



Research Matters

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First thoughts...

It's amazing how much "lived experience" we all have, probably without realising it.

And tapping into that rich human resource is becoming an increasingly important aspect of health research – particularly in mental health and social exclusion.

In this issue of Research Matters, **Stan Burridge** describes his incredible journey from chaotic lifestyle on the streets to professional researcher enabling homeless people to get their voices heard by policymakers (Page 4).

Sonia Johnson, director of the NIHR Mental

Health Policy Research Unit, also reveals how they draw on a wide network of people with lived experience to help plan aspects of their research (Page 10).

Tony David says that bringing researchers under the umbrella of the new UCL Institute of Mental Health is an important step in addressing the problems of people who experience depression, anxiety and other mental disorders (Page 7).

Peter Fonagy explains how smartphones and AI could help flag whether somebody with mental health problems is heading for a relapse (Page 3).

Paul Lelliott, the departing deputy chief inspector and lead for mental health inspection at the Care Quality Commission, gives his verdict on progress in driving up care standards (Page 8).

Leading academics **Claudia Cooper** and **Liz Sampson** explain how important the grants they have received are to helping tackle dementia, now the most common cause of death in England and Wales (Page 12).

Finally, **Sharon Millard** on how the Michael Palin Centre is leading a new trial into improved ways of providing speech therapy to empower schoolchildren who have a stammer (Page 14).



● Visit our website <http://www.noclor.nhs.uk> or follow us on **Twitter @NoclorResearch** for more news and details of how we support the vital research work carried out by our partner trusts. We welcome your feedback, as well as any suggestions for topics to be included in future issues of the newsletter.

“Tapping into lived experience is becoming an increasingly important aspect of health research”

– **Lynis Lewis**,
Service Director, Noclor
Research Support



Hopes rest on AI detecting early signs of breakdown

Can artificial intelligence (AI) help to detect when someone with a mental illness is about to have a relapse?

This is what Peter Fonagy, professor of contemporary psychoanalysis and developmental science at UCL, is hoping to discover as chief investigator for an innovative trial called Relapse Evaluation using Smartphone Technology (REST)¹.

He came up with the idea when he visited a US start-up called Mindstrong Health², which has developed an app called Discovery³.

It uses an algorithm that enables learning about an individual's digital habits, and can be used to measure brain function.

The REST trial seeks to establish whether Discovery could be used to monitor the wellbeing of individuals who have frequent mental health crises that often lead to hospital admission.

“The app gives an indication of your current mental state – how well your executive function is operating at any one time,” Prof Fonagy says.

“The speed with which you find a number that you often ring, how quickly you find an app



on your phone, how long you pause between strokes, the speed of your swipe – these movements can tell us quite a bit about how your brain is functioning.

“We hope to be able to get an early indication of deterioration in individuals with serious mental illnesses, so that we can anticipate relapse and provide support.”

Currently, when a person has a relapse – the most common cause being failure to take medication – it often leads to expensive interventions and the involvement of the police and social services.

It is hoped that the app will be able to provide an early indication of this, enabling outreach intervention before the person hits

crisis point. The concept of the app is based on digital fingerprinting, which was developed in the security industry to uniquely identify individuals through the way they use their keyboard.

However, trial co-ordinator Dr Alisa Anokhina is keen to point out that they have minimised any privacy issues. She says: “Content-free data from the phone is anonymously uploaded on to a Cloud server in the UK. This is done under an ID number; the data is not linked to a person's name.”

In the pilot trial, even people who frequently experienced paranoid thoughts were receptive to using the Discovery app, and Dr Anokhina says the feasibility trial will also indicate whether any particular group is especially apprehensive.

The three-year trial is looking to recruit 400 participants with a diagnosis of schizophrenia, bipolar disorder or psychosis. Five sites have started screening potential participants and three more sites have agreed to take part. Results are expected in spring 2022.

