An exploration of trainees' experiences undertaking longer-term supervised psychotherapy with individual patients:

A trainee-led study

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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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“Prior to entering core training, I was predominantly focused on the neuroscientific basis of mental illness. However, my long case gave me a unique insight into my patients’ lives, and focused on the vital experience of the countertransference during sessions. This allowed me to decipher meaning – not just for my patient but for myself as a clinician and person. The long case was by far the most valuable experience of my training and felt like a critical and challenging period of developing the skills to be an effective psychiatrist.”

“It provides an opportunity for continuity, reflection and a deeper understanding of the psychological and social factors in mental distress. I feel that involvement in psychotherapy has made me a much better clinician, and I feel it is a hugely important part of core training.”

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Introduction

A number of publications highlight the importance of psychotherapy within psychiatry training and the benefits it provides to psychiatrists and patients[1]. This is reflected in the Royal College of Psychiatrists' (RCPsych) curriculum for core training in psychiatry, which considers the development of psychotherapeutic competencies an essential component of training, without which trainees cannot progress to higher training pathways[1].

The stated aims of psychotherapy competencies within the core curriculum include 'learning to think psychologically, learning to take a reflective and psychotherapeutic approach to all aspects of routine clinical practice in psychiatry, and being able to respond to patients with greater understanding of emotional complexities'[2]. Achieving these competences has been suggested to contribute to psychotherapeutic psychiatrists developing enhanced reflective capacity' which 'can increase the effectiveness of psychiatric interventions, enabling them to manage a patient's therapeutic journey skilfully, thereby reducing pressures on the NHS'[3].

Previous publications have suggested that the development of 'psychotherapeutic psychiatry' could improve recruitment to psychiatry and would lead to the development of resilient psychiatrists more likely to maintain a therapeutic attitude, enjoy their work and avoid burnout over the longer course of their careers[3]. This links with research that shows that Balint groups improve empathy[4, 5], reduce burnout[6], increase interest in psychiatry as a career[7] and improve job satisfaction[6] in medical students and doctors across disciplines.

Background

Psychiatry Core Trainees (CTs) are expected to undertake a psychotherapy 'long case' (PLC), with a minimum of 20 sessions and appropriate supervision, as part of the achievement of psychotherapy competences. A 2012 psychotherapy survey[10] indicated that trainees were five times more likely to achieve their psychotherapy competencies, including their PLC, where their psychotherapy training was under the governance of a psychotherapy tutor with a CCT in medical psychotherapy. This led to the GMC making this a mandatory requirement for all core psychiatric training schemes.

The RCPsych Psychotherapy Survey[2] published in 2018, based on data collected in 2016, collated data from training programme directors and college tutors to 'identify challenges to effective psychotherapy training delivery and promote solutions'[2]. It found that 90% of trainees were expected to meet their psychotherapy training competencies and suggested that access to appropriate supervision was sufficient[2]. The challenges to training completion were found to mirror broader challenges facing the NHS, such as service closure (especially secondary care psychotherapy services), rotation pressure and therapy termination by patients[2]. Almost 90% of respondents said that their psychotherapy tutor held GMC specialist registration with a certificate of completion of training (CCT) or equivalent in medical psychotherapy[2]. This paper emphasised the importance of monitoring psychotherapy training to ensure 'it benefits trainers, trainees and their patients'[2].

The Psychiatric Trainees' Committee (PTC) is an RCPsych committee comprising trainee representatives from each training region in the UK. The PTC was concerned that there was a paucity of formal data regarding the trainee experience of the PLC and its value to training. Informal feedback from trainees highlighted that barriers could exist to completing psychotherapy competencies, and that there were wide differences in psychotherapy training experiences across the UK. A medical psychotherapy trainee-led survey of 33 trainees in the East of England reinforced this view[11]. It found that trainees valued the PLC and that it significantly increased self-rated competence in empathy, managing boundaries and difficult clinical interactions[11]. It was concerning, however, that 47% of trainees reported facing barriers to completing the PLC, including on-call commitments, difficulties in identifying patients and supervisors, and fitting in the PLC around other work commitments[11].

After this survey was completed, the PTC felt it was necessary to understand the trainee experience of the PLC across the UK and to unpick the barriers to completing the PLC and the regional variation that had been reported. The PTC was also interested in whether the PLC was valued by trainees and whether they believed it increased competence in a range of skills which are important to all areas of psychiatry. The 2017 Core Values for Psychiatry RCPsych report was useful as a guide for which skills and values were important to consider[12]. This framework highlights the core values for psychiatrists as communication, dignity, empathy, fairness, honesty, humility, respect and trust[12].

Aims

The PTC set up a national survey with the following purpose:

1. To gather baseline information from trainees across the UK about the quality of the PLC training experience, covering rates of completion; barriers to completion; modality of therapy and characteristics, and experience of supervision.

