



UCLUS

UCL Unit for Stigma Research



UCL



the british
psychological society
promoting excellence in psychology

Supporting and
valuing lived
experience of mental
health difficulties in
clinical psychology
training



Dr Natalie Kemp
Prof. Katrina Scior
Dr Henry Clements
Dr Kathy Mackenzie-White



the british
psychological society



Division of
Clinical Psychology

ACP UK
ASSOCIATION OF CLINICAL PSYCHOLOGISTS



[@Uclusresearch](https://twitter.com/Uclusresearch) #ExpertsWithExperience

Nobody is an island...



- Informed by early conversations with colleagues in the RCPsych and RCN
- Co-produced with stakeholders within the clinical psychology training community in the UK: trainees, trainers and clinical supervisors, many of whom are #ExpertsWithExperience
- Supported and published by the BPS
- Supported by ACP-UK

We warmly thank the following colleagues and trainees for their contributions:

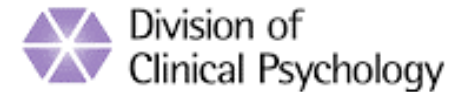
Jo Armitage, Rajinder Ballman, Frances Blumenfeld, Anne Cooke, Laura Dickens, Clare Dixon, Julie Evans, Lorna Farquharson, Lorna Fortune, Catherine Gamble, Laura Golding, Dave Harper, Camilla Hogg, Lorna Hogg, Cheryl Hunter, Kirsty Killick, Aliénor (Lili) Lemieux-Cumberlege, Olga Luzon, Jennifer Oates, Richard Payne, James Randall, Molly Rhinehart, Imogen Rushworth, Inke Shreiber, Viv Smith, Rachel Terry, Jane Vosper, Ste Weatherhead, and Nick Wood.

Context

- Work and course cultures maintaining ‘us-versus-them’
- Pressure on Mental Health Professionals (MHPs) to appear ‘invulnerable’ and remain on the side of the ‘helper’
- Need to support and value trainees with lived experience



Context



BPS/DCP (17.08.20) ‘**Statement on clinical psychologists with lived experience of mental health difficulties**’:

“The Division of Clinical Psychology publicly recognises and supports the **unique and valued contribution** that lived experience of mental health difficulties brings to individuals working within clinical psychology. When lived experience is **actively valued** in aspiring, trainee and qualified clinical psychologists, it can help to enrich practice and improve service provision.”

Context

BPS/DCP (17.08.20) '**Statement on clinical psychologists with lived experience of mental health difficulties**':

1. Lived experience of mental health difficulties is common
2. Lived experience of mental health difficulties is diverse
3. Decision making about sharing mental health difficulties is complex
4. Destigmatising lived experience and addressing discrimination is a whole-system responsibility
5. Lived experience is an asset

BPS/DCP (April 2021) 'Building a caring work culture – what good looks like'



Key Aims / Principles

- Guidance for the training community to increase likelihood trainees with MH difficulties will be supported
- Recognise MH difficulties common among MHPs and those in training
- Challenge silence, stigma and shame
- Culture of compassion and openness
- Normalizing and valuing stance
- Knowing when to ask for help and doing so is a sign of professional competence
- Provide good practice examples and information about multiple sources of support for trainees and trainers



Key Sections of the Guidance

1. Setting the Scene
2. Creating a culture of openness and compassion around lived experience
3. Understanding confidentiality
4. Sharing lived experience of MH difficulties
5. Support for trainees experiencing MH difficulties
6. Taking time out
7. Demystifying professional ethics and fitness to practise

1. Setting the Scene

- Language: ‘mental health difficulties’, ‘mental distress’ and ‘lived experience’
- The full range of mental health difficulties
- A whole-systems perspective: course staff, trainees and placement supervisors
- NHS Staff and Learners Mental Wellbeing Commission Report (2019) and fears of learners
- Legislative context: Equality Act 2010; universities’ common law duty of care to students, Data Protection

2. Creating a culture of openness and compassion

- A culture where trainees and staff feel able to talk openly about personal struggles and lived experience
- All involved in training to think about how they perceive and talk about lived experience
- Avoid assumptions that trainees will not have experienced particular difficulties



Creating a culture of openness and compassion

GOOD PRACTICE

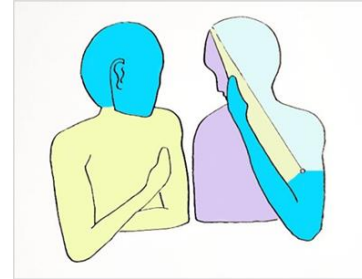
- Supervisor training in supporting trainees sharing mental health difficulties:
 - relationship to lived experience (own and others')
 - power imbalance
 - modelling culture in which openness normalized
- Mentimeter with Year 1 trainees to normalize lived experience, create culture of openness and tackle stigma
- Vignettes of trainees who have struggled with mental health problems
- Staff openly talking about own lived experience
- Trainee-led groups for those with lived experience
- Independent Personal Advisers
- Support in accessing personal therapy
- Personal resonance: placements and research

