
c.			Week ☐ 1 Month ☐ 2
d.			Week ☐ 1 Month ☐ 2
e.			Week ☐ 1 Month ☐ 2

Section C: YOUR EMPLOYMENT

C5. What was your main job in the last 3 months or most recent period of paid work?

C6. What do/did you mainly do in your main job? (check whether any special qualifications, managerial duties etc). Now go to C9.

C7. Have you ever had a paid job?
If yes go to C8.
If no, go to C11.

Yes ☐ 1
No ☐ 2

C8. When did you leave your last paid job? Now go to C11

C9. Have you lost any earnings **during the last 3 months** because of your mental health problems?
If yes go to C10.
If no go to C11

Yes ☐ 1
No ☐ 2

C10. If **YES**, please estimate the amount lost over the last 3 months because of your mental health problems?

£ ☐☐☐☐.☐☐

C11. Over the last 3 months do you think that your employment and/or potential employment opportunities have been affected by your mental health problems?
If yes, go to C12.
If no, go to C13

Yes ☐ 1
No ☐ 2

Section C: YOUR EMPLOYMENT

C12. Thinking about your career and your job, have you experienced any changes in the **last 3 months** because of your mental health problems?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

		(i)	**Tick one category that best describes your employment now** (ii.)
i.	Lost job and became unemployed	Yes ☐ 1 No ☐ 2	☐ 1
ii.	Had difficulty getting a job	Yes ☐ 1 No ☐ 2	☐ 2
iii.	Changed type of work (e.g. lower paid job, but not change in hours worked.)	Yes ☐ 1 No ☐ 2	☐ 3
iv.	Changed hours worked	Yes ☐ 1 No ☐ 2	☐ 4
v.	Promotion prospects/career development restricted	Yes ☐ 1 No ☐ 2	☐ 5
vi	Opportunities for changing job reduced	Yes ☐ 1 No ☐ 2	☐ 6
vii.	Opportunities for overtime reduced	Yes ☐ 1 No ☐ 2	☐ 7
viii	Distance can travel reduced	Yes ☐ 1 No ☐ 2	☐ 8
ix.	Attendance reduced	Yes ☐ 1 No ☐ 2	☐ 9
x.	Other (please describe)	Yes ☐ 1 No ☐ 2	☐ 10

C13. In the last 3 months have you been looking for any kind of paid work or government training schemes?
If yes, go to C14.
If no, go to C16

Yes ☐ 1

No ☐ 2

Section C: YOUR EMPLOYMENT

C14. In the last 3 months, did you do anything to find a new job or government training scheme?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Job seeking activities in the last 3 months	Tick all categories that apply
a. Visited a Jobcentre/Jobmarket or Training and Employment Agency Office?	☐ 1
b. Visited a Jobclub?	☐ 2
c. Had your name on the books of an employment agency?	☐ 3
d. Advertised for jobs in newspapers, etc?	☐ 4
e. Looked for advertisements in newspapers, etc?	☐ 5
f. Answered advertisements in newspapers, etc?	☐ 6
g. Applied directly to employers?	☐ 7
h. Asked friends, relatives, colleagues or trade unions about jobs?	☐ 8
i. Waited for the results of a job application?	☐ 9
j. Been to an interview?	☐ 10
k. Done anything else to find work? Please state.	☐ 11
l. Other (please specify)	☐ 12

C15 How much time have you spent looking for a new job?

If “yes” to C14 and C15, go to C17.
If “no” to C14 and C15, go to C16.

Section C: YOUR EMPLOYMENT

C16 What was the main reason you did not look for work in the last 3 months?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Main reason for not seeking a new job in the last 3 months	Tick one category that best describes why not sought new job in the last 3 months
a. Happy with current job	☐ 1
b. Waiting for the results of a job application/being assessed by training agent	☐ 2
c. Student	☐ 3
d. Looking after the family home	☐ 4
e. Temporarily sick or injured	☐ 5
f. Long-term sick or disabled	☐ 6
g. Believe no jobs available	☐ 7
h. Not yet started looking	☐ 8
i. Other (please specify)	☐ 9
j. Other (please specify)	☐ 12

C17. Do you currently receive any state benefits in your own right or on behalf of anyone in your household?
If yes go to C18.
If no, go to Section D

Yes ☐ 1

No ☐ 2

C.18. On average how many hours per week have you spent in the last 3 months on the following?

	Average number of hours per week
a. Doing paid work (employed or self employed)	☐
b. Looking for work	☐

Section C: YOUR EMPLOYMENT

C19. Which benefits do you receive?