1. <https://bit.ly/2ND2kxj>
2. <https://mindstronghealth.com>
3. <https://bit.ly/2ZpLhpB>

Making research everybody's business

Street voices raise quality of healthcare research

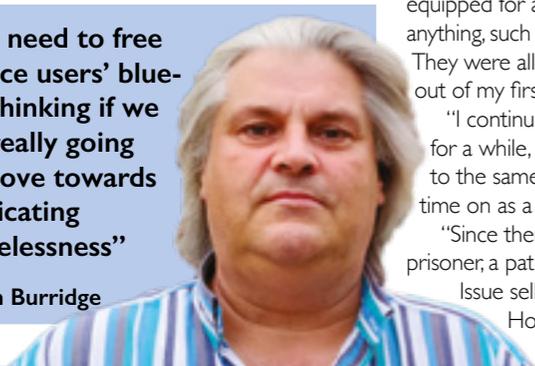
Expert Focus director Stan Burrridge taps into the wealth of lived experience from his chaotic past lifestyle to show how homeless and socially excluded people can make themselves heard.

The one thing you could never accuse Stan Burrridge of is not being streetwise. When he speaks eloquently on issues surrounding homelessness and healthcare, he does so with the authoritative voice of experience.

Burrridge has endured a 54-year journey from troubled childhood to his present position as director of Expert Focus, the company he set up in July this year to enhance service-user involvement in healthcare interventions

“We need to free service users’ blue-sky thinking if we are really going to move towards eradicating homelessness”

– Stan Burrridge



It is the sort of journey many others have not survived, because of complex combinations of physical illness, mental illness, substance misuse, and histories of trauma and abuse.

“I’d been in and out of children’s homes for years before finally going into ‘care’ for good when I was about eight,” he says. “I was moved 17 times in two years, and I first started running away to the streets when I was about nine or 10.

“When I left the care system, I was ill-equipped for adult life. I didn’t have a clue about anything, such as paying bills or cooking food. They were all alien to me. I think I was kicked out of my first flat inside a month.

“I continued on this rapid downward spiral for a while, so it didn’t take very long to return to the same streets that I had spent so much time on as a runaway.

“Since then, I’ve been a rough sleeper, a prisoner, a patient, a hostel resident, and a Big Issue seller outside the BBC’s Broadcasting House. I’ve done the whole nine

yards, which is what gives me credibility in working with and for homeless people.”

His involvement in a protest against the closure of a GP surgery in Watford that had a surgery for homeless people is what eventually led to him becoming a volunteer in 2012 with Pathway, the homeless healthcare charity helping the NHS to create hospital teams to support homeless patients.

Each team includes a specialist GP, nurses, allied health professionals, housing experts and, in some hospitals, Pathway Care Navigators – people who were once homeless and who are given training to support homeless patients.

Burrridge recalls: “One day, I got a phone call from a GP in Watford, Dr Tim Robson*, asking me if I would like to take part in a conference in London. It was being organised by Pathway Faculty for Homeless and Inclusion Health (FHIIH), a network of health professionals working with homeless people, vulnerable migrants, people selling sex, and Gypsy and

Traveller communities. “Needless to say, I jumped at it. I was homeless, no work, no money, and he was going to pay for me to attend. I bumped the train both ways and kept the fare!

“Anyway, I must have made a couple of good points when I spoke at the conference because the Pathway chief executive, Alex Bax, introduced me afterwards to Sir Muir Grey, who was then Chief Knowledge Officer of the NHS.

“Sir Muir asked me if I would collect research data from homeless people on engaging with online carer support. I said not only would I do it, but I’d write the report as well. And that was the first report I had published.

“I was offered more work by Pathway after that, and so I said, ‘Why don’t you give me a job?’ And they did.”

Burrridge worked for seven years with Pathway and was Experts by Experience (EbE) project lead, helping homeless patients to get their often-chaotic lives back on track.



In some areas, Pathway teams can also access specialist “respite care”, offering a place for homeless patients to recover after they’ve been in hospital, and relieving pressure on hospital bed spaces. “In my role at Pathway, I was responsible for making sure that people with lived experience of homelessness and social exclusion were brought in and involved in every aspect of the organisation’s work – and that they were having their voices heard.

“It was almost as if all those years being homeless and volunteering had primed me for the role.

“One of the standout pieces of work that I’m really proud of is what we did around accessing GP services. As Alister Ferguson, a valued EbE volunteer who sadly died in 2016, once said, it’s almost like you need three forms of ID and a letter from God to get to see a GP if you’re homeless.