2. To explore trainees' views regarding the impact of the PLC on their competence in a range of skills required for the practice of psychiatry, on resilience and on career satisfaction.

3. To identify what aspects of the training experience were impacting positively or negatively on trainees' experiences.

Method

A cross-sectional survey using quantitative components (rating scales) and qualitative components (free-text boxes), was distributed by email to all 4,169 core and higher psychiatry trainees in the UK from the Royal College of Psychiatrists. Data gathered included: demographic and geographical information, rating scale items and free-text responses regarding the quality of supervision; barriers faced in PLC completion; attitudes towards changes in self-rated clinical skills and the value of the PLC to clinical training. The response period was open between 6 and 25 February 2019 and entry

into a prize draw was offered as an incentive to completion. SurveyMonkey was used as the commercial platform for the survey.

There are approximately 4,000 active psychiatric trainees in the UK and RCPsych's distribution list includes all of these trainees. The RCPsych distribution list is likely to also include some trainees who have recently left training or have become consultants and have not updated their details, however this is less than 5%.

Data analysis

Qualitative data

Thematic analysis of the qualitative data was completed by two of the authors independently. Free-text responses were analysed in two broad domains: trainee attitudes regarding the importance of the PLC to psychiatry training and trainee experience of supervision. Responses were then further divided into two, separating attitudes indicating a favourable or negative experience. This created four data sets. The following process was then completed for each data set:

1. Initial reading of all the responses.
2. Data from the first 100 responses was read again and initial themes documented. These themes were developed from the research objectives and the themes that emerged from the data.
3. The researchers compared their individual themes, re-read the data and confirmed the concepts of these themes, including specific keywords or phrases.
4. Each theme was given a numeric code.
5. The rest of the data set was examined for these themes and any new ones.
6. Coding was compared at intervals of 100 responses and again at the end of the process. Any data item that had two different codes was discussed and a consensus agreed.
7. Once this preliminary coding was complete, researchers worked together to group some themes, due to their similarity. This provided the final list of themes.

Quantitative data

The statistical analysis of quantitative data was completed using Minitab 17. With the exception of categorical items many individual attitudinal and behavioural survey questions were structured to invite Likert-type responses within a range of 0 to 100 to a provided statement. Despite this very broad response range, such items remained ordinal (categorical) in nature and, accordingly, were subject only to statistical analysis based

on frequencies. In order to facilitate a useful and meaningful analysis across the full range of variables addressed by the quantitative items, two data-reduction approaches were adopted to dealing with Likert-type responses. Firstly, the range of scores was reduced by recoding in five bands as follows: strongly disagree (0–19); disagree (20–39); neither agree/disagree (40–59); agree (60–79) and strongly agree (80–100). This enabled individual items to be explored using just five commonly used frequency categories. Secondly, multivariate techniques based upon Principal Component Analysis and Reliability Analysis were used as a further data reduction technique to identify and use underlying factors and related scales within the data. The subsequent identification of two such scales (see below) permitted the use of powerful parametric statistical methods such as T-tests and Analysis of Variance (ANOVA) to investigate the significance of differences between various groups (for example, between deaneries, supervisor qualifications or PLC stage).

PLC Effect Scale

The first potential scale to be investigated was named the ‘PLC Effect Scale’. Thirteen survey questions gathered data relating to the trainee attitudes towards the effect of PLC on a range of attitudes and behaviours of relevance to psychiatric practice, specifically:

- Listening skills
- Management of boundaries
- Empathy
- Continuity
- Management of challenging interactions
- Self-reflection
- Biopsychosocial formulation
- Understanding of psychological therapies
- Understanding of team dynamics
- Resilience
- Job satisfaction

The obvious question to be addressed was: ‘Is there a common factor which could be explored using a scale which underlies the responses to these 13 questions’? In technical terms this is explored by examining and then utilising the common variance between items using a two-stage multivariate analysis process. In stage one, a Principle Component Analysis (with varimax rotation) identified one component which explained 77.7% of the common variance between the 13 variables. This permitted a further item analysis (also known as a scale reliability analysis) of these 13 variables based upon Cronbach’s alpha coefficient. Common practice is to accept a value of Cronbach’s alpha of 0.7 or above (maximum is 1) as evidence that the variables under consideration can be treated as a scale for further quantitative analysis. The obtained value of Cronbach’s alpha was 0.9756 (and the correlation between pairs of items were themselves strong ranging from $r = 0.605$ to $r= 0.846$). Accordingly, the PLC effect scale was created and used as a more powerful data reduction technique for further parametric analysis.

Supervisory experience scale

The second potential scale to be investigated was eventually named the supervisory experience scale which drew on the five survey questions which gathered data relating to the trainee experience during PLC supervision. These questions explored whether trainees felt they were able to do the following during supervision:

- understand the therapeutic dynamic
- speak freely about their feelings towards patients
- speak freely about problems arising in the work
- feel supported to manage risk arising in the work
- the trainees' overall rating of the quality of their supervision.

