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THE SUMMER EDITION

The Assisted Decision-Making
(Capacity) Act 2015:

Paper 1: An overview of the Act and
guiding principles for practice.

Paper 2: Key Questions for Clinical
Psychologists

Evaluating a
Stepped-Care
Approach to
Delivering
Primary Care
Interventions

Reflections on
Diverse
Pathways to
Paid Assistant
Psychologist
Roles

Domestic
Violence: A
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Psychology

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Clinical Psychology Today

FOREWORD

Welcome and hope the sun is shining wherever you are!! We are pleased to introduce to you the fourth edition of Clinical Psychology Today.

The core vision of this journal is to provide a forum where clinical psychologists can connect, debate, present their research and discuss the evidence base. We also aim to highlight the innovative and valuable work that clinical psychologists provide throughout services around Ireland. In doing so we hope to stimulate debate on the ways we can enhance the profession and provide the most effective services to our clients.

The current edition presents five articles covering a diversity of topics which will be informative and thought-provoking to a wide range of psychologists. Two of the articles are focused on the Assisted Decision-Making Act, providing both an exploration of the core principles, as well as a discussion of the key practical challenges for psychologists. We are delighted to have an article exploring the experience of reflective practice from the perspective of assistant psychologists, consistent with the aim of the journal to be inclusive of early career psychologists. A service evaluation of APSI highlights the efforts to increase access to psychological services while a literature review on the impact of working in the area of domestic violence will stimulate a reflection on the topic of self-care.

Also don't forget to check out the podcast accompanying this edition with Rufus May and Elisabeth Svanholmer. Here they will discuss their Voice Dialogue work, providing an original approach to management of hearing voices which involves actively engaging with voices. It can be accessed at <https://soundcloud.com/user-811173165-185749227/cpt-rufus-may-and-elisabeth-svanholmer>

Lastly, this edition would not be possible without the considerable work of many. We would like to thank the authors who chose to submit their articles to this edition and to the many reviewers who provided considerable time and attention to help enhance the quality of the articles. We would like to thank the CPT steering group, and Pdraig Collins who has led this project from the beginning. We would like to give special thanks to Siobhan O'Neill for her work on the design of this edition.

Wishing you a long, hot summer!

Thanks,

Edition Co-Editors: Patrick McHugh, Ruth Melia

THE ASSISTED DECISION-MAKING (CAPACITY) ACT 2015: AN OVERVIEW OF THE ACT AND ITS GUIDING PRINCIPLES FOR PSYCHOLOGISTS

CATHERINE O'KELLY AND GARRETT MCDERMOTT



ABSTRACT

The current article aims to provide a simple and succinct overview of parts of the Assisted Decision-Making (Capacity) Act 2015 that may be relevant to Psychologists. This Act marks a departure in the field for Ireland as it entails a significant conceptual shift away from the previous 'best interests' focus towards one that emphasises 'will and preference'. In this article, we outline the nature of the Act. We provide a brief overview of

traditional approaches to understanding capacity. We describe the definition of capacity under the Act. Finally, we highlight the key guiding principles of the Act with which all Psychologists should be familiar.

INTRODUCTION

The advent of the Assisted Decision-Making (Capacity) Act 2015¹ brings a range of challenges for healthcare professionals and Irish society in general. It heralds a welcome new era in which a rights-based approach takes centre-stage when it comes to decision-making capacity. The current article aims to provide a straightforward overview of key parts of the Assisted Decision-Making (Capacity) Act 2015 (hereafter called the Act) that will be relevant to Psychologists

in Ireland. Some of the fundamentals of the Act will be set out.

Firstly, the traditional approaches to understanding decision-making capacity will be explored, as well as the functional definitions and principles contained in the Act. The authors' explanations of these underpinning principles may help to clarify many issues that arise about the Act and assessment of decision-making capacity.

This article will not address Enduring Powers of Attorney, Advanced Healthcare Directives or proposed legislation on Safeguarding Vulnerable Adults. Although very relevant and worthy of discussion, these topics require significant exposition in their own right.

Psychologists are only too aware that the outcomes of assessments of decision-making capacity can literally be life-changing and the Act means that the weight of responsibility for these assessments no longer lies solely with medical consultants. In this context, numerous questions may arise for Irish Psychologists and other health care professionals. It is the hope of the authors that the current paper will help to

communicate some of the key points about the Act. In an associated article, the authors offer opinions on some of the practical questions that are being discussed among Psychologists as we await the full commencement of the provisions of the Act.

WHAT IS THE ACT?

The Act is a key piece of legislation that was enacted in December 2015. It is a statutory framework to support decision-making by adults who have difficulty making decisions without help. Parts of the Act that have already been commenced, i.e. are now in legal force, include Sections 1, 2, 5, 6, 82, 91(1), 91(2), 94, 95, 97, 98, 103^{1,2}. Most notably, perhaps, this includes establishing the Decision Support Service within the Mental Health Commission and the office of the Director of the Decision Support Service. Substantial parts of the Act remain to be commenced in the coming years.

Thus far, 17 draft codes of practice have been devised with significant input from the National Disability Authority. These codes are currently being reviewed by the

Director of the Decision Support Service and further public consultation is likely. They comprise both healthcare related and non-healthcare related codes including procedures for financial and legal professionals. Full commencement of the 2015 Act is expected by 2020 although this is contingent on multiple elements including the judicial structures being in place to work under the new arrangements.

More specifically, the Act aims to support persons who:

- I. For one reason or another are having difficulty reaching a specific decision without support or assistance;
- II. May be able to make some decisions without support but struggle with others;
- III. Currently require support to make key decisions or may require such support in the future^{1,3}

The Act will replace outdated laws from the 1800s such as the Lunacy Regulations (Ireland) Act (1871)⁴ which govern Wards of Court. Under that regime people deemed to lack capacity legally had no

participation in decisions made on their behalf and their status as a Ward was not subject to review; a situation that could potentially persist indefinitely. The Act will also update legislation regarding Enduring Powers of Attorney from the 1996 Act⁵ which did not address healthcare issues. Under the 1996 Act, Enduring Powers of Attorney required High Court applications to address issues that arose, and there were no reporting requirements to ensure standards were being met by Attorneys.

WHO IS THE ACT FOR?

Well, everyone in fact. We all have the potential to lose capacity through injury or illness either temporarily or permanently. This can be life-altering. The Act aims to provide a framework that protects the rights of anyone whose capacity may be called into question. Those with dementia, acquired brain injuries and intellectual disabilities are among the groups where capacity is often questioned. In such cases Psychiatrists often (and Psychologists occasionally) carry out assessments of decision-making capacity. Of course, the Act is not limited to these groups. The decision-making

capacity of people with mental health difficulties, of older adults, and of people who may make choices that are seen to be unwise is also often questioned. Assisted decision-making legislation is a significant change to how large numbers of our population will be supported to exercise their legal rights to self-determination related to the most fundamental of matters.

WHAT ARE THE TRADITIONAL APPROACHES TO CAPACITY?

With the advent of the new Act, it is timely to revisit the inherent tension in the field between two important ethical principles. These are: the right to autonomy (or self-determination) versus the right to protection. When a person makes decisions that are seen by others as unwise, unsafe or out of character this tension can come to the fore. In clinical practice, individual practitioners and teams are often tasked with asking whether a person is (still) a so-called competent decision maker. In healthcare settings, duty of care is very much tied to the right to protection. One outcome of this strong but important association can be a cautious, risk averse and overly

protective approach that could potentially fail to fully recognise and support the right to autonomy among those with great need. These issues are not simple and often not easily resolved.

The **status** approach to capacity involves expert opinions – often medical – as to whether a person has capacity to decide matters relating to their lives and welfare. It is an ‘all or nothing’ or global approach that may determine the person’s decision-making ability based on diagnosis (e.g. Moderate Intellectual Disability) or performance on tests such as the Mini Mental State Examination or other such brief assessment tools. The current Irish Wards of Court system is, at least in part, consistent with such a global approach.

Another dominant approach for determining capacity has been called the **outcome model**. This is the practice of assessing capacity based on the opinion of the assessor as to whether or not the decision being made by the relevant person is ‘sensible enough’. If the assessor decides it is sensible enough the person is deemed to have capacity. If not, the person is deemed to lack capacity.

The status approach to judging capacity and the outcome model have previously been dominant in clinical practice. They may be implicit rather than explicit and, at times, are difficult to challenge. They are more in line with the right to protection than the right to autonomy. The Act shifts the emphasis towards self-determination.

IN WHAT WAY DOES THE ACT DEPART FROM THE TRADITIONAL APPROACHES TO CAPACITY?

The Act is grounded in a social, rights-based model and promotes a functional approach to determining capacity. As such, decision-making capacity is seen to be time specific and issue specific. This allows a greater level of flexibility and, from a clinical standpoint, takes account of important realities including that capacity may fluctuate over time or that lack of decision-making capacity in relation to one decision does not imply lack of capacity in relation to a separate decision.

The Act enshrines a **functional** approach to determining capacity. It means that the relevant person's capacity to make a specific decision, on a specific topic, at a specific time should be determined. This

recognises that a range of skills are involved and is the antithesis of the global 'status' approach mentioned. These skills include the ability to understand relevant information, assimilate it, weigh it up and communicate a decision. It is to do with the way in which the person makes the decision, not the nature of the decision itself. Under the Act, a person also has the option to make an 'unwise' decision and this should *not* be a basis upon which to decide that the person lacks capacity. In this way, the Act is also the antithesis of the so-called outcome approach.

The Act is essentially at odds with the traditional approaches to capacity mentioned above laying out, as it does, the various levels of decision-making assistance available to the relevant person. The fundamental goal is to enable people with different levels of decision-making ability to have the greatest amount of autonomy possible; these different levels reflect a nuanced approach to capacity that has heretofore been absent in Irish legislation.

HOW DOES THE ACT DEFINE CAPACITY?

In this Under the Act, there is a clear delineation between mental capacity and decision-making capacity ultimately meaning that decision-making capacity is separate from, for example, intellectual functioning. All adults over the age of 18 shall be presumed to have *decision-making* capacity until proven otherwise. Furthermore, a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision needs to be made, the nature and consequences of that decision in the context of the available choices at that time.

The test of capacity is very clear in the legislation; a person lacks capacity if unable to understand information relevant to the decision being made, is unable to retain it long enough to make a voluntary choice, is unable to use the information to weigh it as part of the decision-making process or is unable to communicate the decision made by any method. This is summarised in Table 1, below.

Table 1: Functional definition of capacity includes four key elements

Test of capacity
1. The person is able to understand information relevant to the decision being made.
2. The person is able to retain the information long enough to make a voluntary choice.
3. The person is able to weigh the information as part of the decision-making process.
4. The person is able to communicate the decision made (by any method).

The Act signals a fundamental shift in how we understand and assess decision-making capacity. Furthermore, the burden shifts away from the onus being on the relevant person (decision-maker) to achieve scores on specific assessment tools or to provide 'responsible' decisions as deemed by the assessor *towards* the assessor facilitating and enabling the relevant person to demonstrate capacity. This 'meeting the person where they're at' approach signals a recognition of the complex nature of capacity issues and shows a flexibility and respect for the individuality of those to whom the legislation applies.

The Act includes provision for where the relevant person has planned ahead in terms of having advanced healthcare

directives and has set up an enduring power of attorney. The current focus is on situations in which the person has not adequately planned ahead. Where capacity to make a specific decision is justifiably questioned an assessment of decision-making capacity will take place. The outcome of such an assessment introduces an approach characterised by stepped levels of support. Assessments will be required to indicate the level of the person's decision-making capacity. The relevant person may, of course, be found to have adequate decision-making capacity and therefore no support is required.

Where the outcome of the assessment is that the person does *not* have adequate decision-making capacity to independently make this decision at this time there are three possible levels of support outlined in the Act.

- The first is that a **decision-making assistant** can be chosen by the relevant person to support him or her. In this case, the decision-making assistant is not involved in decision-making *per se* but, rather, facilitates and enables the relevant person. This indicates an unobtrusive level of support that fosters independence.

- The second is that a **co-decision maker** may be appointed by the relevant person to assist with making the decision. This is a more intrusive level of support that recognises that some people may not independently have capacity to make a specific decision but with the right supports in place they will still play a large role in decision-making.

The third level will entail the circuit court appointing a **decision-making representative** and will apply where an assessment of decision-making capacity has a clear finding that the person lacks capacity. This opens practical questions in relation to how long this process will take and the need for some decisions to be made urgently. The Act stipulates that if the decision is important or significant then the Decision Support Service or Circuit Court will play a role. In cases of urgency where this is not feasible, decision supporters must act in good faith and in accordance with the guiding principles of the Act

WHAT ARE THE GUIDING PRINCIPLES OF THE ACT?

A number of key guiding principles underlie the Act. Given our commitment

under our code of ethics to ‘respecting the rights and dignity of the person’ it may be increasingly important to make ourselves aware of these principles⁶.

1. Presumption of capacity

All people over the age of 18 shall be presumed to have capacity. This is the basic starting point for every person to whom the Act applies. The relevant person shall not be considered unable to make a decision unless all practicable steps have been taken, without success, to facilitate him or her to do so. The onus of facilitating this lies on the assessor of capacity as noted above. Furthermore, the Act outlines that people have the right to make unwise decisions. This principle raises complex questions about duty of care and the culture of risk aversion that often arises in health and social care facilities.