“Along with Pathway, the FHIIH and other

Continued on next page >>

Making research everybody’s business

>> Continued from previous page

third sector organisations, the EbE team helped drive through an agenda of change that meant that homeless and socially excluded people are no longer required to provide photo ID or give an address to be able to register with a doctor.”

In July this year, Burridge decided it was time to move on and take up the challenge of establishing his own independent company to continue developing initiatives that involve people with lived experience, offering them the same level of training and support.

“The involvement of EbEs is vital if we are to be able to drive the changes needed to address homelessness and social exclusion,” he says.

“User-involvement initiatives in many cases can just become tokenistic, because they work to the agenda of the umbrella organisation, rather than have a free voice and provide an opportunity to bring people together on an emotional level.

“It can often be a dumbed-down voluntary approach to service delivery, rather than a well-resourced, empowering model of peer involvement.

“Such initiatives are often denied the opportunity to hold organisations to account because they are funded and hosted by the very structures they should be free to challenge.

CHANTAL EDGE, speciality registrar in public health and NIHR Clinical Doctoral Research Fellow at UCL, is currently doing her PhD on prison health within the newly-formed UCL Collaborative Centre for Inclusion Health (CCIH), a multidisciplinary team aiming to improve the health of vulnerable and marginalised members of society.

She says: “I work closely with the CNWL Offender Care team on a project to try to set up video consultations, or telemedicine, in Surrey prisons where CNWL provides primary healthcare services.

“As university-based researchers, it’s not enough for us to design the research

“The huge advantage of service users is that they come with blue-sky thinking. We need to create opportunities for them, enable them to feel a sense of belonging and a sense of self-worth – make them understand this isn’t just a talking shop, that they can really make a valued contribution and will be listened to.

“What we need to do is find and set free that

by ourselves. Without the voice of lived experience, we can’t be sure we have prioritised the right research questions, or designed appropriate and acceptable methods or research materials.

“It can be struggle to recruit people with lived experience of exclusion to participate in research. We don’t have the networks, and sometimes people just want to engage with someone who fully understands their position.

“That’s why, to us, Stan Burridge is so important. He does have the networks, is trusted, and can put himself truly in other people’s shoes.

“With his help, we are able to amplify the lived voice of exclusion in both our research design and our data collection.”

blue-sky thinking if we are really going to move towards eradicating homelessness.”

● <https://www.expertfocus.co.uk>

*FOOTNOTE: Dr Tim Robson OBE is now clinical lead for the Pathway Homeless Healthcare Team at UCLH, completing Stan Burridge’s journey from a GP-patient relationship, via GP-campaigner and GP-friend, to GP-colleague.



Mental health experts share UCL institute’s umbrella

A virtual centre for mental health has been created at UCL, highlighting the importance of research in helping to improve the lives of the one in four people each year who experience depression, anxiety and other mental disorders.

The UCL Institute of Mental Health (IoMH), officially launched in July this year, will act as a virtual umbrella network for all activity around mental health at UCL and its partners, particularly the NHS.

Professor Tony David, director of the institute since it was first set up in October 2018, says: “Within UCL, there are lots of great people with

“Within UCL, there are lots of great people with expertise in mental health, but they are spread out”

– Tony David



expertise in mental health, but they are spread out, so the idea of the IoMH is that they’ll all be affiliated to this new umbrella organisation

“Hopefully, that will help people to work together, share ideas, and to work better with policymakers, funders and the NHS. Building those connections will be a priority.”

In particular, he hopes people working in the NHS will feel that the challenges and questions that arise in their clinical work will be thoroughly answered by the academic community.

The IoMH will foster research across the spectrum, but one of the areas of interest will be adolescent mental health. There are plans for collaborations between neuroscientists, epidemiologists and those in the UCL Institute of Education who are also interested in mental health interventions in schools.

In the field of dementia, there is also lots of work already going on with experts in mental health, policy, social care and neuroscience.

So far, the institute has funded three studentships where people from different disciplines have come together to supervise PhD students, and it recently awarded three small

grants as pilot funding to bring together people from fields such as psychology, psychiatry and public health, with a view to them applying for bigger grants.

The direction for the new network will be set by an advisory board, comprising people from across disciplines and professions, as well as users and carers with lived experience to ensure that the institute’s work is relevant to people with mental health problems in the community.