Again, the obvious question to be addressed was: 'Is there a common factor which could be explored using a scale which underlies the responses to these survey questions?' The same two-stage multivariate item analysis was followed. In stage one, a Principle Component Analysis (with varimax rotation) identified one component which explained 81% of the common variance between the five variables. This permitted a further item analysis of the five variables based upon Cronbach's alpha coefficient. The obtained value of Cronbach's alpha across the five items was 0.9414. A Supervisory Experience Scale was therefore created which was treated as a ratio scale for further analysis.

Further parametric analysis using t-tests and ANOVA

It should be noted that the value of Cronbach's alpha for the PLC Effect Scale and the Supervisory Experience Scale are both exceptionally strong, being far in excess of the required 0.7 value. The availability of these highly reliable scales allowed the subsequent quantitative analysis (reported below) to combine both frequency-based analysis for individual items with the use of both t-tests and ANOVA to compare differences between trainees when grouped in a number of ways as follows:

- Not yet started the PLC vs started the PLC vs completed the PLC
- Faced barriers to completing PLC vs did not face barriers to PLC
- Psychotherapy scheme led by medical psychotherapist vs not led by medical psychotherapist
- Qualification of supervisor of PLC
- Undertaking of personal therapy during PLC
- Duration, frequency and composition of PLC supervision

Results

The online survey generated a response rate of 598 responses, which is 14.3% of the estimated total number of UK psychiatry trainees (core and higher).

Demographic data

Using 2020 eportfolio information for trainee numbers in each deanery at the time, the response rate for the survey ranged from 8 to 21% across deaneries.

The North West, Scotland and Peninsula/South West deaneries had the highest response rates, whereas Northern Ireland and Wessex had the lowest.

Table 1: Trainee response numbers by deanery

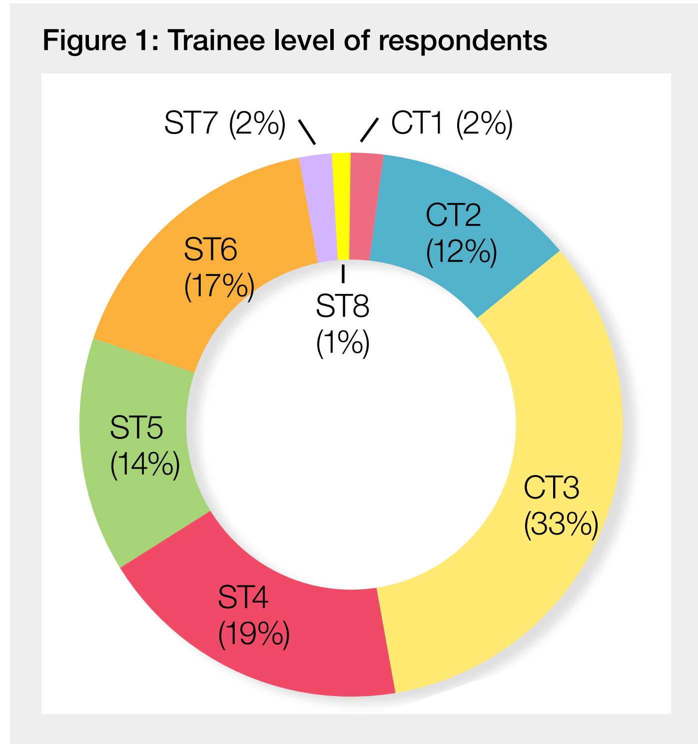
Deanery	Number of respondents	Response rate
East Midlands	21 out of 180	**11.6%**
East of England	42 out of 278	**15.1%**
Kent/Surrey and Sussex	(16 out of 150	**10.6%**
North East	20 out of 189	**10.5%**
North West	77 out of 415	**18.5%**
London* (Data combined for North West London, North Central and East London, and South London)	144 out of 1084	**13.3%**
Northern Ireland	10 out of 113	**8.8%**
Peninsula/South West	47 out of 223	**21.1%**
Scotland	65 out of 331	**19.6%**
Thames Valley	21 out of 119	**17.6%**
Wales	19 out of 126	**15.1%**
Wessex	10 out of 115	**8.6%**
West Midlands	48 out of 265	**18.1%**
Yorkshire and Humber	54 out of 306	**17.6%**

*** The eportfolio data is not separated into the individual London deaneries, so has been combined**

Respondents' stages of training

47.1% were core trainees and 52.9% were higher trainees.