2. Proportionate and least intrusive interventions (only when necessary)

In terms of providing interventions, subsequent to finding a result of a lack of capacity, the guiding principles state that there shall be no intervention unless it is necessary to do so and any intervention made shall be done in the least intrusive manner possible. It should minimise the

restriction of the relevant person’s rights and freedom of action and

‘have due regard to the need to respect the right of the relevant person to dignity, bodily integrity, privacy, autonomy and control over his/her financial affairs and property’⁷.

Any intervention should be proportionate to the significance and urgency of the matter which is the subject of the intervention. This should also be as limited in duration as is possible given the particular circumstances of the situation. Guiding principles state that an intervener must permit, encourage and facilitate the relevant person to participate as fully as possible in the intervention highlighting the need for a range of communication methods to be available.

3. “Will and Preference” rather than “Best Interests”

One of the key guiding principles of the Act is the emphasis on **the past and present will and preference** of the individual in so far as these are ascertainable. This represents a subtle yet significant shift away from the approach taken in some nearby jurisdictions including the UK which privileges the ‘best

interests' of the person. It also departs from traditional custom and practice in Ireland.

This departure from the UK phraseology suggests to the current authors an effort to prevent the difficulties encountered in the UK in implementation of their 'best interests' guidelines. The House of Lords Select Committee for Health review of their 2005 Mental Capacity Act⁸ found that 'best interests' is frequently interpreted in a medical/paternalistic sense. They highlighted that this term is one of the most misunderstood and abused across health and social care professions.

In order to privilege the rights of the relevant person, the Irish Act stipulates a duty for the intervener to act '*at all times in good faith and for the benefit of the relevant person*'. Use of different terminology such as 'good faith' and 'for the benefit of the person' may seem purely semantic but it signals a concerted effort to distinguish the new Irish legislation from the precedents set in the UK. It signifies a change from the approach in which experts decided on the best interests of relevant persons even

where this differed significantly from the person's past and current expressed wishes. Fundamentally the new Act places the 'relevant person' very emphatically at the centre of the decision-making process and in so doing raises uncomfortable questions about how we can best respect an individual's basic right to dignity and autonomy while being mindful of the duty of care to vulnerable adults.

PRACTICAL IMPLICATIONS

The guiding principles of the 2015 Act interlace to produce a complex array of issues; take the example of a frail older person wishing to return home from hospital to a house that has been deemed unsuitable for them (e.g. due to a risk of falls and absence of ideal supports). Say that the team of healthcare professionals are of the view that it would be in the person's best interests to move to a nursing home or care facility. Where the person has the decision-making capacity to make this decision then their wishes should be respected despite the risks. Imagine further that the person's decision-making capacity is questioned. If the person is found to lack the capacity to

avail of the decision-making assistant route or the co-decision maker route, a decision-making representative must be assigned to make the decision on the person's behalf. The '*right to make an unwise decision*' guiding principle and the '*past and current will and preference*' guiding principle could combine to indicate that the decision that should be taken is that the person returns home. This decision would be on the basis that the person's will and preference were clearly ascertained. In such circumstances, it seems to the authors that the Act is on the side of the relevant person even where a decision-making representative must be assigned, *and* the healthcare team believe the decision is unwise. How Psychologists and other healthcare professionals will reconcile this with their duty of care remains unclear and may require court intervention to resolve the conflict. The tension between ethical principles such as autonomy and duty of care towards vulnerable adults is a complex one. As Atul Gawande remarks in his book 'Being Mortal', "...We want autonomy for ourselves and safety for those we love...Many of the things that we want for those we care about are

things that we would adamantly oppose for ourselves because they would infringe upon our sense of self"⁹.

A draft guidance document from the HSE Assisted Decision Making Steering Committee¹⁰ notes that there are times in complex cases when staff may be asked to explain the reasoning behind their decisions if the relevant person's decision leads to serious harm. The document states that what is vitally important is clear documentation of the reasoning and the adherence to the guiding principles of the 2015 Act. The document also acknowledges that supporting people to make their own decisions (which, as above, may seem unwise) means accepting the potential for poor outcomes. This must entail a widespread cultural shift away from paternalism and risk aversion in relation to the vulnerable adults in our society. This shift is embodied in this legislation but must be upheld and supported in the ethos of the HSE, broader health and social care services, and the judiciary system.

CONCLUSIONS

The current paper aims to provide a simple and succinct overview of some elements of the Assisted Decision-Making (Capacity) Act 2015. It outlines that the Act entails a shift away from the traditional 'status' and 'outcome' approaches to assessing decision-making capacity which focused on 'global' capacity to a functional definition that is time and issue specific. Under the Act, the test for capacity has four parts: the person can understand information relevant to the specific decision, the person can retain information long enough to make a voluntary choice, the person is able to use the information to weigh it as part of the decision-making process and the person can communicate their decision by any method.

The Act is based on a social, rights-based model that, for example, emphasises autonomy and the person's will and preference rather than their best interests. Although this is progressive and reforming it differs from some of our close neighbouring legal jurisdictions and raises many practical and ethical questions. While we await commencement of the

remaining parts of the Act, the current authors aim is to encourage discussion and debate. It is our view that attempting to apply the guiding principles will help to prepare us for full implementation of the Act. The guiding principles are the presumption of capacity, proportionate and least intrusive interventions, and an emphasis on will and preference rather than best interests.

In closing, we await the commencement of the remaining provisions of the Act. As a result of the Act however, Psychologists, and other healthcare professionals may be faced with ethical challenges associated with it and with assessments of decision-making capacity. In the meantime, we have an opportunity to discuss the issues, to reflect on our current practices, and to prepare for the changes that will be necessary.

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THE ASSISTED DECISION-MAKING (CAPACITY) ACT 2015: A DISCUSSION PIECE EXPLORING SOME COMMON QUESTIONS ARISING FOR PSYCHOLOGISTS

GARRET MCDERMOTT AND CATHERINE O'KELLY



ABSTRACT

The aim of the current article is to provoke discussion and debate among Psychologists in Ireland in relation to the Assisted Decision-Making (Capacity) Act 2015. While we await the full commencement of the provisions of the Act many questions are being asked about how this will impact Psychological practice. Based on careful consideration of the Act, we discuss four such questions: (i) Who can carry out assessments of decision-making capacity? (ii) How can Psychologists ensure that assessments of decision-making capacity are consistent with the Act? (iii) How can Psychologists

fulfil the responsibility to maximise decision-making capacity among relevant persons? and (iv) Is there a role for cognitive or neuropsychological testing in assessments of decision-making capacity under the Act? A schedule of questions to help guide the Psychologist will be provided in answering the second of these questions while practical suggestions are provided in answering the third of these questions. Other questions remain, some of which are highlighted.

INTRODUCTION

The implications of the Assisted-Decision Making (Capacity) Act (2015)¹ (hereafter referred to as the Act) for practice among Psychologists in Ireland remain unclear. In recent years we have seen this topic come up time and again at training events, team meetings, and in supervision sessions. The current article builds on the overview of

the Act published separately in our companion article. The authors note that many questions about the Act have arisen for Psychologists. Here, we discuss some of those that we have encountered.

Firstly, one question that has come up relates to who is qualified to complete an assessment of decision-making capacity. We briefly outline what the Act says about this. Current custom and practice appears to differ across the country. The Act is quite clear and opens the way for a range of healthcare professionals to play a role in such assessments.

A second question common question relates to how Psychologists can ensure that their assessments are consistent with the Act. Such questions are perhaps typical during any period of legislative change (e.g. the introduction of the Mental Health Act, 2001). It is one thing to understand the Act but another to change and transform/reform practice. Building on the outline of the Act we provide in our companion article, we have devised a short schedule of questions that Psychologists can ask themselves to try to stay true to the definition of decision-making capacity in the Act as well as the Act's guiding

principles. We intend this schedule to be classed as a work in progress and we hope that it will spur on discussion. It is not intended as an instructional guide nor is it a replacement for legal advice.

As outlined in our companion article, the onus is on those assessing decision-making capacity to maximise capacity among relevant persons. This forms the subject of our third question. In our view, such an onus represents a significant step. If implemented conscientiously it should greatly help to maintain the integrity and quality of decision-making assessments. We offer some initial views on this subject.

The fourth and final question relates to the role of cognitive or neuropsychological testing during assessments of decision-making capacity. There is a debate in the field on this topic and the authors accept that is not yet resolved. We offer our view based on our understanding of the Act. In short, such testing is likely to have a limited, if any, role in assessments of decision-making capacity under the Act.

There are many other questions that we will not touch on, some practical and some conceptual. We hope that our views trigger discussion and debate in the coming

months while we await further developments in terms of the Act being fully commenced.

QUESTION 1: WHO CAN CARRY OUT ASSESSMENTS OF DECISION-MAKING CAPACITY?

The Act specifies that medical and other relevant healthcare professionals are appropriately qualified to conduct assessments of decision-making capacity in relation to matters relevant to consent to treatment or examination. While there is a tradition in Ireland of such assessments being conducted by medical professionals, such as psychiatrists, and – perhaps to a lesser extent – by psychologists, the Act recognises that members of other professions may be the most relevant persons in certain circumstances. The professional assessing capacity should be the person with the best knowledge of the decision to be made. In most circumstances, it is the professional that requires a specific decision to be made that will have responsibility for ensuring that the person's decision-making capacity is maximised.

Differing views among healthcare professionals relating to whether or not a

relevant person has capacity to make a specific decision may be a key factor that leads to an assessment of decision-making capacity. The HSE published draft guidance on the Act in 2017¹³ which offers broad guidance about this eventuality in more detail than is possible here. Their guidance emphasises the importance of following due process under the Act and ensuring that the functional definition of capacity is used. In cases where it is not possible to reconcile conflicting views among professionals following appropriate assessments, the professional that requires the decision to be made must either act in good faith on behalf of the relevant person or refer the case to court. At present, codes of practice to support this are not available.

In practical terms, seeking the assistance of other appropriate health and social care professionals may be necessary in the course of an assessment of decision-making capacity. This may also reflect ethical practice. Indeed, some assessments of decision-making capacity in health, social care and mental health settings may be carried out by more than one professional. For example, one of the authors has conducted a number of

decision-making capacity assessments in an acute psychiatric unit for older adults together with an Occupational Therapist where the decisions have pertained to choosing where to live. On these occasions, it was clear when planning the assessment that the Psychologist possessed skill required to maximise communication and experience in conducting such assessments while the Occupational Therapist possessed expertise regarding the person's functional and daily living skills and needs. Both professionals had pre-existing relationships with the patients.

The question of who can and should carry out an assessment of decision-making capacity is of particular interest to Psychologists. Anecdotally, we are aware that in many settings there is a reliance on Psychology to carry out such assessments. It is common that other healthcare professionals are reluctant to engage in assessments of decision-making capacity even though they may be the most well-placed to ascertain the person's will and preference as well as their decision-making capacity. In contrast, in other settings, there may be reluctance to cede the role of assessing decision-making capacity to

Psychology even where a Psychologist might be the most well-placed professional. This contrast highlights that the full commencement of the Act may impact Psychologists across settings differentially. It cannot be assumed, for example, that all Psychologists will have a significant increase in referrals for assessments of decision-making capacity. In some settings, however, this likelihood is a risk.

At this stage, without full commencement of the Act and clear codes of practice, it is worth emphasising the spirit of the Act: it does not aim to increase the number of formal assessments but is rather aimed at ensuring that relevant persons are involved to the greatest extent possible in decision-making. Current practice is already consistent with many aspects of the Act. The HSE draft guidance for health and social care professionals¹³ indicates that a functional approach to capacity has already been taken by Irish courts. Furthermore, this guidance document highlights elements of the Act that are consistent with the National Consent Policy¹⁴, with which all health and social care staff should be familiar, as well as guidance from HIQA in relation to

supporting people's autonomy and decision-making¹⁵.

Psychologists are among the professions in health and social care settings that can reasonably hold a strong position in relation to maximising the capacity of relevant persons. This is covered in further detail in Question 3, below. It may be the case that Psychologists can offer training, education and support to healthcare colleagues in relation to this. Even though the Act remains incompletely enacted at present, it is our view that ethical practice guides us to operate within the spirit of the Act in this way.

QUESTION 2: HOW CAN PSYCHOLOGISTS MAKE SURE THAT ASSESSMENTS OF DECISION-MAKING CAPACITY ARE CONSISTENT WITH THE ACT?

Based on the overview of the Act provided in our companion article, a schedule of questions has been designed to support Psychologists to ensure that their assessments of decision-making capacity are consistent with the Act (see Table 1, below). In designing this, we paid specific attention to the definition of (functional) capacity as well as to the guiding principles

of the Act. Effort has also been made to briefly outline the rationale for each question posed in the schedule. This should allow transparency in relation to our interpretation of the Act and allow debate. The Act is not prescriptive in relation to assessments of decision-making capacity. However, within health and social care settings best practice considerations must be taken. There is no set form or pro forma for conducting an assessment. Given the range and breadth of contexts in which an assessment will be carried out and also the range of professionals and, indeed, non-professionals to be involved this helps to support the spirit of the Act. In fact, drawing on documents from other jurisdictions must also be done cautiously given the differences between the Irish Act and its equivalent in other countries.