3. Understanding confidentiality

- Key guiding principle: Need to know
- What will happen if a trainee shares a past or current MH difficulty?
- When will confidentiality be broken, both with and without consent, and how will it be broken?
- Importance of a clear confidentiality statement in relation to confidentiality and MH difficulties
- Course tutor and an alternative member of staff

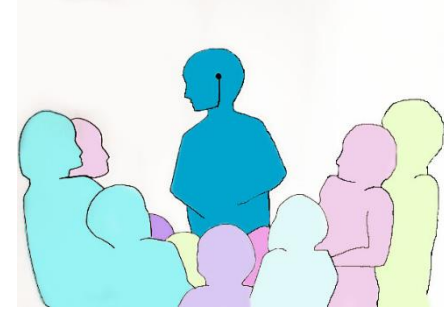


4. Sharing lived experience



- Deciding whether, and if so how and with whom, to share lived experience: context dependent and no ‘one-size-fits-all’
- Resources to help make decisions around sharing:
 - Heads Up:** Resources and guidance for employees to plan a conversation about MH difficulties at work; tools to weigh up potential benefits and costs of sharing
 - Conceal or Reveal (CORAL):** practical guide for employees
 - Honest, Open, Proud:** manual to help weigh up benefits and costs of sharing and template for how to tell one’s story

Sharing lived experience



- Isolation is common: it may be helpful to link with others, e.g. www.in2gr8mentalhealth.com
- Social media: key role in promoting open conversation about MH and anti-stigma campaigns **but** carefully consider implications of trainees sharing on social media:
 - “Remember that social networking sites are public and permanent. Once you have posted something online, it remains traceable even if you later delete it.”
(BPS Ethics Committee ‘Supplementary guidance on use of social media’)
- Sharing lived experience in the therapeutic relationship: research is in its infancy but important carefully to weigh up potential risks as well as benefits

5. Support for trainees experiencing mental health difficulties



- Both the trainee and service users should be kept at the heart of thinking and safeguarding service users must be taken seriously
- So far as possible, 3 or 4 way conversations between trainee, course staff, supervisor and OH
- Involve trainee in deciding what peers are told
- Avoid need for multiple conversations
- Courses to provide info about sources of support (e.g. NHS, Independent Personal Advisers, university support services, lived experience peer support groups, Union support)

Support for trainees experiencing mental health difficulties

- Making reasonable adjustments (which need regular review), e.g.:
 - Increasing frequency/length of meetings with course tutor or supervisor
 - Adjustments to teaching and/or placement hours
 - Part-time hours
 - Extra time for academic work
 - Tailoring structure and content of placement
- Mindful Employer and ACAS resources



6. Taking time out

- Identifying a need for time out can be seen as a strength in a trainee's professional development and 'competency-in-action'
- Think through what the trainee would like the course to share with peers and other staff
- Keeping in touch: importance of a single link person and agreeing when and how check-ins would be helpful and their preferred format



Returning after time out

- Returning to training:
 - Any adjustments
 - If joining a new year group then support trainee to facilitate meeting the new group and think through beforehand what, if anything, needs sharing
 - Safe space to discuss what lived experience brings to professional practice and supervision and, if wished, possibility of sharing this with others
 - Regular planned meetings to check how things are going / make adjustments where needed



7. Demystifying professional ethics and Fitness to Practise

- Trainees should seek to recognise when they are experiencing MH difficulties, ask for support where needed and, if necessary, consider taking time out in discussion with training providers
- Training programmes must ensure a compassionate context where trainees feel able to come forward to discuss any need for help

Demystifying professional ethics and fitness to practise



- Name the **very rare** occasions when Fitness to Practise procedures may be invoked, for example where trainees do not do the following:
 - seek appropriate treatment or other support
 - follow medical advice or care plans for a chronic and serious mental health condition, including monitoring and reviews
 - recognise current limits to their abilities

Where next for you?

- Read and please widely disseminate the Guidance
- What narratives / conversations / regulations are there within my systems / contexts about mental health difficulties / lived experience / “burnout” / “resilience”, and what impact do these have? What could be done to change unhelpful narratives / conversations?
- What might help to “break the silence” and encourage openness?
- What steps can I take to help to value staff with lived experience within my setting?
- How can I help to foster a compassionate and open work culture?
- Who to involve as stakeholders?



Thank You!