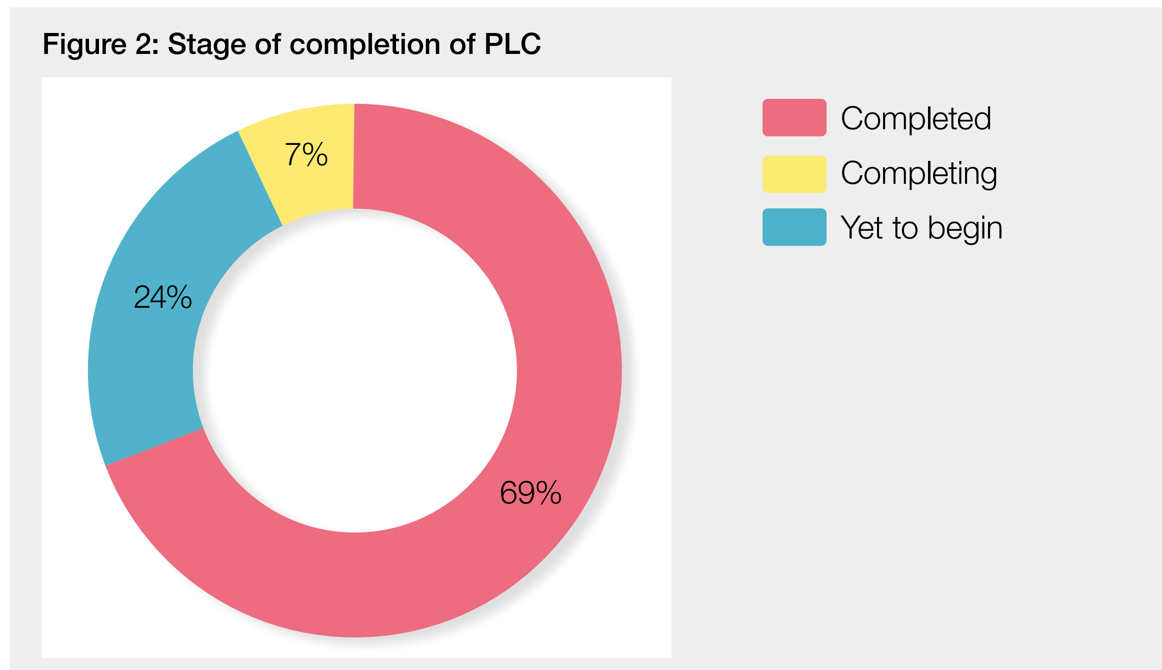
Figure 1: Trainee level of respondents



PLC completion

69.1% had completed their PLC, 23.7% were completing it and 7.2% were yet to begin. As more than 50% of trainee's that responded had completed core training, these results are expected, as higher trainees are required to have completed the PLC competencies to advance to higher training. Trainees are encouraged to start their PLC early in core training to allow time for it to be completed by the end of CT3.

Figure 2: Stage of completion of PLC



Psychotherapy modality

Psychotherapy modalities refer to the psychotherapeutic approach, theoretical framework and knowledge base that guide a therapist's interactions with their patient. Some approaches, such as psychoanalytic/psychodynamic psychotherapy and cognitive analytic therapy (CAT) are more suited to being used for a PLC (requiring >20 sessions) due to the standard treatment time for CAT or a more open-ended negotiable time frame for a psychodynamic psychotherapy. The core training psychotherapy competencies require a trainee to complete a long and short case, in different modalities. This allows them to gain experience of at least two different psychotherapeutic approaches during their core training.

The majority of trainees, 80%, were undertaking/had undertaken the PLC in a psychodynamic/psychoanalytic modality. Of the remainder, the modalities used were 7% cognitive behavioural therapy (CBT); 7% cognitive analytic therapy (CAT) and 1% family systemic therapy. The remaining 5% used 19 other therapeutic modalities including: interpersonal, dialectical behavioural therapy, mentalisation-based therapy, compassion-focused therapy, supportive therapy, transference-focused therapy and schema therapy. The variation in modality is likely to be largely due to the provision of psychotherapeutic services that are available in the local area.

Thirteen people who had not started their PLC and therefore had not identified a modality (2%). Fifteen people (3%) listed more than one modality, which may be listed when a number of different psychotherapeutic modality techniques are combined with one patient, when more than one PLC has been completed or when therapeutic modalities overlap and the trainee is not clear how to categorise it.