Noclor will be represented on the advisory board by Lynis Lewis, service director for research and development, and it is hoped that a physical home for the institute might be found during the redevelopment of the St Pancras hospital site.

Professor David says: “The response within UCL has been fantastic. There’s been great enthusiasm, and the next step will be to show that the institute is making a difference.

“There are new research funding calls and national initiatives coming up, so our goal will be to take advantage of this over the next two or three years. Our hope is that the IoMH becomes known as the pre-eminent centre for mental health research in the UK.”

Making research everybody’s business

Regional accent emphasises strengths of inspection

Q&A: Paul Lelliott, deputy chief inspector and lead for mental health inspection at the Care Quality Commission for the last five years, assesses progress in driving up standards of care as he prepares to move on

Q. What positive developments have you seen during your tenure at the CQC?

A. The establishment of dedicated regional teams across the country that specialise in inspecting mental health services – rather than generic teams with a range of services in their portfolio – has been important. We have also developed clear guidance for our inspectors about what to look for, and have customised the CQC’s key lines of inquiry for mental health services.

Q. Has there been a decline in the quality of care on mental health wards?

A. Our biggest concern over the last few years has been about the quality and safety of mental health wards as the number of beds has reduced. Today’s wards accommodate a patient group with more severe problems than in the past.

We have strengthened the criteria we use for assessing inpatient services and will pay close attention to the quality of the environment on these wards – physical, therapeutic and social.

This is a problem for wards for people with mental health problems, as well as for wards for people with learning disabilities and autism, in both the NHS and the independent sector.

The extent of the problem is shown by the fact that we’ve put a total of 18 or 19 independent hospitals into special measures over the last three years.

Q. Does inspection drive up standards?

A. It does, partly because we

identify problems that we put into our reports and that sometimes cause us to take enforcement action. But, to me, the biggest effect is as a result of the self-review and self-improvement that providers undertake in the expectation of being inspected.

Q. What have been your findings since the CQC was asked by the government to review the use of restraint, seclusion and segregation in mental health and learning disability hospitals?

A. We visited just over 60 children and young people to review their care and treatment, and to understand why they had been segregated. The great majority of them had autism – often in addition to other diagnoses, including learning disability and mental disorders.

The typical picture was that, when young, they’d been excluded from school and had unsettled childhoods, with repeated failed placements in care. It had then been decided the only option available was admission to hospital.

The people in segregation had not responded well to a new and strange environment, and had communicated their distress in ways that staff had found difficult to manage, leading to them being cared for in isolation.

Our main conclusion was that the care system does not provide the support young people with very challenging behaviour need to continue to live at home, with no proper response that can prevent admission when a “crisis” happens.

Many hospitals that admit people with a learning disability or autism don’t have staff with the necessary specialist skills, so being segregated is an almost inevitable product of the system. The model of care needs to change.

Q. Back in February, you said there were still concerns about the profile of learning disability and autism services. Can you elaborate?

A. It’s been accepted for years that too many people with learning disability and autism are being cared for in hospital.

The Transforming Care programme, which was working for five years with the stated intention of reducing the number of people in hospital,



hasn’t been fully successful in bringing about the development of alternative community services.

There’s been a lack of investment, and I’m sure that the reduction in local authority budgets has had a knock-on effect. A lot of the services have disappeared, which means there isn’t as much support for people living in the community as there used to be, and that can’t be anything other than a bad thing.

Q. What are your proudest achievements during your time at the CQC?

A. Rather than simply publishing our findings and moving on, I’ve tried to work with my team to encourage and support the rest of the national system to take them seriously.

One of those issues is the high number of people placed out of area in mental health

rehabilitation units – often small hospitals in isolated places. We’re very glad that NHS Improvement has funded work through the Getting It Right First Time (GIRFT) programme to enable local systems to help move people to more local services.

Also, last year we flagged up concern about sexual safety on mental health wards, and in

response, the Royal College of Psychiatrists and the Royal College of Nursing are about to produce guidance and standards on this issue – backed up by collaboration involving many mental health trusts.

Q. What’s next for you?

A. I’m retiring for a second time to go travelling with my wife – I was travelling for two years before I came into this job – through India and central Asia in our own overland vehicle.