*Please code the clients responses on the following list, **BUT DO NOT** read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Benefits currently receiving	Tick all benefits that apply
a. Child Benefit	☐ 1
b. Guardian's Allowance	☐ 2
c. Invalid Care Allowance	☐ 3
d. Pension (of any kind, i.e. retirement, widow's, etc)	☐ 4
e. Severe Disability Allowance	☐ 5
f. Disability Working Allowance	☐ 6
g. Job Seekers' Allowance	☐ 7
h. Income Support	☐ 8
i. Incapacity Benefit	☐ 9
j. Statutory sick pay	☐ 10
k. Industrial Injury Disablement Benefit	☐ 11
l. Maternity Allowance	☐ 12
m. Working Families' Tax Credit	☐ 13
n. Disabled Persons' Tax Credit	☐ 14
o. Disability Living Allowance	☐ 15

Section D: YOUR EDUCATION

D1. Do you have any qualifications from school, college or university, connected with work or from government schemes?
If yes go to D2.
If no, go to D4

Yes ☐ 1
No ☐ 2

D2. Which qualifications do you have, starting with the highest qualification?

D3. When did you last study for any qualifications?

D4. Are you studying for any qualifications at the moment?
If yes go to D5.
If no, go to D6.

Yes ☐ 1
No ☐ 2

Section D: YOUR EDUCATION

D5. What qualifications are you studying for at the moment?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Qualifications currently studying for	Tick all that apply	Are you studying full time or part time
a. Degree level (graduate membership of a professional institute, PGCE, undergraduate and postgraduate)	☐1	F/T ☐1 P/T ☐2
b. Diploma in higher education	☐2	F/T ☐1 P/T ☐2
c. HNC/HND	☐3	F/T ☐1 P/T ☐2
d. ONC/OND	☐4	F/T ☐1 P/T ☐2
e. BTEC, BEC or TEC	☐5	F/T ☐1 P/T ☐2
f. SCOTVEC, SCOTEC or SCOTBEC	☐6	F/T ☐1 P/T ☐2
g. Teaching qualification excluding PGCE	☐7	F/T ☐1 P/T ☐2
h. Nursing/other medical qualification not yet mentioned?	☐8	F/T ☐1 P/T ☐2
i. Other higher education qualification below degree level	☐9	F/T ☐1 P/T ☐2
j. A-level or equivalent	☐10	F/T ☐1 P/T ☐2
k. SCE highers	☐11	F/T ☐1 P/T ☐2
l. NVQ/SVQ	☐12	F/T ☐1 P/T ☐2
m. GNVQ/GSVQ	☐13	F/T ☐1 P/T ☐2
n. AS-level	☐14	F/T ☐1 P/T ☐2
o. Certificate of sixth year studies (CSYS) or equivalent	☐15	F/T ☐1 P/T ☐2
p. O-Level or equivalent	☐16	F/T ☐1 P/T ☐2
q. SCE Standard or Ordinary (O) grade	☐17	F/T ☐1 P/T ☐2
r. GCSE	☐18	F/T ☐1 P/T ☐2
s. CSE	☐19	F/T ☐1 P/T ☐2
t. RSA	☐20	F/T ☐1 P/T ☐2
u. City and Guilds	☐21	F/T ☐1 P/T ☐2
v. YT certificate/YTP	☐22	F/T ☐1 P/T ☐2
w. Other professional, vocational or foreign qualification	☐23	F/T ☐1 P/T ☐2

x. Don't know	☐24	F/T ☐1 P/T ☐2

D6. In the last 3 months, have you been on any taught courses or undertaken other types of structured learning?
If yes go to D7.
If no, go to D8.

Yes ☐1

No ☐2

D7. What courses/other types of learning have you done in the last 3 months?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Taught course or other learning in the last 3 months	Tick all that apply	Number of courses
a. Taught courses meant to lead to qualifications (even if you did not obtain them)	☐1	
b. Taught courses designed to help you develop skills that you might use in a job	☐2	
c. Courses or instruction or tuition in driving, in playing a musical instrument, in an art or craft, in a sport or in any practical skill	☐3	
d. Evening classes	☐4	
e. Learning which involved working on your own from a package of materials provided	☐5	

D8. In the last 3 months, have you studied or received any other type of training
If yes go to D9.
If no, go to D14.