We do not expect that this schedule provides an exhaustive guide that will ensure that all assessments meet all the requirements of the Act. It is, however, intended to be a prompt that will help Psychologists to plan and conduct their assessments. As such, the schedule is intended to support reflection and learning. It does not replace legal advice. This is our summary of key points. We

encourage Psychologists to engage with the Act and further develop this basic schedule. A similar schedule is provided in

the recently published BPS document *What makes a good assessment of capacity?*¹⁶

Table 1: Schedule of questions suggested to help ensure that assessments of decision-making capacity are consistent with the definition of capacity in the Act and with the guiding principles of the Act

Stage of assessment	Question	Rationale for Question
Before the assessment	What was done to support this person to make this specific decision at this time?	Before deciding if a decision-making capacity assessment is required, efforts to enhance/maximise capacity should be made. This supports a person's right to autonomy. The implication here is that we must support decision-making and the development of capacity as an inherent part of our work. In some settings, this may entail ensuring appropriate methods of communication are in place. Being explicit about such supports will help to ensure that the relevant person's rights under the Act are respected. It may be that efforts should be focussed on this prior to commencing a formal assessment. This is not specific to a professional completing an assessment of decision-making capacity but rather holds true within health and social care settings.
	What is the evidence that an assessment of capacity is required?	This is in line with the Presumption of Capacity guiding principle. Cognitive impairment is not synonymous with impairment of decision-making capacity. As such, a diagnosis of, say, Acquired Brain Injury, Intellectual Disability or dementia alone does not provide sufficient evidence that such an assessment is required. Explicitly articulating who has questioned that the relevant person may lack capacity and why they are concerned will also help to maintain clarity and ensure the Presumption of Capacity is respected. Identifying what is triggering the need for the assessment will also help to clarify the purpose of the assessment.
	What is the specific decision being assessed?	This is both time and situation specific and fits with the functional definition of capacity . This calls into question a consideration of timing issues: can the decision be deferred until the person is in a better position to make the decision?
	What is the pertinent information regarding the decision?	The assessor needs to be fully informed about the decision and should have the best knowledge of the reasons for and against the proposed decision.

<p>Before and/or during the assessment</p>	<p>What is the person's will and preference about the decision being assessed?</p>	<p>This is in line with the Will & Preference guiding principle. It may touch on the person's right to make an unwise informed decision. It also allows for the person having the right to change their mind. This will entail the practitioner discussing the specific decision to be made with the relevant person.</p> <p>This also opens up consideration of how the person wishes the assessment of decision-making capacity to proceed and also issues pertaining to consent to the assessment. The person's will and preference in relation to loss or potential loss of capacity should also be taken into account.</p>
<p>During the assessment</p>	<p>Is the person able to understand information relevant to the decision being made?</p> <p>Is the person able to retain the information long enough to make a voluntary choice?</p> <p>Is the person able to weigh up the information as part of the decision-making process?</p> <p>Is the person able to communicate the decision made (by any method)?</p> <p>What efforts to enhance capacity have been put in place?</p>	<p>This is a core part of the functional definition included in the Act. A general understanding of the most essential points of information may be sufficient.</p> <p>This is a core part of the functional definition included in the Act. Note: the person does not need to be able to retain the information for longer than the time required to weigh it up as part of their decision.</p> <p>This is a core part of the functional definition included in the Act. It is only necessary to demonstrate an ability to use and weigh-up the key points rather than every detail.</p> <p>This is a core part of the functional definition included in the Act. Note: this communication can be by any method and is not necessarily verbal.</p> <p>The onus is on the assessor to maximise capacity under the Act. In contrast to the first question in the schedule, here we indicate that efforts to enhance capacity can form part of the assessment process as required.</p>
<p>Following the assessment</p>	<p>Is a clear statement of the outcome of the assessment made?</p> <p>Are any interventions required and, if so, are they proportionate and least intrusive?</p>	<p>A clear statement of the outcome of the assessment should be made. Where the person is deemed not to have capacity to make the specific decision, then the basis for this should also be articulated. This should be discussed with the relevant person if possible.</p> <p>This is in line with the Proportionate and Least Intrusive Interventions (only when needed) guiding principle. It may also touch on the stepped levels of support indicated in the Act. Such interventions should be consistent with the person's will and preference, beliefs and values, even where it is found that they currently lack decision-making capacity.</p>

In the experience of the authors, many of the questions in the schedule can (or should) form part of a comprehensive psychological assessment and be reflected in an assessment report. Again, these questions are not designed to structure a report, but it might be an instructive exercise to compare a completed report to this list. Finally, it is also the view of the authors that many Irish Psychologists have already been conducting assessments of decision-making capacity that meet most of these criteria for a number of years. As above, in awaiting the full commencement of the Act, such attention to the spirit and provisions of the Act is appropriate in our view.

QUESTION 3: HOW CAN PSYCHOLOGISTS FULFIL THE RESPONSIBILITY TO MAXIMISE DECISION-MAKING CAPACITY AMONG RELEVANT PERSONS?

One of the responsibilities falling to the assessor is to maximise the decision-making capacity of the relevant person. The onus to maximise decision-making capacity emerges from the rights orientation of the Act: this supports autonomy and self-determination and

protects those who may have cognitive impairment (and, indeed, those without cognitive impairment) that fundamentally have the capacity to make specific decisions or be involved in decision-making. As implied above, capacity building should not be limited to the course of a formal assessment: efforts to support and enhance decision-making capacity should be built into typical clinical practice.

Various authors and bodies have given advice about maximising capacity. British Psychological Society² guidance, for example, broadly indicates that consideration must be given as to whether it would be possible to improve decision-making capacity through supporting the person's functional abilities by:

- a. Offering education or additional support in relation to the decision to be made and/or
- b. By simplifying information about the decision to be made (e.g. by providing pictorial and other augmentative communication aids).

Moye and colleagues³ offer a detailed range of practical clinical strategies for maximising decisional capacity in their review of neuropsychological predictors of

decision-making capacity in dementia. These strategies are similar to the kinds of strategies that Psychologists typically employ when working with any service-user. Their suggestions consist of the following:

1. Minimize background noise; speak slowly and directly; make eye contact with the patient;
2. Break diagnostic and treatment information into small segments;
3. Discuss one segment of information at a time;
4. Inquire about understanding of such information with simple questions;
5. Use cues, such as bulleted lists with key information, pictures, and diagrams;
6. Allow extra time for responses and, in general, slow down the discussion process;
7. Repeat and rephrase information that may not be understood;
8. Summarize key aspects of information, such as reviewing key risks and benefits of each treatment, prior to asking the patient for treatment preference;
9. Provide corrective feedback if the patient has misunderstood key information;
10. Inquire directly about values or concerns that may underlie treatment preferences including concerns about pain, consideration of “being a burden,” worries about finances, fears of dying, religious and cultural traditions;
11. Focus on the most salient information for the patient in light of personal preferences and values, to minimize the amount of information the patient must balance when weighing preferences.

The recent BPS¹⁶ document outlines that where a person has been deemed to lack capacity, an awareness of the reasons for this may indicate specific inputs to increase capacity. They offer broad suggestions similar to those by Moye and colleagues for situations in which lack of capacity relates to mood, learning or intellectual disability/cognitive impairment, lack of knowledge of the necessary procedure, and cognitive decline due a neuro-degenerative condition such as dementia.

In their editorial on moving toward an inclusionary approach to decisional capacity, Peisah and colleagues⁴ introduce the acronym **ASK ME** as a practical model to maximise participation in decision-making. This stands for:

- **ASSESS:** being aware of strengths and deficits may help the assessor to construct the assessment in a way which best simplifies the task and maximises understanding;
- **SIMPLIFY:** limit the assessment to covering the decision to be made. Move away from global decisions to specific decisions. Pitch information at the person's level of understanding;
- **KNOW:** being aware of who the person is, what they prioritise in their life, what their values are, and their past patterns of decision making may set the assessor in the best place for an assessment that is as collaborative as is possible. In short, find a common ground with the person by learning about what is important in their life right now;
- **MAXIMISE:** Scaffold the person's ability to understand by adapting information. Attend to factors that may detract from the person's ability to engage with the assessment. Find the most appropriate way to communicate (e.g. use of visual aids, translators, written materials, worksheets etc.). Based on your knowledge of the person, conduct the assessment at a time that is best for them;
- **ENABLE:** tailor the degree of support as required to facilitate the person's participation in the assessment. If the assessment takes

multiple sessions, then allow for that.

By emphasising the onus on the assessor to maximise capacity, the need for the most appropriate person to carry out the assessment is clear. Different healthcare professionals will be differently qualified to complete specific assessments. This may raise challenges to the individual or collective power base within healthcare settings. The onus also makes it clear that great efforts should be applied before a final conclusion is reached – an assessment of decision-making capacity is not a simple thing. This is only fitting, in our opinion, given the often great implications of assessments of decision-making capacity.

As outlined in the schedule of questions to support a Psychologist to meet their obligations under the Act (Table 1, above), the person conducting the assessment may also be involved in developing a programme to support and enhance capacity development following the assessment. This may entail seeking input of other health and social care professionals.

The above suggestions are useful in helping Psychologists plan how to maximise capacity. Although written in the context of other jurisdictions, these ideas seem clinically applicable and consistent

with the Act. Based on the experience of the authors with conducting assessments of decision-making capacity across a range of settings, we offer the additional generic pointers outlined in Table 2, below.

Table 2: Additional generic ideas to help maximise decision-making capacity

Maximising decision-making capacity
Treat modifiable conditions (e.g. episodic mental health difficulties)
Treat delirium
Compensate for sensory difficulties where possible
Choose most appropriate location and time for assessment
Augment and adapt communication styles where required
Make use of multiple assessment sessions if needed
Provide appropriately pitched information and education to the person to deepen their knowledge of the decision to be made. This can be in multiple formats (written, audio, video)
Encourage the person to ask questions
Help the person to fully understand their rights
Devise vignettes to help the person understand the pertinent information
Provide pertinent information to the person if required
Conduct the assessment in a familiar environment if this supports the person to engage
Make use of formal assessments of decision-making capacity only where they are relevant and best suited to the person's circumstances

QUESTION 4: IS THERE A ROLE FOR COGNITIVE OR NEUROPSYCHOLOGICAL TESTING IN ASSESSMENTS OF DECISION-MAKING CAPACITY UNDER THE ACT?

A question that frequently arises is whether decision-making capacity assessments should include cognitive or neuropsychological testing. Conceptually, decision-making capacity may be classified as either a purely cognitive task, a purely procedural task or a mix of both⁵. Moye and Marson⁵ outline, for example, that capacity to consent to treatment may be considered primarily a cognitive task whereas capacity to drive may be primarily a procedural task. Capacity regarding independent living and financial management, both of which frequently come up in clinical practice, may involve elements of both. Given that decision-making capacity is so often at least partly a cognitive task, it is understandable that Psychologists conducting assessments of decision-making capacity ask this question.

A growing body of research has investigated the neuropsychology of decision-making capacity often with an emphasis on neuropsychological correlates or predictors of decision-making capacity.

A full literature review is beyond the scope of the current paper but consider, for illustration, decision-making capacity among people living with dementia. One relevant study by Palmer and colleagues⁶ explored the neuropsychological correlates of the capacity to consent to taking part in clinical research and to appoint a research proxy among those with Alzheimer's Dementia. Their findings indicated that different elements of decision-making capacity were correlated with different patterns of cognitive functioning. The capacity to appoint a proxy and to consent to a drug trial were predicted by performance on the conceptualisation and initiation/ perseverance subscales used while the capacity to consent to a neurosurgical RCT was predicted by the memory subscales used. The authors advise caution due to the exploratory nature of the study but note that the results are consistent with our current understanding of Alzheimer's Dementia and also with previous research findings.

A range of other studies and reviews converge on the general point that cognitive testing in people with dementia predicts or correlates with decision-making capacity^{3,7,8,9,10}. Overall, the literature

might appear to make a compelling case for conducting assessments of cognitive functioning as part of decision-making capacity assessments. In the view of the authors, however, Irish Psychologists should be aware that this may not always be consistent with the Act. Our reasoning for this is outlined below.

Firstly, the use of general measures of cognitive or mental status, such as the Mini Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA), is discouraged in assessments of capacity. They are screening measures designed to identify the presence of cognitive impairment with reasonable sensitivity and specificity. They were not designed for judging a person's ability to make a specific decision at a specific time. The HSE draft guidance document¹³ states clearly that tests of cognition and intelligence should not be used for assessing decision-making capacity. As Grisso and colleagues state, cognitive dysfunction cannot be considered to be synonymous with critical impairment of decision-making abilities¹¹. It is our view that the use of such tests to determine decision-making capacity would be consistent with the status or global approach to capacity. This would be

inconsistent with the functional approach enshrined in the Act. If a score below a cut-off that indicates the presence of cognitive impairment is interpreted to indicate that the person lacks decision-making capacity, this could be seen to contravene the presumption of capacity. Similar reasoning may apply to broad measures of current or premorbid intellectual functioning.