Q. What will you miss about the CQC?

A. I’ll miss the cut and thrust of identifying issues and working with the rest of the national system, which has led to some productive joint collaborations. I’m happy that the long-term plan for learning disability and for mental health is very much moving services in the right direction.

“There isn’t as much support for people living in the community as there used to be, and that can’t be anything other than a bad thing”

– Paul Lelliott



Whitehall slow to act on policy unit's speedy start

PROFILE: Professor Sonia Johnson, director of the NIHR Mental Health Policy Research Unit, on the Mental Health Act review, and concerns about human rights, loneliness, social inclusion – and Brexit.

The first year of operation for our policy unit was heavily dominated by providing evidence for the independent review of the Mental Health Act (MHA), announced by Theresa May in 2017.

Among the concerns we had to address were the human rights of people – particularly black patients – detained under the MHA, and the rising rate of MHA admissions.

We also did some new analysis of data already available – for instance, looking at international

variations on people being sectioned, and what might drive those.

The report came out last December, but we're just getting towards the end of publishing all eight papers associated with the report.

Obviously, it was closely linked to the policy-making work, although the conclusions of the review are yet to be implemented as the government policymaking process isn't exactly going along at speed at the moment.

Brexit has had an impact on the way things are working in government. Although a lot of our work is with bodies such as NHS England and Public Health England, which are less under pressure, we have been aware – with the conclusion of the MHA review, for instance – of people moving on in the Department of Health (DoH), and that policy recommendations may be slower than usual to find their way into practice.

However, the review appeared to meet the needs of the policy process and resulted in some, hopefully, high-impact research that should be of wider interest to people in the UK.

The other big initiative I'm currently involved with is the establishment of a network on loneliness/social isolation and mental health, for which Dr Alexandra Pitman, clinical academic at UCL, and I have been awarded a UK Research and Innovation grant.

We also have a large lived-experience network that feeds into the work we do. It consists of a core group of a dozen people, plus a wider group that we can call on for specific pieces of work.

For instance, a key piece of work we've embarked on since the MHA review is on services for people with a "personality disorder" diagnosis – although we're using the term "complex emotional needs", which is more acceptable.

For that, we've drawn on a wider



lived-experience network of people who are helping us plan the research we do and to interpret the data we get.

One innovation with our first set of papers is that, alongside them, we're publishing selections of 500-word lived-experience commentary from two or three people. This has been taken up by all the journals we've submitted to and has had a good response.

Our NIHR research policy unit, established at UCL and King's College London in 2017, is now nearing the end of its second year: It is essentially there to provide for the evidence needs of the government and of policymakers, and our programme of research is negotiated with the DoH and arm's-length bodies, such as

Public Health England and NHS England. The aim is to do research – quite often in the form of evidence synthesis, but sometimes gathering research – within a timescale that's suited to the needs of policymakers. This is generally a shorter timescale than for research work commissioned from scratch.

Part of our remit is to help get hold of people who can provide an expert view quickly, but most of our time is spent doing new data collection, analysis and synthesis that provides fresh evidence for government policymaking purposes.

The lead organisation is UCL, but part of the research team is at King's College London, plus we have a wider network of co-applicants and

collaborators that spans a lot of universities and also charities.

With a typical research project, you have a set of clear and agreed milestones, but this is much more fluid for us, so it's harder to say whether we've done what we should have done by now.

Certainly, we've done quite a lot, and the work around the MHA seems to be regarded as a successful example of feeding evidence – including new evidence – into the policy process.

I think my butterfly-like tendency is quite helpful in the policymaking setting. I've led a good number of research grants, have worked in different areas of mental health, using a range of methodologies, and I've carried out work on crisis care, early intervention, women's mental health and employment in mental health.

I've also had a reasonable amount of experience of working with policymakers – including in our programme of work with crisis care systems – which has fed into policy, and also as a member of various guideline groups. Those are things that are helpful when it comes to leading the policy research unit.

● Independent Review of the MHA, final report: <https://bit.ly/2D2Gqw8>

● Loneliness and Social Isolation in Mental Health Network: <https://bit.ly/2IV0ufl>

“Brexit has had an impact on the way things are working in government and policy recommendations may be slower than usual to find their way into practice”

– Sonia Johnson



Major grants boost development of new ways to tackle dementia

Claudia Cooper, professor of psychiatry of older age at UCL and principal investigator for the £3.8m APPLE-Tree project (Active Prevention in People at risk of dementia through lifestyle, behaviour change and technology to build resilience').