Yes ☐1

No ☐2

Section D: YOUR EDUCATION

D9. Which of the following types of learning have you been involved in over the last 3 months?
If yes to any of D9 go to D10.
If no go to D11.

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Other types of learning in the last 3 months	Tick all that apply
a. Studied for a qualification without taking part in a taught course	☐1
b. Received supervised training while you were actually doing a job	☐2
c. Spent time keeping up-to-date with developments in the type of work you do without taking part in a taught course (e.g. by reading books, manuals journals, or attending seminars)	☐3
d. Spent time deliberately trying to improve your knowledge about anything or teach yourself a new skill without taking part in a taught course	☐4

D10. Please give details of any other types of learning you have been involved in over the last 3 months (e.g. what, number of occasions in last month, length of time, etc)

If the participant is currently studying for a qualification, has had taught courses or been involved in any other form of learning (ie answered yes to any of D4, D6 or D8) go to D11.

If the participant is not currently studying or involved in taught courses or other forms of learning go to D14

D11. On average how many hours per week have you spent on taught courses or other forms of learning in the last 3 months?

Section D: YOUR EDUCATION

D12. On how many occasions in the last 3 months did you spend time studying at home outside of teaching sessions?

D13. During the last 3 months, how long did you study for the last time you did any? How long on average do you normally study for?

D14. Thinking of the last 3 months, have you been looking for any kind of education/course?
If yes go to D15
If no, go to Section E

Yes ☐ 1
No ☐ 2

D15. Please give details of any education or course you have been looking for or considering (eg what, how much time, etc)

Section E: OTHER ACTIVITIES

Voluntary work is work that people may do for which they are not paid, except perhaps for expenses.

E1. Have you done any voluntary work through a group or on behalf of an organisation at any time during the last 3 months?
If yes go to E2.
If no, go to E5

Yes ☐ 1
No ☐ 2

E2. What types of voluntary work have you done in the last 3 months

E3. How many different times did you do this work during the last 3 months?

E4. How many hours did you work for, the last time you did this? How many hours per week do you normally spend doing this?

Section E: OTHER ACTIVITIES

E5. What activities do you do in your spare time? Do not include sports or other physical activity, which we will talk about afterwards. For each activity could you please tell me whether you have done this in the last 3 months, how often and the amount of time you spend each time you do the activity?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts or examples. Please tick the appropriate box for each category reported.*

Activities you have done in the last 3 months	Tick all that apply	Number of times in last 3 months	Amount of time spent each time you do the activity
Been to a sports event as a spectator	☐1		
Been to cinema, film society or club	☐2		
Been to a play, musical, pantomime or the opera	☐3		
Been to a concert, gig or live music performance	☐4		
Been to the ballet or to a modern/contemporary dance performance	☐5		
Been to a museum or art gallery	☐6		
Been to an historic house, castle or other heritage site or building	☐7		
Been to a library	☐8		
Been out to eat or drink at a café, restaurant, pub or wine bar	☐9		
Been to a shopping centre, or mall, apart from regular shopping for food and household items	☐10		
Been to a car boot sale, antiques fair or craft market or similar apart from regular shopping for food and household items	☐11		
Been to a theme park, fairground, fair or carnival	☐12		
Been to a zoo, wildlife reserve, aquarium or farm park	☐13		
Been to some other place of entertainment (e.g. dance, club, bingo, casino)	☐14		
Been on any other outdoor trips (including going to places of natural beauty, picnics, going for a drive or going to the beach)	☐15		
Other (please state)	☐16		

Section E: OTHER ACTIVITIES

E6. What sports or other physical activities do you do in your spare time? For each activity could you please tell me whether you have done this in the last 3 months, how often and the amount of time you spend each time you do the activity?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Sports and physical activities you have done in the last 3 months	Tick all that apply	Number of times in last 3 months	Amount of time spent each time you do the activity
Swimming or diving	☐1		
Cycling	☐2		
Indoor or outdoor bowls	☐3		
Tenpin bowling	☐4		
Keep fit, aerobics, yoga, dance exercise	☐5		
Martial arts	☐6		
Weight training or weight lifting	☐7		
Gymnastics	☐8		
Snooker, pool or billiards	☐9		
Darts	☐10		
Rugby	☐11		
Football	☐12		
Gaelic sports	☐13		
Cricket	☐14		
Hockey	☐15		
Netball	☐16		
Tennis	☐17		
Badminton	☐18		
Squash	☐19		
Basketball	☐20		
Table tennis	☐21		
Track and field athletics	☐22		
Jogging, cross country, road running	☐23		
Angling/fishing	☐24		
Yachting or dinghy sailing	☐25		
Canoeing	☐26		
Windsurfing/board sailing	☐27		
Ice-skating	☐28		
Curling	☐29		
Golf	☐30		
Skiing	☐31		
Horse riding	☐32		
Climbing/mountaineering	☐33		
Motor sports	☐34		
Shooting	☐35		
Walking or hiking for 2 miles or more	☐36		

(recreationally)			
Volleyball	☐37		
Other (please state)	☐38		

E7. How much time do you spend socialising per week?