Secondly, the current research literature, as touched on above, broadly demonstrates the unsurprising association between significant impairment and lack of decision-making capacity. It seems a truism to state that cognitive impairment is a strong predictor of decision-making capacity. However, the way in which cognitive functioning and capacity are associated remains incompletely understood. For example, discrepancies between global cognitive ability as measured on standardised neuropsychological tests and decision-making capacity in relation to financial and healthcare decisions may be more common among older adults than some Psychologists anticipate. Han and colleagues¹² recently demonstrated that in a sample of 689 older adults almost 24% of their sample showed a significant

discrepancy between the two. Within this, two patterns were found; in some, the level of decision-making capacity fell below the level of global cognition while for others it surpassed the level of global cognition. Han and colleagues conclude that this finding supports the idea that cognition and decision-making capacity are in fact separable constructs. This also reinforces the point made by Palmer and Harmell⁷ that conclusions cannot easily be drawn about the associations between cognitive deficits and impairments of decision-making capacity. There is a clear need for further research and the development of appropriate tools in this area.

Thirdly, the limits of the tools available to us also influence how we understand the association between cognitive function and decision-making capacity. Palmer and Harmell⁷, in their review of healthcare related decision-making capacity, cogently outline that such research, their own included, does not allow empirically based conclusions to be drawn about the associations between specific deficits in cognition and impairments in decision making capacity. This, they outline, is in part associated with the psychometric

characteristics of available tests of decision-making capacity. We would add that this holds true for neuropsychological tests too. For example, floor effects may interfere with the Psychologist's ability to accurately interpret performance and adequate norms are not always readily available (e.g. for older adults or for people with intellectual disabilities). The range of contexts in which Irish Psychologists may find themselves asked to assess decision-making capacity further emphasises this point about the available tools. Many neuropsychological tests and other psychometric tools are heavily verbally loaded. This may pose challenges for people with limited verbal skills for reasons that are developmental (such as some of those with Autism Spectrum Disorders) or acquired (such as some of those who have had a stroke). Sensory and motor difficulties may also impact reliability due to necessary subtle shifts from standardised administration. All Psychologists are expected to be aware of and account for such factors that may affect test taking performance.

Fourthly, returning to the nature of the tests available to us, some areas of cognitive functioning may be more easily

measured than others. We invite Psychologists to engage with this debate critically. Many of us have access to tools that will measure abilities such as acquiring and retaining new visual and verbal information or measuring basic receptive and expressive language abilities. We do not, however, have ready access to reliable tools that tap into complex skills that may involve the interplay between cognitive and procedural elements. Our assessments of complex reasoning, problem-solving and judgment tend to have lower reliability. The ecological validity of such assessments may also be questioned.

It is our view that the use of specific cognitive or neuropsychological tests, such as memory tests, should be judicious. Well-chosen neuropsychological or psychometric tests may add depth for the Psychologist once the above cautions are recognised. Such tools have many uses including helping to assess insight, reasoning, specific cognitive functions, establishing a baseline of functioning, and finding sensible ways to support a person's decision-making. The recent BPS document indicates the value such tools add in aiding the Psychologist to form an opinion regarding capacity, helping the

Psychologist prepare for interview with the relevant person, and helping to clarify how best to support the person's capacity¹⁶. However, even when a person performs very poorly on a well standardised tool, it does not necessarily imply a lack of capacity. Under the functional approach to capacity, the person must only retain the information long enough to make the decision voluntarily. Efforts to maximise the person's capacity in this case should aim to compensate for a memory impairment.

CONCLUSION

Psychologists, and other healthcare professionals in Ireland, await the full commencement of the Assisted Decision Making (Capacity) Act 2015. In the interim it is our view that Psychologists should work within the spirit of the Act. Familiarity with the guiding principles of the Act, the National Consent Policy, and documents such as HIQA's guide to supporting autonomy¹⁵ and the recent BPS document¹⁶ are useful resources in this respect. It is expected that the HSE's draft guidance on the Act¹³ will be updated following the initial consultation process.

We remain uncertain of the exact implications of the Act for Psychologists. We believe this is reflected in the conversations about the Act that take place within multi-disciplinary teams and among groups of Psychologists. In this paper we have discussed four questions that we have come across frequently in recent years. Our aim was to encourage discussion and debate regarding the Act. We hope that Psychologists will use this paper as a departure point for this. There are many other questions to which we have not attended. We hope that others may begin to weigh these up. Included among the other questions we have heard with some frequency are:

- If there is a significant rush for assessments when the Act is fully commenced, how can Psychologists manage this?
- What resources does a Psychologist require when conducting an assessment of decision-making capacity?
- What happens in a case where the person says all of the things appropriate to pass the assessment but does not/cannot apply any of them in their day to day life? Is this related to the frontal lobe paradox that is written about in the context of Acquired Brain Injury and can we accommodate this under the Act?
- What supports and protections will exist for a Psychologist when the relevant person wishes to make a decision that may be deemed as unwise?
- How do we reliably establish the person's current and past will and preference?
- Can we resolve the tension between 'best interests' and 'will and preference' in a healthcare setting where there is a clear duty of care?
- Are we really ready for the emphasis on will and preference and all of the challenges that it entails?
- What are the implications for Psychologists when people refuse to engage in an assessment of decision-making capacity?
- How does the Act interact with the Mental Health Act and how does it pertain to those involuntarily detained?
- How does the Act deal with the topic of advance healthcare directives?
- How will our professional code of ethics align with the provisions of the Act?

- When will a question be referred to court and what process will be in place around this?

The Act makes clear that a range of healthcare professionals can (and should) be involved in conducting assessments of decision-making capacity. We offered a schedule of questions to help Psychologists to judge whether their assessments are in line with the definition of capacity and with the guiding principles of the Act which departs slightly from similar Acts in other jurisdictions. Psychologists also need to consider the practical ways in which we can maximise capacity among relevant persons. Finally, it is our current view that cognitive or neuropsychological testing in assessments of decision-making capacity may not always be consistent with the guiding principles of the Act. We advise cautious and limited use of these tests in this context. We look forward to future developments regarding the Act and to continuing this conversation.

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AN EVALUATION OF AN IRISH STEPPED-CARE, ASSISTANT PSYCHOLOGIST-DELIVERED PSYCHOLOGICAL SERVICE: APSI: YEARS TWO AND THREE

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ABSTRACT

Background: While the benefits of stepped-care psychological interventions, based on cognitive-behavioural (CBT) principles, have been well established, the published results to date have been predominantly UK-based, urban-centred, and with a multidisciplinary workforce. This study aimed to evaluate whether applying such a model in a rural Irish

setting, delivered by Assistant Psychologists could replicate such results.

Aims: To evaluate the clinical effectiveness of a primary care psychology service (Access to Psychological Services Ireland - APSI), delivered by Assistant Psychologists, in an Irish rural setting, throughout its second and third operational years.

Method: A repeated measures design was used to evaluate the clinical outcomes of service users who completed one or more brief CBT-oriented interventions within a two-year period. Psychometric measures of psychological distress (K-10), everyday functioning (WSAS), health and economic outcomes (Eco-Psy and EQ-5D-3L), anxiety (GAD-7) and depressive (PHQ-9) symptomatology were administered to

service users at assessment, post-intervention and three-month follow-up.

Results: Statistically and clinically significant reductions were observed in the 567 service users who completed an intervention on measures of clinical distress, daily functioning and economic outcomes, between assessment and follow-up, for those who completed brief cognitive behavioural therapy (bCBT) and guided self-help (GSH). There were mixed results for those who completed computerised CBT (cCBT).

Conclusions: Clinical outcomes consistent with those reported by stepped care services in other predominantly urban, international settings, were achieved. The results provide additional evidence that a stepped-care, cognitive behavioural approach can reduce clinical distress for those with mild-to-moderate mental health presentations in a primary care setting.

INTRODUCTION

The National Institute for Health and Clinical Excellence (NICE) has recommended the use of certain psychological therapies as initial

treatments for mild-to-moderate mental health difficulties^{1,2}. One such recommended therapy is cognitive behavioural therapy (CBT) for anxiety and depression. NICE also advocates a stepped care model of service provision in the management of psychological distress³. Based on these recommendations, Access to Psychological Services Ireland (APSI), was established and piloted in Roscommon, Ireland (established 2013). Key service objectives of APSI include the provision of brief, evidence-based psychological interventions in a high throughput and cost-effective service model that allows rapid access to treatment. This new service aimed to maximise accessibility by offering next day assessments to all new referrals.

APSI utilises a stepped care system, offering a suite of psychological interventions for adults with mild-to-moderate mental health presentations, including computerised CBT, guided self-help, and brief one-to-one CBT⁴. Service users are first provided with the least intensive intervention that is likely to bring about clinical change. The stepped care model ensures that service users not demonstrating a clinical improvement

from low intensity interventions are stepped up to a higher intensity intervention.

APSI is modelled on Increasing Access to Psychological Therapies (IAPT), a stepped care service developed in England, and the STEPS programme developed by Jim White in Scotland⁵. Within this service, mental health practitioners aim to support service users' self-management of their recovery through the provision of low intensity, CBT-based interventions along with higher intensity individual therapy. Demonstration sites in the U.K. have found good recovery rates (55-56%) for those who engaged with IAPT⁶. Similar results were found for APSI one year after establishment, in which 67.9% of treatment completers saw significant clinical change on measures of clinical distress. APSI Roscommon has also demonstrated significantly reduced waiting times (nine days was the median time between referral and assessment), thereby increasing access and providing early intervention for those presenting with mild-to-moderate mental health difficulties⁴.

The current paper evaluates the clinical effectiveness of APSI in its second and third operational years wherein a large dataset facilitated a more comprehensive analysis of therapeutic outcomes. An expansion of types of service provision provided an additional rationale for this analysis. Changes include the inclusion of computerised CBT as a form of intervention. The WSAS and K-10 were also utilised in year two to examine whether these psychometrics added value to the analysis of outcomes. By year three, the research question for evaluation broadened to not only investigating therapeutic outcomes for individual interventions but comparing these outcomes between interventions.

METHOD

Evaluation Design

A repeated measures design was employed to evaluate service users' clinical, health and economic outcomes. Measures of psychological distress for year 2 included the Core – Outcome Measure (CORE-OM) and the Kessler – 10 (K-10), depressive symptomatology as measured by the Patient Health Questionnaire-9 (PHQ-9), anxiety symptomatology as measured by the Generalized Anxiety Disorder-7 (GAD-

7), and everyday functioning as measured by the Work and Social Adjustment Scale (WSAS) which were administered at assessment, post-therapy and three month follow-up. Service user health status, as measured by the EQ-5D-3L, was compared at assessment and post-therapy, and service users' economic outcomes were compared at assessment and three-month follow-up using the Eco-Psy.

In year 3, a service review highlighting the impact of the use of extensive psychometrics on service user engagement at initial assessment led to a reduction of psychometrics at assessment to the PHQ-9, GAD-7 and WSAS. These were administered at assessment, post-therapy and three-month follow-up whilst service users' economic outcomes were again compared at assessment and three-month follow-up by the Eco-Psy.

Service users

APSI provides treatment to adults (18+) with mild-to-moderate mental health presentations. Exclusion criteria include, debilitating major mental disorders that preclude engagement in brief, self-directed work, (e.g. schizophrenia, eating disorders, bipolar disorder) and/or the presence of

active suicidality. Severe presentations, with or without an active risk of suicide, are referred to secondary care or other appropriate services. The nature of a service user's mental health presentation is assessed at an initial assessment session and discussed in clinical supervision.

A total of 624 referrals were made to APSI within year 2 which increased considerably to 1,482 in year 3 (subsequent to an expansion into two further counties), equating to a total of 2,106 referrals across year 2 and 3. The number of referrals received for which service users fully completed at least one intervention were 146 in year 2 and 421 in year 3, totalling 567 interventions completed across two years. There were almost twice as many females (60.3%) that completed interventions than males (39.7%), with an overall mean age of 41.16 (SD 14.05).

Interventions

Service users were offered a range of interventions including guided self-help (GSH), computerised cognitive behavioural therapy (cCBT), group psycho-educational programmes and brief one-to-one cognitive behavioural therapy (bCBT). The cCBT programme consists of four modules

delivered over 4 weeks. Using cognitive behavioural theory, the program aims to increase psychological and behavioural flexibility through modifying patterns of maladaptive behaviour and challenging cognitions. GSH involves the provision of psycho-educational materials to inform and empower users in managing their mental health difficulties. One-to-one bCBT consists of six sessions delivered on consecutive weeks. This involves the delivery of standard CBT strategies including thought diaries, behavioural activation and cognitive restructuring. Group psycho-educational programmes consist of stress management skills workshops and wellness groups that inform service users about stress and anxiety whilst promoting self-care and stress management skills. The intervention offered was dependent upon the severity of presentation at initial assessment, consistent with NICE guidelines^{1,2}

Practitioners

The service was delivered by Assistant Psychologist practitioners working in primary care team areas across the midland counties of Ireland. Practitioners had either a primary degree/higher diploma in psychology, masters in

psychology, or both. Prior to delivering treatment, practitioners attended training workshops on the assessment and treatment of mental health difficulties in primary care, including workshops on delivering GSH and bCBT. This training was delivered by a senior clinical psychologist who also provided weekly group supervision.

Measures

Clinical Outcomes in Routine Evaluation (CORE-OM).

The 34-item CORE-OM is a measure of changes in clinical distress post-intervention. This self-report questionnaire assesses psychological distress across four domains including subjective well-being, problem/symptoms, life/social functioning. CORE-OM has demonstrated reliability ($\alpha = .94$) and validity and can be used in a wide range of mental health settings⁷. The clinical threshold for the CORE-OM is 10.