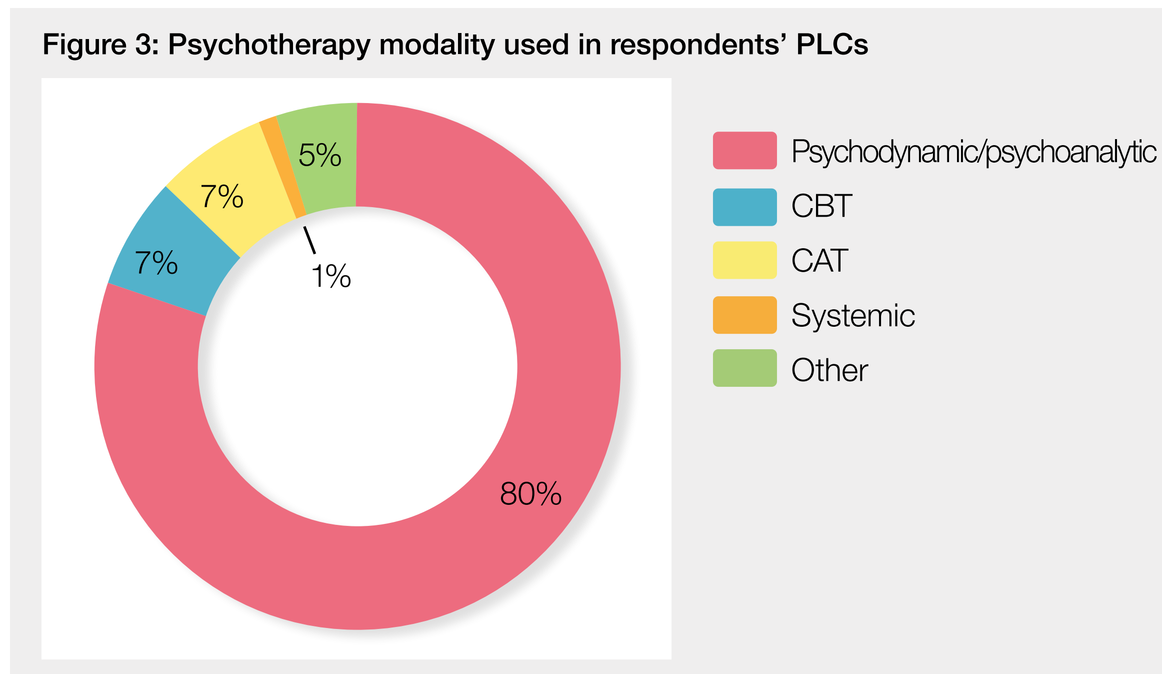


Figure 3: Psychotherapy modality used in respondents' PLCs

Quantitative results: The effectiveness of the PLC as a training experience

We began by asking trainees a broad question regarding their attitude towards the PLC. When asked whether they thought that the PLC, an essential core curriculum component, is an important part of core training, 82.6% of trainees answered 'yes' and 17.4% answered 'no'. Free-text responses were invited regarding these opinions, which underwent further thematic analysis.

Development of core psychiatric skills

The survey responses indicated that the vast majority of trainees strongly valued the PLC as a training experience and strongly agreed that the PLC improved their core psychiatric skills (see Figure 4 on the next page).