The aim of APPLE-Tree, one of four programme grants awarded by the NIHR/ESRC, is to develop and deliver an intervention that will work across socio-economically deprived and BAME communities.

Professor Cooper says: "There's more and more evidence that things that are potentially

"We need to reach out to communities usually less likely to be invited to take part in research"

– Claudia Cooper



modifiable – such as looking after your physical health, diabetic care, eating well, exercising and having an active social life – seem to prevent dementia.

"A previous study in Finland (FINGER) showed that it is possible to delay cognitive decline by helping people make lifestyle changes, offering participants around 300 hours of intervention over a couple of years. This isn't feasible for everybody who might be at risk, so we want to find out if briefer lifestyle interventions work too.

"My work with Dunhill Medical Trust showed inequalities in who gets timely dementia diagnoses and good-quality post-diagnostic care.

"People from black ethnic groups in the UK are more likely to get dementia than people from white ethnic groups, so we need to reach out to communities usually less likely to be invited to take part in research, and make sure the intervention works for everyone."

Around 40 qualitative interviews have been conducted to ask participants what they

think should be in the intervention, and a large trial of 700 people will begin in June 2020.

Prof Cooper is also principal investigator for the five-year New Interventions in Dementia Study (NIDUS²), which started in March 2018.

She says: "We have asked people living with dementia and their family carers about the key things that help them to continue living independently at home.

"We used this work to develop an intervention to support independent living, which we are currently piloting.

"Dementia research is now very much on the political agenda. Co-producing interventions with family carers and people living with dementia, clinicians and academics is a real team effort – and we look forward to working with Noclor to deliver these trials."



Liz Sampson, professor in dementia and palliative care at UCL, is principal investigator for EMBED-Care (Empowering Better End-of-life Dementia Care³), a £3.7m ESRC/NIHR programme grant – the largest awarded for end-of-life care in dementia.

This is an ambitious project in which Prof Sampson and her team want to use the data they collect and the interventions they develop

"We also need to pay attention to how people with dementia can end their lives well"

– Liz Sampson



to promote a step-change in end-of-life care for people with dementia, which is currently a very neglected area.

She says: "At the moment, people with dementia have very poor access to good-quality end-of-life care.

"The focus, and rightly so, has been on preventing dementia and on people living with dementia, but we also need to pay attention to how people with dementia can end their lives well.

"If you have cancer, you can get lots of help from palliative care teams and hospices, and it should be the same for people with dementia."

The first tranche of research will involve reviewing policy and literature to understand the current picture and to generate ideas.

The team will then look at the health

and social care data that's already available, undertaking analyses to understand what the current need is, and using that data to project future need.

A large study of more than 250 people with dementia, plus their carers, will look at the palliative care needs of people with mild, moderate and severe dementia.

The project will map how the patients move through the health system over time, and all the data collected will be combined to develop new interventions.

The research team will work with people with dementia, health professionals, staff in social care and policymakers to design new ways to improve care, and these will then be tested in a trial.

The programme, which started in January this year, will take five years to complete.

"We're really looking forward to working with Noclor as their support is going to be vital in delivering the study," Prof Sampson says.

"It's very exciting. All the way along we'll be working very closely with people with dementia and with policymakers so that we actually get the work out there."

1. <https://bit.ly/2Jjneiu>
2. <https://bit.ly/2kF143g>
3. <https://bit.ly/2H2ORNx>

Child speech therapy trial aims for empowerment

Although children who stammer are known to be at higher risk of bullying, social exclusion and social anxiety, there is little evidence to support intervention with children of school age. But a feasibility trial testing a newly-developed therapy programme is hoping to change this.

Palin Stammering Therapy for School Children (8-14) is an approach developed at the Michael Palin Centre (MPC) at Whittington Health NHS Trust, and the feasibility trial will explore the methods required to conduct a full randomised control trial.

“A stammer will affect how you think about your ability to communicate, your confidence, and your participation”

– Sharon Millard



The aim is to examine whether Palin STSC (8-14) is more effective and cost-effective than services already on offer to children who stammer.

The research is funded by the NIHR Research for Patient Benefit stream, and will see whether this approach can be implemented successfully beyond the centre.