Kessler-10 (K-10). The 10-item K-10 is a measure of psychological distress consisting of items relating to symptoms of anxiety and depression experienced within the last four weeks⁸. It has demonstrated internal consistency reliability ($\alpha = .92 - .93$). Those who score under 20 are likely

to be in good mental health; scores over 20 indicate increased probability of a mental disorder.

Patient Health Questionnaire–9 (PHQ-9).

The PHQ-9 is a self-report measure used to assess depressive symptomatology based on the nine DSM-5 symptoms of a major depressive disorder^{9,10}. This measure has demonstrated high reliability ($\alpha = .86-.89$), sensitivity (88%-92%) and specificity (88%). The PHQ-9 can also be used as a continuous measure of depression. The clinical threshold score for the PHQ-9 is 10.

Generalised Anxiety Disorder–7 (GAD-7).

The Generalised Anxiety Disorder–7 scale is a self-report measure used to assess the seven symptoms of a DSM-5 diagnosis of generalised anxiety disorder¹¹. The questionnaire is also suitable to screen for panic disorder, social anxiety disorder and post-traumatic stress disorder, and was utilized as such. This scale has demonstrated internal consistency ($\alpha = .92$) and test-retest reliability (intra-class correlation = .83). The clinical threshold score for the GAD-7 is 8.

Eco-Psy. The Eco-Psy is a 12 item self-report measure designed to assess economic outcomes associated with

mental health treatment¹². It consists of open and closed questions that examine healthcare utilisation, employment status and work productivity.

EQ-5D-3L. The (5-item) EQ-5D-3L is a self-report measure of overall health¹³. It consists of the five dimensions of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has three answer categories representing three levels of functioning.

Work and Social Adjustment Scale (WSAS).

The Work and Social Adjustment Scale (WSAS) is used to measure everyday functioning. This self-report scale consists of five items measuring the degree to which mental health difficulties are impairing an individual's functioning across five areas: work, home management, relationships, social leisure activities and private leisure activities. Cronbach's alpha measures of internal consistency ranged from 0.7 to 0.94. Test-retest correlation was 0.73¹⁴. The clinical threshold score for the WSAS is 10.

Data Analysis

Repeated measures t-tests evaluated service users' scores on each of the clinical, economic and health measures from pre-

to post-therapy, and pre-therapy to 3-month follow-up in year 2. The improved data collection methods for year 3 allowed for a comparative analysis between interventions. Mixed between-within subjects ANOVA were conducted to investigate overall change in clinical outcome across the PHQ-9, GAD-7 and WSAS psychometrics as well as examining any interaction effects. Levels of clinical recovery and reliable change in pre- and post-intervention scores on the PHQ-9 and GAD-7 were also calculated.

RESULTS

Year Two

Referral Pathways

A total of 624 referrals were made to APSI during the second year of operation, with GP's accounting for the majority of referrals (n = 400; 64.1%), followed by secondary care (n = 101; 16.2%), other (such as social worker; n = 63; 10.1%) and self-referral (n = 55; 8.8%).

Of the 624 referrals received, 69 service users were deemed inappropriate for primary care treatment while 134 declined treatment. A further 145 were referred on to either Counselling in Primary Care (CIPC, local counselling services; n = 117),

secondary care (n = 18) or other (n = 10). Seventy-one attended only the assessment and 55 dropped out. Insufficient data existed for 4 clients. A total of 146 completed an intervention with the service (i.e. 73% completion rate of those who commenced an intervention). Treatment completion was defined as attending all the planned sessions of the intervention. Subsequent statistics were run in this study on treatment completers only (n = 146) with separate future studies analysing the data on non-completers. The mean number of days between receipt of referral and assessment was 13.5 for those who completed at least one treatment (n = 146). Of the 146 who completed at least one intervention, the majority completed GSH, followed by bCBT and fewest engaged with cCBT. A small number engaged with more than one intervention.

Effectiveness of Intervention

Between assessment and treatment completion

Significant reductions on scores between assessment and therapy completion occurred on the K-10 and GAD-7 across all three interventions (cCBT, GSH, and bCBT). Significant reductions in scores across this period on CORE-OM, PHQ-9 and WSAS also

occurred for GSH and bCBT. The mean scores for those who completed GSH and bCBT on the CORE-OM, K-10, and GAD-7 went from above the clinical threshold to below, with a similar reduction in scores

occurring on the PHQ-9 for those who completed bCBT (with the mean score on the PHQ-9 for those who completed GSH already being below the clinical threshold) – see Table 1.

Table 1: *Clinical outcomes of GSH, cCBT and bCBT: Year 2*

Instrument (Clinical Cut-off)	Assessment <i>M (SE)</i>			Post-therapy <i>M (SE)</i>			<i>t</i> (<i>df</i>)		
	<i>GSH</i>	<i>cCBT</i>	<i>bCBT</i>	<i>GSH</i>	<i>cCBT</i>	<i>bCBT</i>	<i>GSH</i>	<i>cCBT</i>	<i>bCBT</i>
K-10 (20)	25.05 (1.46)	24 (3.9)	29.5 (1.43)	16.46 (0.89)	18.57 (3.53)	20 (1.19)	7.64* (36)	1.79 (6)	8.0* (33)
CORE-OM (10)	14.05 (1.12)	-	14.96 (1.3)	5.09 (0.64)	-	7.78 (0.97)	7.18* (17)	-	5.87* (21)
WSAS (10)	12.20 (1.37)	16.17 (3.32)	20.08 (1.72)	6.3 (1.07)	14.33 (4.33)	11.19 (1.58)	4.8* (43)	.49 (5)	5.89* (35)
PHQ-9 (10)	9.87 (0.85)	9.86 (1.93)	13.39 (0.99)	4.6 (0.61)	6 (1.38)	6.51 (0.71)	6.67* (62)	3.01* (6)	7.65* (52)
GAD-7 (8)	8.6 (0.63)	9.14 (1.58)	12.39 (0.77)	3.57 (0.41)	4.42 (1.25)	5.68 (0.61)	8.58* (68)	2.75* (7)	9.75* (60)

* $p < .05$.

No data available on the CORE-OM for those who completed cCBT.

Health and Economic Outcomes.

Health outcomes as measured by the EQ-5D-3L were available for service users who engaged with either GSH or bCBT. Completed GSH intervention resulted in a significant change in the domain of ‘Anxiety/Depression’ from assessment ($M = 1.8$, $SE = .13$) to post therapy ($M = 1.2$, $SE = .13$), $t(9) = 3.67$, $p < .05$. Similarly, for those who completed bCBT a significant reduction was observed in the domain of

‘Anxiety/Depression’ from assessment ($M = 2.33$, $SE = .21$) to post therapy ($M = 1.33$, $SE = .21$), $t(5) = 2.74$, $p < .05$.

Follow-Up

Three months following discharge from APSI, service users were contacted to assess their progress since completing an intervention with APSI. Significant and ongoing reductions on scores between assessment and follow-up were recorded on the PHQ-9 and GAD-7 across all three

interventions (cCBT, GSH, and bCBT). In addition, those who completed GSH and bCBT recorded ongoing significant reductions on scores on the CORE-OM and

K10, with the scores on CORE-OM, K10 and GAD-7 reducing from above the clinical threshold to below for these two interventions – see Table 2.

Table 1: *GSH, cCBT and bCBT treatment completers: Comparison of mean scores at assessment and 3 month follow-up on the K10, CORE-OM, WSAS, PHQ-9 and GAD-7. Yr 2*

Instrument (Clinical Cut-off)	Assessment M (SE)			Follow-up M (SE)			t (df)		
	GSH	cCBT	bCBT	GSH	cCBT	bCBT	GSH	cCBT	bCBT
K-10 (20)	22.89 (1.49)	24 (3.9)	28.55 (1.86)	15.05 (1.35)	18.57 (3.53)	18.39 (1.99)	4.78* (18)	1.79 (6)	7.539* (17)
CORE-OM (10)	11.06 (1.85)	-	12.53 (1.44)	5.75 (.82)	-	6.86 (.57)	2.7* (7)	-	4.21* (10)
WSAS (10)	8.86 (1.76)	21 (4.58)	20.86 (3.16)	3.75 (1.49)	20.66 (6.48)	16.714 (3.36)	3.21* (7)	.96 (2)	1.43 (13)
PHQ-9 (10)	8.64 (.96)	9.85 (1.9)	13.0 (1.36)	4.68 (1.0)	6.0 (1.3)	6.96 (1.28)	3.31* (21)	3.012* (6)	4.62* (29)
GAD-7 (8)	8.6 (.97)	9.14 (1.5)	12.06 (1.03)	4.13 (.74)	4.42 (1.25)	6.76 (1.09)	4.5* (19)	2.75* (6)	4.39* (29)

* $p < .05$.

No data available on the CORE-OM for those who completed cCBT.

Year Three

Referral Pathways and Interventions

A total of 1482 referrals were made to APSI during the third year of operation. As with year 2 referral trends, GPs accounted for the majority of referrals ($n = 958$; 64.64%), followed by secondary care ($n = 219$; 14.77%), self-referral ($n = 175$; 11.8%) and other ($n = 130$; 8.7%). Of the 413 who completed at least one intervention and for whom complete data were available at end of therapy, 66.1% ($n = 273$) completed

GSH, 20.3% ($n = 84$) completed bCBT, 12.34% ($n = 51$) completed cCBT and 1.2% ($n = 5$) completed group intervention. Due to the small numbers of completers for group intervention, this cohort was excluded from the following analysis.

Comparing Interventions Across Time

Mixed between-within ANOVA were conducted to assess the impact of three different interventions (GSH, bCBT and cCBT) on service user psychometric scores

across three time periods (assessment, post-therapy and three-month follow-up).

Depressive symptomatology – PHQ-9

Impact of time and intervention

Where follow-up data was available, a mixed between-within ANOVA was conducted to assess the impact of the three interventions on service user's depressive symptoms as measured by the PHQ-9 across the three time points. There was no significant interaction effect between intervention type and time, Wilks Lambda = .924, $F(4, 202) = 2.027$, $p = .092$. There was a main effect for time, Wilks Lambda = .509, $F(2, 101) = 48.75$, $p < .05$, partial eta squared = .491 (large effect size), with all three groups showing reductions across time indicating an overall reduction in depressive symptomatology regardless of intervention (see Table 3).

The main effect comparing the three types of intervention was significant, $F(2, 102) = 3.401$, $p < .05$, partial eta squared = .063 (moderate effect size) suggesting differences between types of intervention in reducing depressive symptoms (see Figure 1). The mean scores for the GSH and bCBT groups fell below the clinical threshold score of 10 from assessment to

post-therapy and remained below 10 at follow-up. The same was not observed for cCBT as the assessment mean was below clinical threshold and remained below across time.

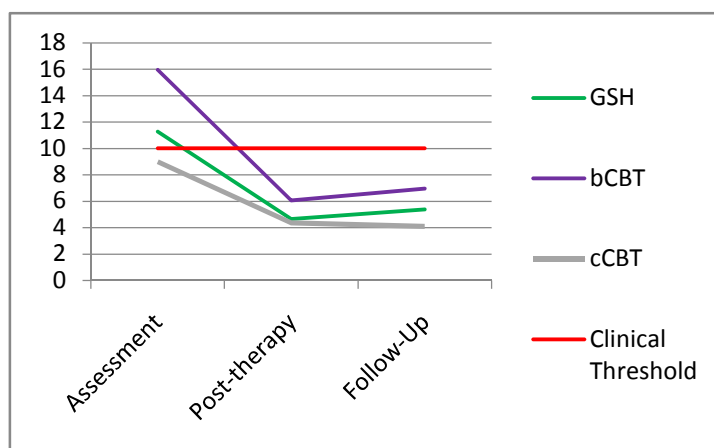


Figure 1: PHQ-9 Scores across Time for Each Intervention

Rates of reliable and clinically significant change

The level of 'reliable change' was defined in keeping with Jacobson & Truax¹⁵, and IAPT research¹⁶, as an improvement of ≥ 6 on the PHQ-9. The level of 'reliable change' following an intervention for clients in the clinical range, i.e. ≥ 10 on the PHQ-9 at assessment ($n = 301$), was 71% ($n = 214$). Of those in the clinical range at assessment ($n = 301$), 66% ($N = 198$) were no longer in the clinical range (i.e. $\text{PHQ-9} \leq 9$) following an intervention.

The two most commonly utilised interventions were Guided Self-Help (GSH) and brief CBT (bCBT). Of those in the clinical range who received GSH ($n = 195$), 73% showed reliable change ($n = 142$), and of those in the clinical range who received bCBT ($n = 78$), 73% showed reliable change ($n = 57$) on the PHQ-9.

Anxiety symptomatology – GAD-7

Impact of time and intervention

Where follow-up data was available, a mixed between-within ANOVA was conducted to assess the impact of the three interventions on service users' anxiety symptoms as measured by the GAD-7 across time. There was a significant interaction effect between intervention type and time, Wilks Lambda = .859, $F(4, 200) = 3.961$, $p < .05$, partial eta squared = .073 (moderate effect size), indicating that the combination of time and intervention were likely responsible for any reduction in anxiety scores.

There was a main effect for time, Wilks Lambda = .474, $F(2, 100) = 55.426$, $p < .05$, partial eta squared = .526 (large effect size), with all three groups showing reductions in anxiety symptom scores between assessment and post-therapy and

a slight non-significant increase between post-therapy and follow-up (see Table 3). The main effect comparing the three types of intervention was significant, $F(2, 101) = 4.756$, $p < .05$, partial eta squared = .086 (moderate effect size), suggesting differences between types of intervention in reducing anxiety symptoms (see Figure 2.). The mean scores for the GSH and bCBT groups fell below the clinical threshold score of 8 from assessment to post-therapy and remained below at follow-up. The same was not observed for cCBT.