E8. On how many occasions in the last 3 months have you seen friends, either visiting them or receiving visitors?

E9. How much time did you tend to spend socialising on each occasion on average?

E10. How much time do you spend resting each day, i.e. taking time out and doing nothing (but not sleeping)? Average per day for last 3 months.

E11. How much time do you spend watching television or listening to the radio each day ? Average per day for last 3 months.

E12. Do you have any hobbies? If yes, what are they?

E13. How much time do you spend on hobbies each week (on average)?

E14. Are you responsible for the care of any children?
If yes go to E15.
If no, go to E17.

Yes ☐ 1

No ☐ 2

E15. How many? How old are they?

Section E: OTHER ACTIVITIES

E16. How much time do you spend doing things with your children?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Time spent with children	Tick all that apply	Number of times per week	Amount of time spent each time you do the activity
a. Physical care (e.g. feeding, dressing, washing)	☐1		
b. Supervision (inside and outside)	☐2		
c. Teaching children (e.g. helping with homework)	☐3		
d. Reading, playing and talking with children	☐4		
e. Accompanying child (e.g. to school, doctor, friend's house, etc)	☐5		
Other (please state)	☐6		

E17. How much time do you spend doing housework and chores per week?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Housework and chores	Tick all that apply	Number of times per week	Amount of time spent each time you do the activity
Food management and preparation	☐1		
Cleaning, dusting, vacuuming, washing dishes	☐2		
Food shopping	☐3		
Washing and ironing	☐4		
Gardening	☐5		
DIY and repairs	☐6		
Other (please state)	☐7		

Section E: OTHER ACTIVITIES

E18. How much time do you spend sleeping per day (on average)? This includes sleep at night time and naps during the day. Ask about good and bad days.

	Time spent asleep
Good days	
Bad days	

E19. Do you spend time doing any activities not already asked about? Get weekly average.

E20. Over the last 3 months do you think that your usual activities and/or potential activities have been affected by your mental health problems?

Yes ☐ 1

No ☐ 2

E21. **If Yes**, thinking about your usual activities, have you made any changes in the **last 3 months** because of your mental health problems?

Please code the clients responses on the following list, ***BUT DO NOT*** *read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

		(a)	Tick one category that best describes usual activities now (b)
i.	Changed to less demanding or less intensive activities	Yes ☐ 1 No ☐ 2	☐ 1
ii.	Changed to more demanding or more intensive activities	Yes ☐ 1 No ☐ 2	☐ 2
iii.	Spend less time on activities	Yes ☐ 1 No ☐ 2	☐ 3
iv.	Spend more time on activities	Yes ☐ 1 No ☐ 2	☐ 4
v.	Opportunities for taking on new activities decreased	Yes ☐ 1 No ☐ 2	☐ 5
vi	Opportunities for taking on new activities increased	Yes ☐ 1 No ☐ 2	☐ 6
vii.	Other *(specify)*	Yes ☐ 1 No ☐ 2	☐ 7

Section F: CRIMINAL JUSTICE SERVICE

F1. *During the last 6 months*, have you been in contact with the criminal justice services? ☐
(No = 1, Yes = 2, Don't know = 3)

If Yes, please complete questions 2 to 7

F2 How many contacts have you had *during the last 6 months with the following (Note: contact = interview or stay of some hours, but not overnight)*

With the police? Contacts ☐

With a probation officer? Contacts ☐

F3 How many nights have you spent in a police cell or prison *during the last 6 months*?

Nights ☐

F4 How many psychiatric assessments have you had whilst in custody *during the last 6 months?*

Assessments ☐

F5 How many (criminal or civil) court appearances have you had *during the last 6 months*?