Dr Sharon Millard, clinical and research lead at the MPC and chief investigator for this study says: “Stammering is now understood to be a neurophysiological disorder, not a psychological problem, as many people might think.

“However, if you have a stammer your experience of talking to people is often difficult, and that will affect how you think about your ability to communicate, your confidence, and your participation. So it becomes something that has an emotional component to it too.”

Some areas offer a very good service for children who stammer, with a specialist or a generalist who has received training. In other areas, services are non-existent, or support might end once a child reaches either primary or secondary school.

A general therapist might see only three or four children who stammer a year, and many express a lack of confidence about working with this group.

Dr Millard and her team want to empower such therapists by giving them specialist skills. That way, more children can access the therapy they need.

The research team has developed a weekly programme of training, based on the work of the therapists at MPC. The aim of the feasibility trial, which started in June and runs for two years, is to compare the therapy with treatment as usual.

Three of the four intended sites have been confirmed, and recruitment is under way for 30 speech and language therapists, each of whom will bring between two and four families with them to take part in the trial.



The team wants to see not only a reduction in stammering frequency, but also in the impact of stammering on the child and parent – to improve their perception of themselves as communicators, increase participation in speaking situations, and lessen the emotional impact it has.

Pathways to training opportunities

The following sessions are being hosted by Noclor and our associates. All the sessions are free and open to all staff who have an interest in research (including doctors, dentists, nurses, research assistants) and who are working in, or are associated with, our partner trusts.

- **Good Clinical Practice in Research**
Fri, 15 November 13:00-17:00
Ground floor, ELFT Headquarters, Aldgate
Mon, 2 December 13:00-17:00
St Pancras Hospital Conference Centre, West Wing
- **Essential Skills for conducting effective Clinical Research**
Tue, 3 December 09:30-17:00
St Pancras Hospital Conference Centre, West Wing
- **Finding The Evidence**
(Literature Searching Skills)
Fri, 29 November 10:00-13:00
Peckwater Centre, 6 Peckwater Street, NW5 2TX
- **Informed Consent in Clinical Research**
Wed, 4 December 13:00-17:00
St Pancras Hospital Conference Centre, West Wing
- **Critical Appraisal Skills Training Workshop**
(Quantitative Research)
Mon, 2 December 10:00-13:00
Mon, 9 December 10:00-13:00
St Pancras Hospital Conference Centre, West Wing
- **Principal Investigator in Research**
Wed, 4 December 17:30-19:30
St Pancras Hospital Conference Centre, West Wing
- **Setting up and Managing the Trial Master File**
Thu, 5 December 09:30-13:30
St Pancras Hospital Conference Centre, West Wing

To register or find out further information about our free training sessions, please visit our Eventbrite page via: www.noclor.nhs.uk/training-resources
All our training sessions are advertised on our Eventbrite page.

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RESEARCH SUPPORT

Projects currently recruiting

● **RADAR:** The Research into Antipsychotic Discontinuation and Reduction (RADAR) randomised control trial will compare a gradual strategy of antipsychotic reduction and possible discontinuation with maintenance (continuous) treatment in people with schizophrenia or who have recurrent psychotic episodes. Recruitment will take place through the Community Recovery, Assertive Outreach, Early Intervention in Psychosis, Older Adults, and Learning Disability teams within participating NHS Trusts. contact.noclor@nhs.net

● **Skill Mix in Primary Care:** Difficulties in recruiting more GPs to deal with increasing workloads mean that practices are employing a wider range of healthcare professionals, known as “skill mix”. GP practice managers across England are therefore being invited to share their views in a short online survey on the employment of new types of practitioners. Survey link: <http://man.ac.uk/nNOou0>

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This paper is Forest Stewardship Council certified

Key Contacts

The Noclor Research Support team is here to help you with research. So please feel free to contact our various teams.

For queries relating to Research Management and Support:

contact.noclor@nhs.net

Funding and Finance queries:

finance.noclor@nhs.net

Looking for advice with or interested in a project in Primary Care? Contact:

noclor.norththamescrn@nhs.net

Keen to learn more about our free training courses, or to offer content suggestions for future Noclor publicity material? Contact:

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If you would like to get in touch with our Service Director, Lynis Lewis, please contact:

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