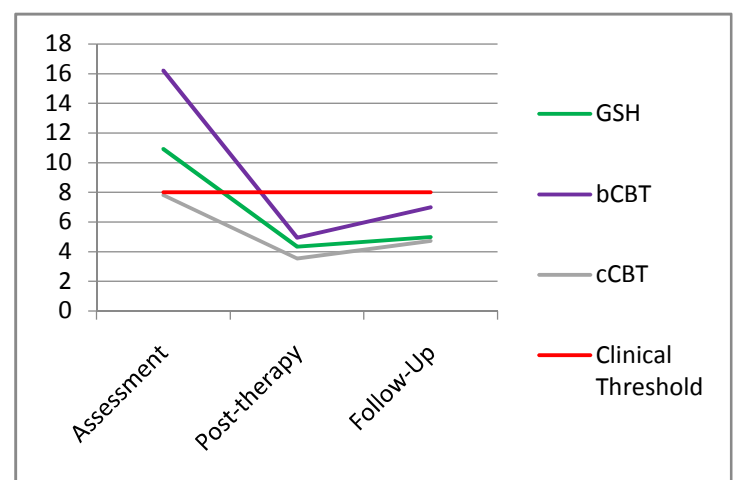


Figure 2: GAD-7 Scores across Time for Each Intervention

Daily Functioning – WSAS

A mixed between-within ANOVA was conducted to assess the impact of the three interventions on service users' daily functioning as measured by the WSAS from assessment to post-therapy. There was no significant interaction effect between

intervention type and time, Wilks Lambda = .997, $F(2, 405) = .697$, $p = .499$.

There was a main effect for time, Wilks Lambda = .783, $F(1, 405) = 112.558$, $p < .05$, partial eta squared = .217 (large effect size), with all three groups showing improved scores from assessment to follow-up, indicating an overall improvement in daily functioning regardless of which intervention engaged with (see Table 3). The main effect

comparing the three types of intervention was significant, $F(2, 405) = 5.608$, $p < .05$, partial eta squared = .027 (small effect size) suggesting differences between types of intervention in improving daily functioning. The mean scores for the GSH group fell below the clinical threshold score of 10 from assessment to post-therapy. The same was not observed for bCBT and cCBT as the mean score post-therapy remained above clinical threshold.

Table 3: Psychometric Scores for GSH, bCBT and cCBT treatment completers across three Time Periods. Year 3.

Psychometric	Time Period	GSH			bCBT			cCBT		
		N	M	SD	N	M	SD	N	M	SD
PHQ-9	Assessment	73	11.27	6.008	21	15.95	5.454	11	9	7.376
	Post-therapy		4.644	4.709		6.048	5.766		4.364	3.749
	Follow-up		5.37	5.526		6.95	7.749		4.09	3.618
GAD-7	Assessment	72	10.917	5.373	21	16.19	3.124	11	7.812	7.547
	Post-therapy		4.333	4.162		4.952	5.454		3.545	2.876
	Follow-up		4.97	5.352		7	7.321		4.73	3.636
WSAS	Assessment	273	15.87	9.611	84	18.845	10.19	51	17.235	10.483
	Post-therapy		9.3	8.603		13.02	10.976		12.12	8.657

Rates of reliable and clinically significant change

The level of 'reliable change' was defined in keeping with Jacobson & Truax¹⁵ and IAPT research¹⁶, as an improvement ≥ 4 on the GAD-7. The level of 'reliable change' following an intervention for clients in the clinical range, i.e. ≥ 8 on the GAD-7 at assessment ($n=323$), was 78% ($n=253$). Of those in the clinical range at assessment ($n=323$), 64% ($N=207$) were no longer in the clinical range (i.e. $GAD-7 \leq 7$) following an intervention.

The two most commonly utilised interventions were GSH and bCBT. Of those in the clinical range who received GSH ($n=207$), 80% showed reliable change ($n=166$), and of those in the clinical range who received bCBT ($n=87$) 75% showed reliable change ($n=65$) on the GAD-7.

Economic outcomes

Wilcoxon Signed-Rank tests were conducted to assess any differences in service users' economic outcomes between assessment and follow-up as measured by the Eco-Psy. There were no significant changes in number of secondary care appointments attended ($Z = -1.496$, $p = .135$) nor number of days missed at work ($Z = -1.373$, $p = .17$). However, there were

significant reductions in the number of primary care appointments attended ($Z = -2.295$, $p < .05$), and number of medications taken by the service user daily ($Z = -2.54$, $p < .05$).

DISCUSSION

Overall, across both years of evaluation, there is evidence that APSI has benefitted many service users in reducing anxiety, depression, and improving overall well-being. The rates of clinical improvement and reliable change for treatment completers were at least equivalent to those reported in UK-based studies of stepped care interventions. The provision of the service delivered by Assistant Psychologists did not result in any obvious deterioration in clinical outcomes. Whether a psychology background adds additional value to service provision may provide a basis for further research. Overall, these results would seem to provide an additional indication that stepped care models, using cognitive behavioural principles, can be successfully applied in other international settings including services based in rural areas. Several Irish national policy documents have promoted an expansion of Primary

Care services (cf: Primary Care: A New Direction¹⁷) and most specifically the increased provision of psychological therapies at the Primary Care level (cf: Sláintecare¹⁸). This research provides further evidence that such expansion is not only needed but can be successfully implemented.

Moreover, this study continues to add to and further elaborate our knowledge of how stepped care provision is helpful to service users with mild-to-moderate levels of distress. In year two, both Guided Self-Help (GSH) and brief CBT (bCBT) were found to be clinically and statistically significant in reducing symptomatology from assessment to post-therapy to follow-up. Furthermore, the GSH intervention appeared overall to be the most effective in reducing service user scores on the WSAS, indicating an improvement in their everyday functioning. One possible explanation for this could be that the use of GSH materials by the service user fostered a sense of being one's own agent of change, potentially boosting confidence for re-engaging with employment, social and leisure activities.

Computerised CBT had mixed results as not all scores on psychometrics had either statistically or clinically significant changes. There were similar findings in year three when analysis also allowed for direct comparison between interventions across time. These results indicated that those who engaged with bCBT and GSH had significantly greater reductions in symptomatology than those who engaged with cCBT. However, these findings do not necessarily suggest that GSH and bCBT are more effective interventions than cCBT. These findings may be due to the stepped-care model of the service which invites service-users with psychometric scores below the clinical threshold to engage with cCBT first. Therefore the baseline scores for service-users that engaged with cCBT were much lower and consequently remained low or showed smaller decreases than those who engaged with GSH or bCBT whose baseline scores were higher.

This evaluation presents similar findings to that of the service's initial evaluation, which also found reductions in depressive and anxiety symptomatology following GSH and bCBT intervention⁴. This study also found that in year three, as in the initial evaluation, there was a

significant reduction in the amount of mental health medications used by the service user. This may suggest that the introduction of brief psychological intervention could reduce the use of or reliance on medication for managing mental health symptoms. Therefore, APSI has increasingly shown evidence of providing an effective service model for treating mild to moderate mental health presentations in its first three years. What remains to be evaluated within the service model is the provision of psycho-educational groups. The scarcity of complete data for service users who engaged with groups reflects the difficulty of initial recruitment. Future studies should consider qualitative evaluations of these groups to investigate these issues, as well as clinical outcomes.

While the level of completion of the interventions of those who commenced them was high (73%), significant proportions of service users were either signposted to alternative services at assessment, or following assessment declined further intervention (with a smaller proportion dropping out mid-intervention). Further research could investigate the decisions of these

categories of service users in greater depth. It may be that certain service users were seeking a different type of support than that on offer, or found that following a swift response to their distress that they did not want or require further input. This may indicate that primary care psychology services that are easily accessible (with walk-in, self-referral options and low waiting times) may need to re-conceptualise themselves as engaging in psychological triage and community signposting work as much as in delivering formal psychological interventions.

Study strengths and limitations

Strengths of this study include the extensive use of multiple reliable and validated psychometric assessment tools. This ensured a comprehensive evaluation of not only service users' presenting distress, but of more generalised functional impairment. Coupled with the iterative nature of psychometric evaluation across three time points, this resulted in a rigorous and longitudinal measure of distress. The study was limited by the modest percentage of service users who completed a full treatment, and were thus eligible for evaluation. This reduced the potential evaluative sample, limiting the

data for analysis. This may have implications for the statistical significance/power of the results. Furthermore, motives for non-completion were not established and therefore, there may be a grouping bias in the presentation of those service users who completed treatment in full. As outlined above a more extensive analysis of the data on non-completers will form the basis of additional studies.

Conclusions and Recommendations

This study provided additional evidence that a stepped-care model of psychological interventions, provided by Assistant Psychologists, can operate effectively in a rural Irish setting. Findings from the current study indicate both clinically and statistically significant changes in outcomes for service users who completed either GSH or bCBT as an intervention with the APSI service. Triangulation of data is recommended for future evaluation, targeting service users, referrers and stakeholders. This may be helpful in establishing factors relevant to non-completion or declining further intervention, efficacy of stakeholder engagement, and the service users' experience of the service. This type of

multi-faceted analysis could also provide a more robust measurement of the APSI service, and help to continue to enhance both service delivery and clinical outcomes.

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REFLECTIONS ON DIVERSE PATHWAYS TO A PAID ASSISTANT PSYCHOLOGIST ROLE

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ABSTRACT

In the current paper, we as five Assistant Psychologists (APs) working in paid posts, reflect on our experiences thus far along our psychology careers. Within, we identify many areas of commonality and contrast woven across our journeys through education, relevant experience, personal development, and our current role. In Ireland, a paid AP post is often anecdotally referred to as the gold standard of experience when applying for the

Doctorate in Clinical Psychology. With this in mind, we reflected on and compared our journeys to this point. Each of our pathways have been significantly different and perhaps not straightforward. However, our experiences have afforded us with a breath of competencies and skills, which we benefit from both personally and professionally. The current paper examines these similarities and differences in order to provide an insight into the experiences of APs through a reflective lens.

INTRODUCTION

Looking at our education, relevant experience and our personal development, we found areas of both commonality and contrast. We chose to focus on these areas as they were themes that reoccurred in our discussions and underpin our career progression. As we reflected on each area, we found that our experiences so far have

afforded us with the competencies and skills required for our current AP post and while different, each of our paths have led us to this point on our clinical psychology journey. Reflection is an essential skill when practicing clinical psychology, as outlined in the British Psychological Society practice guidelines¹ and Psychological Society of Ireland's supervision guidelines². Reflective practice brings a number of benefits to practitioners such as awareness and management of biases. It enables practitioners to be open to feedback and facilitates eagerness to improve¹. According to research, reflection improves decision making³ and aids psychologists in maintaining ethical and professional standards⁴. Reflective practice is a competency which we are actively focusing on to develop. Our focus on reflective practice, together with the commencement of our current AP posts inspired this reflective piece, detailing our journey thus far within the realm of clinical psychology. Having simultaneously taken up employment in these paid AP posts, we now have the opportunity to reflect on each of our pathways to date.

EDUCATION: OPPORTUNITIES AND FRUSTRATIONS

Previous research, which has profiled APs and those pursuing clinical psychology in Ireland, has found that an overwhelming percentage hold a master's degree^{5, 6}. Collectively, we have completed six masters across the Republic and North of Ireland. Yet, in discussing our routes to becoming APs, we found that a lack of clear guidance from secondary level through to university level was a recurring theme. At secondary level, psychology was not a career that was promoted or clearly explained. At university level, there was an overwhelming pressure to choose a relevant master's that would ultimately prepare us to pursue a Doctorate in Clinical Psychology. Conducting our own research into what pathway to follow was essential in choosing an educational path as adequate guidance was not always provided (e.g. searching for a course accredited by the Psychological Society of Ireland).

Each of us had recognised in our undergraduate degrees that we would most likely be required to complete the minimum of a master's level degree.

Bearing this in mind, we have all found ourselves frustrated on occasion with the length of time we have spent in academia. A common frustration stemmed from comparisons to other peers' career paths and how they appeared to progress at a quicker pace than our own; specifically, securing relevant work with an undergraduate degree. Intrinsic to this is both our own and society's expectations of holding a master's degree and gaining employment. In many careers, a masters' degree is not essential and is only required if an individual wishes to become more specialised in their field of work. However, on the path to clinical psychology, it feels as essential as an undergraduate degree. We have found that this can be difficult to explain to family and friends, as well as trying to shake the image of 'the perpetual student'. Our progress seemed minimal then, although reflecting on these experiences with hindsight, we can see that we were on the same trajectory as other aspiring psychologists. However, this was overshadowed at the time by the lack of results for our efforts; such as graduate entry paid employment.

It is widely recognised that the path to clinical psychology is competitive and the

pressure experienced to excel relative to our psychology undergraduate peers can be overwhelming. We felt this was reflected in differing ways during our postgraduate degrees. Some of us experienced this competitiveness almost to an isolating degree and felt little camaraderie among classmates. Contrastingly, some of us experienced a nurturing and supportive environment of classmates and unsurprisingly reported more positively on our postgraduate experiences. Upon reflection, we feel the courses that were more supportive, tended to be smaller and had a more diverse student population. The absence and presence of a supportive peer group has guided our own interactions with each other as a group of APs within a clinical psychology service. We recognise the value of peer support and how it is more beneficial to help each other towards a career in clinical psychology rather than perpetuate a competitive environment.