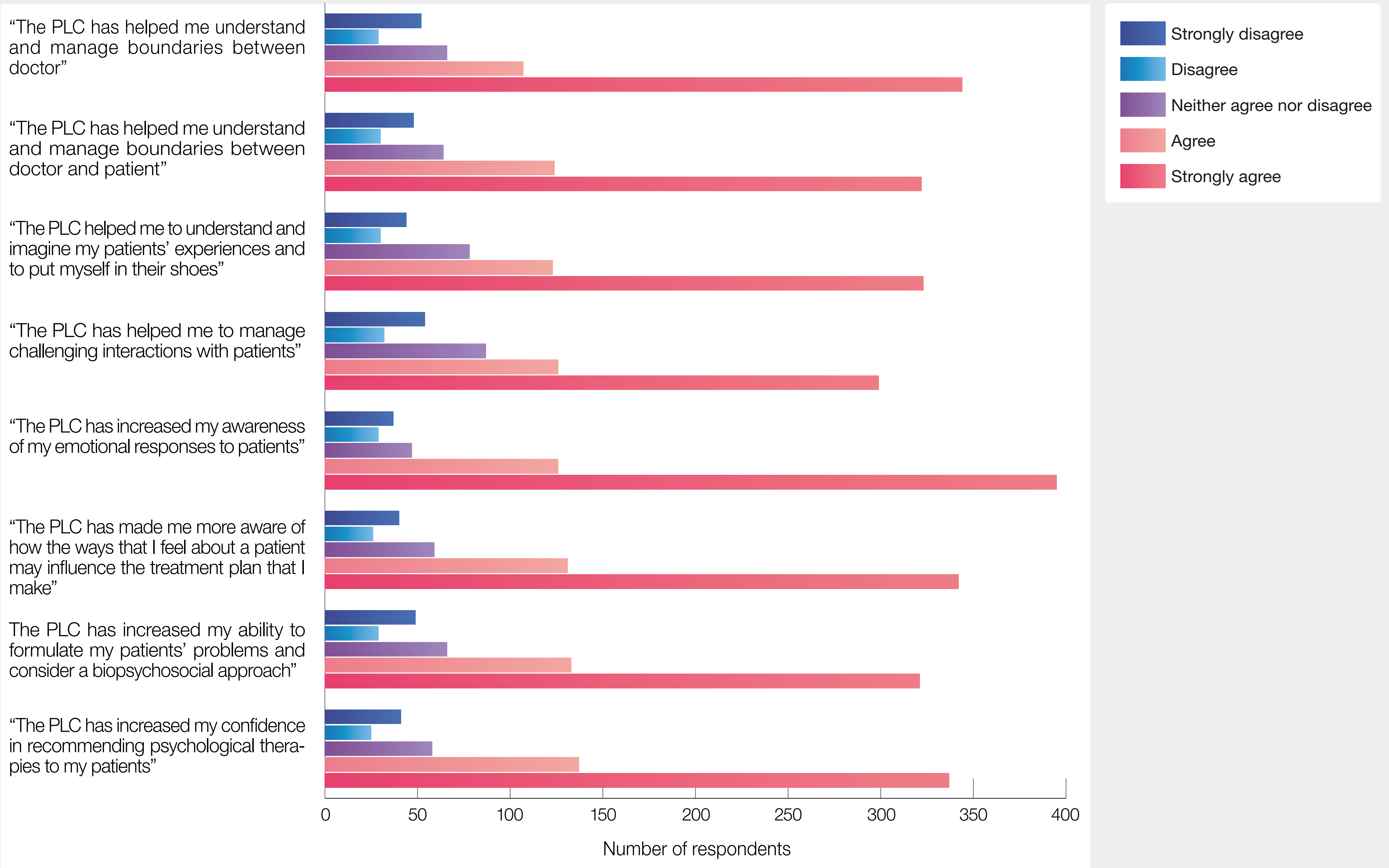


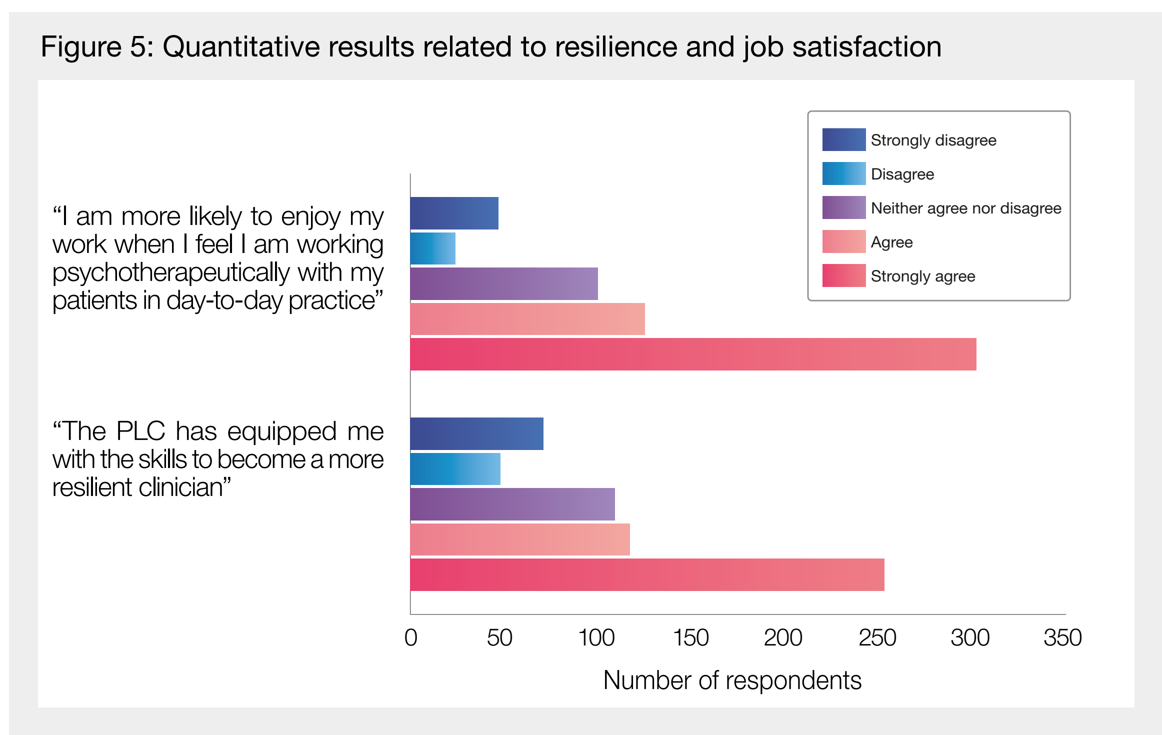
Figure 4: Quantitative results related to core psychiatric skills
"The PLC has helped me understand and manage boundaries between doctor"
"The PLC has helped me understand and manage boundaries between doctor and patient"
"The PLC helped me to understand and imagine my patients' experiences and to put myself in their shoes"
"The PLC has helped me to manage challenging interactions with patients"
"The PLC has increased my awareness of my emotional responses to patients"
"The PLC has made me more aware of how the ways that I feel about a patient may influence the treatment plan that I make"
The PLC has increased my ability to formulate my patients' problems and consider a biopsychosocial approach"
"The PLC has increased my confidence in recommending psychological therapies to my patients"
0
50
100
150
200
250
300
350
400
Number of respondents
Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree

Impact on resilience and job satisfaction

The majority of trainees agreed or strongly agreed that they use skills learnt during the PLC in their day-to-day practice, with 71% agreeing, 14% neutral and 15% disagreeing. The majority of trainees agreed or strongly agreed that working psychotherapeutically with patients in day-to-day work improved their enjoyment of their work, with 71% agreeing, 17% neutral and 12% disagreeing.