Criminal courts ☐

Civil courts ☐

F6 *During the last 6 months*, have you been convicted for any offences ☐
(No = 1, Yes = 2, Don't know = 9)

If Yes, please complete question 7

F7 What offences have you been convicted of *during the last 6 months*
(No = 1, Yes = 2, Don't know = 9)

*Please code the clients responses on the following list, **BUT DO NOT** read it out to the participant. Items from the list can be used as prompts. Please tick the appropriate box for each category reported.*

Please see the notes on the next page for broad definitions of the categories.

Category of offence	**Convicted (No = 1, Yes = 2, Don't Know = 9)**	**Name of offence (as given by respondent)**
Homicide/manslaughter		
Serious assault leading to major injury		
Less serious assault leading to minor or no injury		
Sexual offences (ask to specify if appropriate)		
Robbery		
Burglary		
Theft and handling stolen goods		
Fraud and forgery		
Criminal damage		
Drug offences		
Other (please specify)		
Other (please specify)		
Other (please specify)		

INTERVIEWER COMMENTS

Before filing this questionnaire or proceeding on to the next interview, please complete the following section while your impressions of the patient's responses are still fresh in your memory.

1.	How long did the interview take?		Number of minutes
2.	How reliable or unreliable do you think the patient's responses were?	1	very reliable
		2	generally reliable
		3	generally unreliable
		4	very unreliable
3.	Any other comments?		

Definitions of categories of offence

1. Homicide/manslaughter
This includes offences of violence against a person that result in death and includes the following:

- Murder
- Manslaughter
- Infanticide
- Causing death by dangerous driving, careless driving while under the influence of drink or drugs, or by aggravated vehicle taking

2. Serious assault leading to major injury
This include offences of violence against a person that cause major injury and includes the following:

- Attempted murder
- Threat or conspiracy to murder
- Serious wounding or other act endangering life

3. Less serious assault leading to minor or no injury
This includes less serious offences of violence against a person or violence that causes minor injury or no injury and includes the following:

- Less serious wounding
- Possession of weapons
- Harassment
- Cruelty, neglect or abandonment of children
- Procurement of illegal abortion
- Concealment of birth
- Common assault with minor or no injury
- Assault on a constable

4. Robbery
This includes offences of theft and violence. When a robbery is committed there has to be both violence, or the threat of violence, and a theft. A typical example of robbery would be where someone is approached in the street, knocked to the ground and their

wallet or handbag is taken. It is also robbery to approach someone, threaten them with a knife or similar weapon and take their property. The legal definition of robbery is where **'a person steals and immediately before or at the time and in order to do so, uses force on any person or puts or seeks to put, any person in fear of being, then and there, subjected to force'**. Robbery can take many forms ranging from a street mugging as described above, to an armed robbery of a bank or a night security guard of a warehouse being tied up while its contents are stolen.

5. Burglary

Burglary is defined as an offence committed by any person who enters a building or part of a building, as a **trespasser** who either:

a) has the **intent** to **steal, inflict grievous bodily harm, rape,** or **commit criminal damage**.

b) or does **steal, attempt to steal, inflict grievous bodily harm, or attempt to commit grievous bodily harm.**

In its basic form, burglary is committed by a person going into a building, or a part of a building, where they are not welcome and either stealing or seriously assaulting someone. Burglary is also committed if someone attempts to do either of these.(see b) above). Burglary is also committed by a person who goes into a building, or part of a building, wanting to either steal something, seriously assault or rape someone, or cause unlawful damage, even if none of those things actually happen. (see a) above).

6. Theft and handling stolen goods

The legal definition of theft is **'the dishonest appropriation of property belonging to another with the intention of permanently depriving that person of it'**. Put simply this means, taking someone else's property intending that it will not be returned. There needs to be an element of dishonesty. This category includes theft of vehicles, theft by employees, theft of mail and electricity as well as theft of property from individuals and businesses.

7. Fraud and forgery

Fraud is defined as a deception deliberately practiced to secure unfair or unlawful gain, and forgery is defined as the act of creating a false document or modifying a real one so that it can be used as if it were the original. This category includes cheque and credit card fraud, forgery or use of false drug prescriptions and vehicle/driver document fraud.

8. Criminal damage

This category is defined as:

- damage to or destruction of property belonging to another person whether by intent or recklessness
- damage to or destruction of own property or property belonging to another person, and intending to endanger the life of another person or being reckless about endangering the life of another person.

The category of criminal damage includes:

- arson
- destruction or damage to dwellings
- destruction or damage to other buildings
- destruction or damage to vehicles
- destruction or damage to of other property

9. Drug offences

This category includes dealing, supplying or trafficking controlled drugs (classes A, b or C), possession of controlled drugs.