Reflecting on our experiences throughout our educational careers, we are now able to recognise the benefits of these challenges as they prepared us for our roles as APs and have given us a solid foundation for our potential careers as

clinical psychologists. These formal and informal teachings during our educational careers, so far, have become skills that are integrated into our daily practice as APs.

CLINICALLY RELEVANT EXPERIENCE

Due to continuing development of the AP position, the disconnect between study and postgraduate employment can feel like a large jump into the abyss. The established culture of unpaid AP roles within the Republic of Ireland⁶ requires many aspiring psychologists to seek paid employment in other clinically relevant roles, following study. Despite this challenge, combined with the limited amount of AP positions, we all secured psychologically relevant roles, such as support worker or research assistant posts. Indirect clinical experience was gained through voluntary roles and for some of us, through clinical research. Our involvement in a range of divergent research projects has led to an assortment of differing interpersonal and research strengths that we each now bring to the role as a team of APs.

Equally, all of us have been fortunate to experience a rich variety of clinical work

with both general and clinical populations throughout the lifespan. However, acquiring this experience was not as straightforward as simply gaining an AP role. Instead, we chose to take on available caring roles in order to develop our skill sets, which often meant taking a detour from the idealist's direct route to clinical psychology. For many of us, this required welcoming new challenges, which has since afforded us a wealth of knowledge and a colourful source of individual learning that we may not have otherwise gained. Some of us have worked with vulnerable populations for the purpose of research (e.g. homeless populations), with others working in more specialised settings (e.g. tutoring children with an autism diagnosis informed by Applied Behaviour Analysis). Working directly with clients has fostered applied skills, which we use as part of our practice today. Volunteering (e.g. Samaritans) has also been a valuable outlet to learn and apply clinical skills. Openness to experience in meeting our individual learning needs has been a necessity for all of us and may partly explain why we have worked with multiple agencies of diverse purpose and ethos. Having experienced many different

organisations ranging from clinical and addiction settings to various disability and mental health services, we each have a broad baseline to contrast our current role. This has also fostered a broader understanding of healthcare provision.

At times, the sense of competition to progress along the clinical path has imposed feelings of urgency and haste towards gaining experience. With our current knowledge and experience, we recognise the limits to our competencies and appreciate that earlier frustrations with workloads and clinical exposure may have been borne out of this urgency. As time has passed, having worked in a number of roles between differing organisations, an understanding has developed that workloads were devised differently and mostly tailored according to acquired skill set and limits to competency. This has been a key learning point that we have all taken into our current role and use to manage our expectations.

Despite our varying experiences, a commonality has been the inconsistent value placed upon training across different organisations. This resulted in the absence

of training being generally reported as a barrier to professional development. Looking back, efficacious training has informed and prepared us for our current roles e.g. 'Children First'. Training nurtures a sense of capability and readiness, which acts as a medium to remove some of the unknown that can maintain anxieties in new settings.

PERSONAL GROWTH AND DEVELOPMENT

Personal development is arguably one of the most significant aspects of growth we have experienced in our journeys towards clinical psychology. It is a lifelong process, which we continue to maintain, while also recognising the extent to which we have already personally developed through embarking on our individual paths. We acknowledge how our experiences to date on this journey have been crucial in making us more informed versions of ourselves today, both as APs and as individuals.

The concept of self-worth, or lack thereof, was a theme that was prominent in our reflections of our own personal development. In pursuing a career in psychology, questioning our self-worth has

manifested as considerations of changing academic paths and invariably questioning our abilities and competencies. These feelings may well be attributable to the challenging nature of pursuing psychology as a sustainable career. We concurred that there is a profound lack of opportunities to demonstrate skills and competencies while completing a degree in psychology. The work that we engaged in to maintain our financial independence (e.g. retail work) both during and after our studies, generated feelings of inadequacy which we felt negatively impacted on our self-worth. We felt that this arose from questioning our skills as early-career psychologists, rather than recognising the lack of availability of AP roles. This may have been compounded by taking on the expectations of others. However, we all agreed on the necessity of completing and balancing various employments, which ultimately led to a significant amount of our personal development; including an opportunity to take a break from psychology and the enhancement of competencies, such as organisational, teamwork, and communication skills. These are essential competencies we continue to apply in our current role as APs.

We explored the relationship between questioning one's self-worth and the inevitable crossover with experiencing "Imposter Phenomenon"⁷. This concept is well-established within psychology and denotes an internal barrier to empowerment and achievement through internalised self-doubt that one will be exposed as a fraud⁷. All of us at various points have experienced this phenomenon, and continue to experience it at times. Central to this widespread feeling across our group, is the fact that we are now paid for roles which we would have previously held in a voluntary capacity. Although challenging at times, feeling inadequate or incompetent is something, which may have hugely helped our personal development. Feelings of anxiety or inadequacy have helped fuel efforts that have made us ensure that we are always striving to reach our full potential. Simultaneously, realising our own limits of competency relative to the stage we were at individually, remains important. Personal development and reflective practice has allowed us to become cognisant of our own limits of competency while also acknowledging our abilities.

Self-care is a practice deemed necessary in a vast range of caregiving positions, including psychology^{8,9}. Although we were all aware of its importance and necessity, we discovered upon reflection that we were not always practicing what we were preaching. Balancing the demands of pursuing a career, financial stability, and attempting to maintain interpersonal relationships made the task of engaging in self-care seem extremely difficult. Now that we are receiving stable finances, relevant experience, and regular working hours, most of us agree that it has become significantly easier to practice self-care. It was also gleaned that many of us experienced feelings of guilt initially when considering self-care. We were suddenly exposed to regular hours with free weekends without requiring extra work or study. Initially, filling free time with self-care activities felt like a foreign concept for many of us. Having this opportunity to reflect has allowed us to recognise our limits and the signs of becoming burnt out, which is essential in our current roles. Each of us acknowledges that to be fully present and deliver the most optimal service and skills we have to offer to our clients, we must first look after ourselves, listen to our

bodies, and practice self-care. Therefore, we now recognise self-care as more of an achievable priority than we may have previously. It is worth noting that some reflections discerned amongst us reported that engaging in self-care is still something we struggle with. This is a commonly reported issue amongst caring professionals, in which one's own self-care is disregarded as a means of focusing on the client's care⁹.

OUR CURRENT ROLE

In our current role as APs, we are working together on paid fixed-term contracts as part of a team with other clinicians. Since beginning in this role, we have been granted numerous opportunities for training and have had the fortunate experience of being able to access much needed practical resources and support. We receive weekly individual supervision with a clinical psychologist and have the opportunity to engage in bi-monthly peer supervision with other APs based in similar services. While working directly with clients, each of us have had differing experiences from past roles which highlighted a range of supervision formats and how clinical supervision has been

delivered. Supervisors have played a paramount role in the growth and support of our learning, which has developed from both clinical observation and supervision. For some of us who received structured, regular supervision, this is where much of our learning was consolidated. For others, supervision was less frequent and often informal. This was reported as a barrier to reflective practice. Through this experience, we have learned the merits of quality supervision practice in our role today.

Aspects of this role are both similar and contrasting to previous psychological work we have experienced. Gaining paid employment brought a sense of relief and comfort as we could now focus all of our working energy on developing within a field we enjoy and are passionate about, without needing to add an extra source of income. As previously mentioned, self-care was an aspect that we had all struggled with. However, our new positions have afforded us with time and means to truly invest in self-care at a higher level on Maslow's hierarchy of needs¹⁰. Although we have been experiencing a sense of career stability that has been uncommon for us all up until this point, our contracts

still include an end date; which brings with it an element of uncertainty for the future. To date, nothing along any of our varying paths has signalled a definite arrival at the positions we now hold. Similarly, these positions do not guarantee a place on the Doctorate of Clinical Psychology as our next stop. They do, however, guarantee an enrichment of our careers in the world of psychology.

Working alongside four other APs has been a new experience for us all. This peer environment has allowed for informal and formal peer supervision, an opportunity to build upon teamwork competencies, and the chance to foster an environment in which we can learn from each other's journeys and gained perspectives. All humans have the ability to uniquely perceive one same situation or event¹¹. Likewise, although in practical terms all five of us are experiencing the same role within the same setting, all of our takings from this role will be unique. In the context of the broader team, this was the first time some of us were provided with the opportunity to work under the guidance of a clinical psychologist. For others, it was another opportunity to gain a real sense of the diverse nature and ways

of working within this profession. Being part of this broader team has allowed us to experience great levels of both professional and personal support. Experiencing this nurturing and supportive culture has fortified our careers and it is something that we can now take into our future working lives and endeavours.

An important aspect, which has remained a central thread along all of our individual paths, is an appreciation for the opportunity to engage in meaningful work with those in our communities. Having the privilege of being a part of individuals' intimate psychological journeys has afforded us perspective on the reasons why we are endeavouring to become clinical psychologists. Reflecting on the human impact of this type of work has also inspired us to continue our learning within this broad field and renew our motivation for career progression.

CONCLUSION

The experiences of questioning self-worth, enduring "Imposter Phenomenon", navigating education, tolerating social sacrifices, and engaging in self-care, while extremely challenging, have also led to the

personal development which we deem to be hugely beneficial for who we are as individuals and clinicians today. However, we experienced none of these elements within a vacuum, but rather surrounded by the immense support, guidance and reassurance, which we each received in our personal lives, something that we cannot ignore. Throughout our discussions, we realised that each of us have followed different paths to arrive at the same destination. This realisation instilled huge personal reassurance for us; the recognition that some individuals will have done more, some will have done less, all will most likely have done differently, and that is okay. The pressure to gain experience and secure, paid, relevant employment often obscured our abilities to fully acknowledge the value of our experiences. However, now that we each have had an opportunity to look back, and collectively reflect on previous experiences, we can identify the value of these and acknowledge their contribution to our practice today. Having said this, we are aware of the limitations and barriers to reflection, namely that it is both anecdotal and coloured by our personal experience. Also, we acknowledge that the current

paper is not without bias. Our views are not representative of all AP experiences and are subjective to our own personal recall.

Comparing our journeys has also allowed us to appreciate the variety of experience we each bring to our team and how this provides our clients with a more enriched service provision. We now embrace our learning role and realise that developing competencies is a process, which takes time. Ultimately, we hope to continue along the path of clinical psychology through completion of the Doctorate in Clinical Psychology. The contrast between the path now and before, however, is the realisation that hopefully, the positions that we are in will allow us to further develop our reflective practice and be mindfully appreciative of the value in our experiences. The path seems less intimidating without thorns and darkness; now it is just a journey that we are each progressing along and will arrive at our destination when we are ready. Reflecting on where we are today has helped us acknowledge our strengths and achievements to travel along an enlightened path that is more illuminated and less daunting.

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DOMESTIC VIOLENCE: A LITTLE EXPLORED AREA IN CLINICAL PSYCHOLOGY

SORAYA MATTHEWS AND JONATHAN EGAN



ABSTRACT

This article reviews the literature on psychological, emotional and physical factors related to compassion satisfaction and fatigue experienced by professional female domestic violence support specialists. The Irish context is discussed and recommendations are made in relation to protective organisational and psychological factors, as well as identifying common risk factors.

ROLE OF A PROFESSIONAL CAREGIVER IN A DV CONTEXT

Female domestic violence support specialists (DVSS) provide a range of

comprehensive services to their clients. These services can include; providing practical and emotional support to clients, teaching and mobilising coping skills, sourcing emergency accommodation, conducting risk assessments, designing safety plans and safety leaving planning protocols, accompanying clients to court and An Garda Síochána, supporting clients making applications for barring and safety protection orders, and supporting clients with accessing their rights and entitlements. In addition to, or instead of, working with DVSS, many DV survivors will seek help from mental health professionals, often engaging with therapists who specialise in trauma^{1 2}. By working with a trauma therapist, survivors can work on addressing the potential short-term and long-term psychological, emotional, and physical effects resulting from their traumatic DV experiences. Often, DVSS will also be working within a diverse range of settings that differ in

terms of access to resources and organisational structures³. This can include; challenging policies, challenging institutional values and public attitudes, writing legislation, training organisations, campaigning, and educating students⁴. By working within this sector, DVSS deliver empathetic and non-judgemental comprehensive services that are tailored to their client's needs and objectives, and normalising their client's feelings surrounding their experiences⁵.

WHAT ARE THE POTENTIAL SIDE-EFFECTS OF THIS WORK?

Professional quality of life refers to “the quality one feels in relation to their work as a professional helper” and is influenced by both positive and negative facets of the work⁶. In providing support services to clients who have experienced high levels of trauma, it is important to consider the potential secondary effects of continual traumatic material exposure on DVSS. For a number of years, research has indicated that secondary traumatic stress (STS) and compassion fatigue (CF) are an occupational hazard for health care professionals including DVSS, social

workers, psychologists and psychotherapists,^{7 8 9} and that these professionals often have their own personal trauma history, similar to that of their clients¹⁰. Similarly, a study found that when compared to 26 other employment domains, social workers were one of 6 professions that reported the worst levels of psychological well-being, health outcomes, and job satisfaction, in their organisations¹¹. This is believed to be due to this population's high exposure to clients, and their need to balance complex case responsibilities and organisational demands, similar to that of DVSS. Unfortunately, there is relatively little research examining the organisational and individual factors involved in the experiences of those who work specifically with DV survivors and to our knowledge, there is no such research examining this within an Irish context at present.