The majority of trainees agreed or strongly agreed that the PLC increased resilience with 62% rating agreement, 18% neutral and 20% disagreeing that the PLC increased resilience.

Figure 5: Quantitative results related to resilience and job satisfaction



For further analysis of factors influencing trainee experience of the PLC, statistical analysis was completed based on the PLC effect scale, including question stems about attitudes and behaviours as above.

It is important to note that there was a clear and highly significant ($p=0.001$) difference in attitude between those who had not yet started the PLC and those who had started or completed the PLC. This shows that those trainees who had experience of the PLC rated the impact on their psychiatric skills, behaviours and attitudes, including resilience and enjoyment of working therapeutically, significantly more favourably than those who did not have experience of the PLC, with an effect size in the medium range (Cohen's $d = 0.5$).

Figure 6: PLC effect scale score by stage of PLC completion (95% CI for the mean)

The pooled standard deviation was used to calculate the intervals

Qualitative results: The effectiveness of the PLC as a training experience

For the purposes of reporting, comments were broadly divided into those reflective of a positive attitude towards the importance of PLC as a training experience and those of a negative attitude towards the importance of PLC as a training experience. Recurrent themes were coded, listed and summaries including the frequency of recurring themes as illustrated below in the word cloud.

Positive themes

525 trainee (87.8%) responses were coded to contain at least one positive training experience theme.

- Doctor–patient relationship (23.72% of participants): Trainees reported value in learning about boundaries, improving dynamics, the psychological process and recognition of unhelpful interactions.
- Development as a psychiatrist (11.7%): Trainees described their long case experience as changing their approach to psychiatry and making them better psychiatrists.
- Development of formulation skills (10.5%): Trainees stated that there was little exposure to this elsewhere.
- Transferable skills (8.4%): Trainees' responses contained the term 'transferable skills' or commented on improvements in skills in psychiatry in general. Where a trainee documented a specific skill, this was coded separately.
- Value of learning about different psychotherapeutic modalities (8.4%): Trainees noted the value of this as an aid in understanding treatment options for patients.
- Biopsychosocial approach (7.9%): Trainees spoke of the PLC allowing for a more holistic view of mental illness.
- Management planning including risk management (7.4%): Trainees noted feeling PLC improved skills in formulation and management, including of risk.
- Peer-enhanced learning (5.4%): trainees valued learning through supervision in groups.
- Improvements in communication skills (5.4%): improved communication, talking or listening skills.
- Further training (5%): Trainees commented on being inspired to pursue special interest or further training in psychotherapy.
- Group dynamics (3.2%): Development of skills for working in organisations and managing team dynamics.

Some example quotes from the trainees are included below:

> Understanding of psychodynamic/psychoanalytic modalities in particular is essential to holistic understanding as a psychiatrist. Without it, understanding of the psychological aspect of the biopsychosocial model would be significantly poorer.

> (It) helped me to become a better all-round psychiatrist.

> Understanding of psychodynamic/psychoanalytic modalities in particular is essential to holistic understanding as a psychiatrist. Without it, understanding of the psychological aspect of the biopsychosocial model would be significantly poorer.

> Psychotherapy experience is crucial to assist in the care of patients.

> Has provided useful insight into dealing with patients in a broader and more holistic

> "To give non-pharmacological tools to doctors to understand and manage patients better."

> "As a CT…there was very little space and time for thinking in depth about patients and the therapeutic process, and the long case and supervision time was really the only time we had to develop these thinking skills - the fact that the supervision and clinical time was protected hugely helped this."

> PT training has increased my awareness of complex team dynamics and transference/countertransference which helps me to be a more reflective consultant team leader.

> Without the opportunity to practise psychotherapeutically, I don't think I would have continued in psychiatry as I found a purely medical model inadequate and frustrating.

> "The long element of this encouraged me to really try to understand the subjective experience of the patient and build my confidence of sitting with uncertainty."

Negative themes

228 trainee (38%) responses were coded to contain at least one negative training experience theme. The overwhelmingly strong theme in comments reflecting a negative attitude towards the PLC importance were related to barriers being faced and difficulty achieving the competence, with clear frustration from trainees feeling penalised in progressing through training by not meeting PLC competence.