10. Other

Offences and convictions that do not appear to fit into one of the categories above should be recorded as other, and details of the offence recorded.

Appendix H: Patient Information Sheet

Greater Manchester West
Mental Health NHS Foundation Trust

The University of Manchester

Nicola Roberts
Trainee Clinical Psychologist
School of Psychological Sciences
2nd Floor, Zochonis Building
Brunswick Street
Manchester
M13 9PL

Tel: 0161 3060400

Mobile number:

Participant Information Sheet:

Exploring Patient Relationships with Services

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Ask us if there is anything that is not clear or you would like more information about. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

We are inviting you to take part in a study looking at exploring patient relationships with community-based mental health services. The study will look at factors that are associated with good relationships such as patient symptoms, how well you are able to carry out everyday activities, well-being and service use. This project is being

completed as part of a doctorate in clinical psychology and is funded by the University of Manchester.

Why have I been invited to take part?

We are approaching all clients who have been receiving care from community-based mental health services, for at least 3 months, to ask if they want to help us understand the effects of different types of relationships with mental health professionals and their teams on important patient outcomes. Your care co-ordinator has agreed for us to approach you.

What will I have to do if I take part?

We would like to recruit a total of 45 clients in community-based mental health services. If you decide to take part, you will be asked to take part in the following;

- Complete a set of questionnaires during an interview with the researcher about your activities, mental health, service use and your relationship with the service. The interview will take no longer than 1 hour in total and can be carried out in one go or over several meetings. We will try to make appointments at times which suit you. Interviews will take place in a private room in the service.

The researcher may need to look at your medical notes and records to get basic information about your diagnosis and treatment, and contact with services.

Will my taking part be kept confidential?

Information which is collected during the course of the study will be strictly confidential, although we do have a responsibility to inform the relevant authorities about any disclosures that may cause harm to yourself or others. If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and in accordance with in the Data Protection Act of 1998. Your name will not appear on any of the forms, we will give you a study number instead. With your permission, we would like to inform your GP and care co-ordinator if you agree to take part in the study. As you are under the care of a mental health NHS Trust, a copy of your consent form will be copied into your usual medical notes and this copy may be reviewed by the Trust Clinical Audit Department to confirm that you have given written informed consent. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What are the possible risks of taking part?

The assessments in the study are simple and unlikely to cause you any distress or harm. You do not have to answer any questions you do not want to. If you do feel distressed as a result of the interview you can contact the researcher at the University on 0161 306 0400. If you are feeling very distressed out of office hours, we suggest you speak to your care co-ordinator or another member of staff on-call.

Are there any possible benefits?

We cannot promise the study will help you but the information we get from this study

will help us develop ways of improving patient-service relationships, which we hope will ultimately lead to better outcomes for patients. The study is planned for 1 year and the findings will be fed back to interested participants at the end of this time period. You will not be identified in any report of the study.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason. Staff involved in your care will not be upset and your treatment will not be affected. If you take part but later change your mind, you can withdraw at any time from the study without affecting the standard of your care. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.

What do I do now?

A researcher from the study will contact you in a few days. She will go through the information sheet with you and answer any questions you have. We'd suggest this should take about 10 minutes. You can let her know if you are interested in taking part by calling 0161 306 0400.

What do I do of something goes wrong?

If you wish to make a complaint, you can contact a University Research Practice and Governance Coordinator.

Tel: 0161 2757583 or 0161 2758093

Email: research-governance@manchester.ac.uk

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Thank you very much for considering taking part in our research. Please discuss this information with your family, friends or mental health team if you wish.

Appendix I: Informed Consent Form

MANCHESTER 1824

The University of Manchester

Greater Manchester West
Mental Health NHS Foundation Trust

Nicola Roberts
Trainee Clinical Psychologist
School of Psychological Sciences
2nd Floor, Zochonis Building
Brunswick Street
Tel: 0161 3060400
Manchester M13 9PL

Consent form

Patient identification number: ______

Title: Exploring Patient Relationships with Services

Name of Investigator: Nicola Roberts

Please initial the boxes

1. I confirm that I have read and understand the information sheet dated 5th December 2010 (v1) for the above study and have had the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I consent to my GP and care co-ordinator being informed about my involvement in the study. ☐

5. I agree to take part in the above study. ☐

Name of Patient	**Date**	**Signature**

Researcher	**Date**	**Signature**

Copies: 1 for patient / 1 for researcher / 1 to be kept with hospital notes