STS can be described as “the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by another – the stress resulting from helping or wanting to help a traumatised or suffering person”¹². This literature is difficult to

synthesise within the area of DV as previous research has often used the terms STS and CF interchangeably. For the purpose of this article, CF describes the overall exhaustion experienced by an individual as a result of organisational and environmental stress. Whereas STS is specific to indirect trauma exposure and the effects that it can have on the individual secondarily, as opposed to their client who have experienced the trauma primarily. Responses to secondary trauma exposure are often described as falling along a continuum beginning with compassion satisfaction (CS) derived from the helping role on one side, and ending with CF, which is a term often used to represent the most extreme experiences of compassion stress that include psychological distress or disturbance^{12 13}.

Repeated exposure to traumatic material may include the following traumatic stress reactions: re-experiencing, whereby an individual may re-experience material that they had been exposed to previously (e.g. may think about patient's experiences or flashbacks as if they are back at that moment); avoidance, whereby an individual may avoid their thoughts or

feelings towards events, or may begin distancing themselves from the source); arousal, whereby an individual can become hyper-aroused (e.g. increased anxiety and easily startled); and changes in mood (e.g. increased irritability, anger or depression). If these responses continue to persist without intervention, they may begin to impact quality of life. For example: physical ailments; social withdrawal; sleep disturbances; hopelessness; diminished self-care, cynicism; illness; and chronic exhaustion¹⁴.

Professional caregivers are increasingly being expected to identify and respond to family and sexual violence as the chronic nature and severity of the long-term health impacts become increasingly recognised. In an American study of 148 DVSS it was found that 47.3% demonstrated STS symptoms at the clinical cut off for the DSM-V¹⁵ posttraumatic stress disorder (PTSD) criteria. In a similar American study¹⁶, it was found that approximately 65% of the 154 social workers working with DV survivors had at least one or more symptoms of STS and that 20.8% reported experiencing moderate to severe STS. Among the three core STS symptoms

examined (re-experiencing/intrusions, avoidance and arousal), participants demonstrated more symptoms of re-experiencing/intrusions than the other two domains, with more than half reporting re-experiencing/intrusion symptoms at a clinically significant level. Qualitative research⁷ involving 104 trauma clinicians cited the following risk factors for STS: caseload, prior trauma, reduced supervision, reduced social support, worldviews, and self-awareness of self-care.

POTENTIAL RISK AND PROTECTIVE FACTORS?

Review of the literature suggests that potential risk and protective factors relevant to stress responses should be considered on three levels: individual, organisational and environmental. As mentioned earlier, there is a marked difference between the concept of CF and STS when examining risk and protective factors in DVSS. However, general stress models, such as the conservation of resources theory (COR)¹⁷, may help provide a conceptual framework within which CF and STS can be considered. COR

model posits that the ongoing wearing out and down of resources invested to counter organisational demands can result in the depletion of emotional, cognitive and physical energies that is akin to emotional exhaustion. Negative stress experiences thus ensue when these resources are threatened, lost or invested without reward¹⁸.

In this instance, work demands, such as role ambiguity, emotional conflict, time constraints and high caseloads, can pose as losses or threats of loss^{7 19 20}. There are also environmental demands that can arise such as attitudes surrounding DV, inter-agency conflicts, and public stigma of job roles. According to COR, resources refer to factors of value to the individual that are protective against negative emotional, psychological and physical outcomes. Reduced job resources (e.g. supervision, training, organisational social support) have been shown to be predictive of STS and CF in professional caregivers working with DV survivors^{16 21 22}. Loss of personal resources (e.g. self-efficacy, optimism, wider social support, coping strategies) have also been identified as risk factors^{7 23 24 25}. If these resources are depleted over

time and not managed correctly, individuals may engage in 'defensive behaviours', such as depersonalisation, withdrawal or emotional detachment, in an effort to cope with their stress experiences. COR also theorises that if resources are successfully gained, or regained, that the 'resource pool' for counteracting stress experiences is increased for that individual, thus leading to improvements with respect to motivation and well-being²⁶. Figley¹² noted that a sense of achievement (e.g. self-satisfaction with the services provided to clients) and disengagement (e.g. being able to distance oneself from clients' issues between sessions) are factors that lower or prevent compassion fatigue.

HEALTH IMPLICATIONS FOR DVSS

How an individual appraises and copes with stressors is a subjective process. As mentioned in COR, resources constitute concepts of value to a person, and when coupled with stressful experiences, these resources can decrease and the ability to cope with stressors can become compromised. This perspective is reflected

in Lazarus and Folkman's²⁷ transactional model of stress and coping. Although their focus was on appraisal and coping frameworks, they acknowledged that states in which resources become overtaxed or lacking can create or perpetuate stress experiences. They also saw the state in which resources could become overtaxed or lacking as creating or perpetuating stress experiences and this subsequently setting in motion the process for appraisal and coping mechanisms. Therefore, the transactional model views stress experiences as a transaction between individuals and their environments. 'McEwen's²⁸ model of allostatic load provides an explanation within a biological framework in which it is posited that allostasis, the achievement of homeostasis through physiological or behavioural change, is the body's process of maintaining stability through change and stress. However, when these key biological systems become overwhelmed by stressors, allostatic load can increase. Trauma exposure or more stressors in a person's life can increase allostatic load by chronically activating the hypothalamic-pituitary-adrenal (HPA) axis, sympathetic nervous system and immune response²⁸.

Research has suggested that prior trauma “primes” the inflammatory response system so that it reacts quicker to stressors in later life^{28 29}. Thus, if an individual was predisposed to appraising stressors negatively and felt that they did not have the appropriate resources to cope with this, their allostatic load may increase and can result in positive or negative health implications.

This is an important concept to consider in the context of DVSS due to the increase in indirect trauma exposure when working intensely with DV survivors. It has been suggested that trauma professionals who have faced their own traumatic experiences have higher incidences than the general public of a wide variety of serious and potentially fatal illnesses, such as respiratory diseases, cardiovascular disease, chronic pain syndromes and gastrointestinal disorders³⁰. It has been shown that increased exposure to adverse childhood experiences, where a child has been exposed to considerable and prolonged stress in the past, can have life-long health and wellbeing consequences³¹. For example, a study compared medical outcomes of 17,000 adults who did vs. did

not experience stressors in their childhood (e.g. abuse, DV and neglect) with the results indicating that those exposed to early adversity were 1.5-2.0 times more likely to have an incidence of cardiovascular disease, autoimmune disorders, and premature mortality^{32 33 34}.

According to psychoneuroimmunology studies, a number of these illnesses are because severe or overwhelming stress, and any resultant STS, can alter and dysregulate the key systems that are central elements of the stress response²⁸. A study investigating Irish female trauma therapists and body-centred countertransference found that half the sample reported sleepiness, unexpected shift in body, muscle tension, headaches, stomach disturbances, and that there was a significant relationship between higher somatic reports and annual sick leave days taken³⁵. Qualitative work conducted on 20 American clinicians working with trauma survivors identified a major theme of bodily symptom recognition and sensitivity. All of the therapists involved in this piece of qualitative work reported that they were able to identify their experiences of stress via effects on their

body and health, such as muscle tension, headaches, sleep disturbances and lack of energy from working with child protection and DV survivors⁷.

DEPERSONALISATION – DEFENCE OR CONSEQUENCE?

Depersonalisation (DP) is a dissociative phenomenon that is described by the DSM-V¹⁴ as a state in which a person has “experiences of unreality, detachment, or being an outside observer with respect to one’s thoughts, feelings, sensations, body, or actions (e.g. perceptual alterations, distorted sense of time, unreal or absent self, emotional and/ or physical numbing)”. Experiencing transient episodes of DP is common in the general population and can last seconds, minutes, hours or days³⁶. As mentioned previously within the COR framework, if an individual feels as though they do not have the appropriate resources to counter job demands/traumatic stressors, they may engage in DP as a maladaptive defence mechanism, whereby emotions are suppressed to increase alertness and functioning during stress³⁷. Maladaptive

coping strategies such as DP (which negatively impact on a person’s ability to regulate their emotions effectively), and adaptive coping strategies such as seeking social support and practicing self-care all appear to play a role in susceptibility to STS²³. It has been suggested that individuals with emotional regulation difficulties do not possess effective processing skills to regulate distressing emotions and have a tendency to internalise their stress experiences, resulting in an increase in reported somatic complaints³⁸. Therefore, information surrounding the construct of DP and its symptoms, (along with interventions for its management), are extremely important aspects of the stress experience of which professional caregivers working with DV survivors need to be aware so they can recognise its potential effects within their own work.

MAINTAINING COMPASSION SATISFACTION (CS)

CS in DVSS is related to reporting a high level of satisfaction from work, and also feeling both competent and in control over

traumatic material to which they are exposed. In addition, it is associated with positive organisational support¹³. In line with COR, CS has been found to be related to lower levels of distress, greater perceived competence about being able to cope, remaining motivated, and in resolving any personal trauma issues which are elicited. While the experience of CS may contrast from that of STS, research has suggested, however, that individuals can experience both at the same time³⁹. Despite the potential risk factors of this profession, DVSS have also described outcomes of personal transformation, positive growth, and meaning^{23 40}. In addition, adaptive coping methods and positive sources of support have been reported, examples including affiliative peer and organisational support and debriefings²⁵. Separately, the management of boundaries between work and home life⁴¹, cognitive reframing⁴², and specialised trauma training are seen as essential aspects of self care⁴³.

A meta-synthesis examining the impact of trauma work found that it can potentially increase short and long term levels of distress and that these effects can be

managed through personal and organisational coping practices. Similarly, it was also found that this work results in changes in schemas and daily routines, and that these changes can also be both positive and negative⁴⁴. Management of secondary trauma within professional caregivers working with DV survivors involves acknowledging how emotionally challenging the work can be, understanding that STS may affect and distress DVSS, recognising the symptoms early and comprehending the importance of regular self-care; both organisationally and individually. A meta-analysis by Hayes, Gelso and Hummel (2010)⁴⁵ examining countertransference (CT) in therapists found that CT management was related to positive therapeutic outcomes. In turn, they noted that self-integration was a useful management tool which highlighted the importance of resolving major personal conflicts, which underscored the value of professional supervision for this workforce.

According to the literature change should occur on three levels: educational (understanding concepts and prevalence, training); organisational (work-place policies targeted at STS and somatisation,

normalising stress, organisational support, professional development, peer support, adequate supervision to include management of CT and STS); and individual (awareness of own responses to demands, self-care strategies, social engagement, coping skills, maintaining boundaries, and finding a sense of meaning)^{9 45 46}.

IRISH CONTEXT AND IMPLICATIONS

Currently there are 38 DV support centres in Ireland⁴⁷. DV is also called domestic abuse, intimate partner violence or relationship abuse, and it has been defined as “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This abuse can encompass but is not limited to: physical, emotional, psychological, sexual, financial, controlling and coercive control.”⁴⁸. For the purposes of this article the term DV was solely used. According to the most recent female DV services report in 2016, 50,551 helpline calls were answered and 10,101 women received

one-to-one support across Ireland⁴⁷. Statistics pertaining to male rates of DV are unfortunately lacking in Ireland. A single study of DV in 2005 was a study conducted by Watson and Parsons⁴⁹ for the National Crime Council found that 15% of women and 6% of men suffer extreme domestic violence in Ireland. As mentioned previously, no research has been completed to date on the experience and management of STS and CF in DVSS in Ireland.

In terms of knowledge transfer and awareness, there is a need for more robust and diverse research examining the personal and organisational experiences of DVSS within the profession. Of the existing research that specifically examines this topic, there are numerous limitations. Future research should focus on the removal of sampling bias during recruitment and clearly define job titles and DV itself to increase generalisability. At present, the majority of research examining DVSS and their experiences are quantitative surveys that examine multiple variables (e.g. often at the risk of survey burden) or small exploratory qualitative studies^{2 50 51 52 53}. It would be beneficial for

this area if future research was peer-reviewed and included both longitudinal and randomised control trial designs to accurately assess DVSS experiences over time and the effectiveness of both treatment and prevention of STS and CF. In addition to self-report measures, future research could address the need for both direct observation and biological correlates (e.g. cortisol and inflammation) to give a more comprehensive and applicable overview of STS, CF and CS in DVSS.

CONCLUSION

The comprehensive and essential services that DVSS provide are of importance to society. However, exposure to high levels of traumatic material, coupled with organisational and personal demands and personal trauma history, can result in psychological, emotional and physical outcomes when not managed correctly by both organisations and staff. The effects of this work can also provide a significant sense of achievement, fulfilment, and personal growth if DVSS are supported to access and engage in supervision, social support, positive emotion regulation, self-care strategies, and manage potential risk

factors. It is important that the need for adequate supervision is understood by organisations and policies. For DVSS, high quality supervision can normalise their experiences and emotions, offer support and information surrounding the course and nature of their traumatic responses, aid in the identification of transference and countertransference issues, and uncover symptoms associated with this area of trauma work^{54 55}. Overall, this is a multi-component approach to promoting wellbeing within these groups of professional caregivers and requires both individual and organisational participation.

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