- Prevention of progress through ARCP (10.9% of participants): Trainees highlighted challenges completing the set session numbers for the Annual Review of Competence Progression (ARCP). Trainees stated that psychotherapy competencies delayed progression and/or prevented them applying for specialist training.
- Trainee is penalised when patient drops out (6.2%): Concerns about being penalised for patient drop out and/or the affect the fear of this has on the dynamic.
- Other barriers to completing PLC faced:
  - Trainees also reported frustration that there was a lack of suitable patients (8.19%), with no support finding patients causing severe delays.
  - The lack of supervisors and medical psychotherapists (5.35%) was also highlighted.
  - It was also hard to find support and understanding for some trainees regarding their on-call rota and rotations (3.2%).
- Irrelevance to psychiatry training:
  - Some trainees highlighted few psychiatrists would directly work in this area (7%), that relevant skills could be learnt elsewhere (4.8%) or that they would prefer to gain other experiences instead (3.2%).
- Concern about trainee as therapist (3.8%): Trainees reported a lack of confidence in providing therapy

Some example quotes from the trainees are included below:

> **(Trainees) should have adequate allocation of supervisors and patients, particularly if it is deemed a mandatory part of training.**

> **With the difficulty of finding suitable patients and supervision, it seems harsh that your core training could be delayed due to factors out of your control.**

> **"I strongly believe that the strict need to achieve a certain number of sessions with an individual patient was to the detriment of both my learning and the patients' wellbeing…. at times that there was a strong conflict between my own interests and that of the patient. I feel that learning to manage disengagement from therapy is a valuable skill however, this is not recognised and, in fact, it is often logged as a failure and you need to start your long case again."**

Qualitative results: Aspects of the PLC that affected the training experience

Although the majority of trainees found the PLC to be an effective learning experience, there was variation, with and significant outliers reporting negative experience of the PLC. The PTC wished to understand what might influence the trainee experience of the PLC.

Factors related to supervision

Trainees were encouraged to provide free-text comments about their experience of supervision. The themes of these experiences are illustrated in the word cloud below.

Positive themes

554 trainees' responses (92.6%) were coded to contain at least one positive supervision theme.

Seven themes related positively to supervision. The quality of supervision (23.25% of participants) was most frequently commented on, highlighting the value in supervision that is interesting and explorative, as well as providing helpful feedback and practical advice. Having access to a skilled supervisor (18.23%) was the second most important theme, with supervisors being described as supportive, experienced and helpful. Trainees valued group supervision (17.06%), which provided peer support and the opportunity

to learn from each other. Benefit was found in the consistency and reliability in the structure of supervision (8.03%). Having a safe and containing space allowed trainees to reflect and develop their skills (7.19%). Trainees also highlighted the importance of the availability of the supervisor (3.18%), and a feeling of greater support and confidence if supervisors could be contacted with concerns.

Examples of positive experience of supervision comments:

- "Peer support in the group is very helpful and a crucial component for an entire career. Psychotherapy teaches us it's OK to discuss with peers, to show vulnerability, to explore and reflect. These skills prevent burnout in the long term and are therefore crucial in early training."

- "Supervision stimulates intellectual self-exploration and understanding of dynamics during therapy. It also offers interesting and different keys for understanding."

- "I was encouraged to voice the difficulties I encountered and my supervisor was supportive in guiding me on how to manage these."

- "My supervisor was thoughtful and guided me, while allowing space for me to formulate my own ideas about the patient."

- "Supervision was the frame for the challenging work that I had to do. It was essential in terms of crystallising my existing understanding, deepening my understanding of the modality, and understanding both my patient and myself (and absorbing new ways of understanding)."

- "The regularity of supervision was essential."

- "Peer support in the group very helpful and a crucial component for an entire career. Psychotherapy teaches it's OK to discuss with peers, to show vulnerability, to explore and reflect. These skills prevent burnout in the long-term and are therefore crucial in early training."

- "Feeling supported is very important as through the experience of containment of anxiety that happens in supervision, I felt more able to contain the anxiety of my patients."

- "The dynamic of the supervision group was an important and valuable part of the experience."

Negative themes:

164 trainees (27.4%) responses were coded to contain at least one negative supervision theme.

The group setting was commented on by some trainees, who stated that this made supervision stressful, uncomfortable and limited the time available to discuss their case (4.52%). Problems with their supervisor (4.34%) was the next most highlighted concern.

Trainees commented on difficult relationships with their supervisors, as well as a lack of understanding about their training including other commitments and underlying knowledge of psychotherapy. A lack of an allocated supervisor was also a problem for some trainees (2.51%) and some found supervision unhelpful (2.51%).

These comments show the importance of regular supervision, of this starting prior to the trainee starting their PLC, and that non-medical supervisors are aware of what is expected of trainee's in terms of psychotherapy curriculum requirements.

Examples of negative trainee supervision comments:

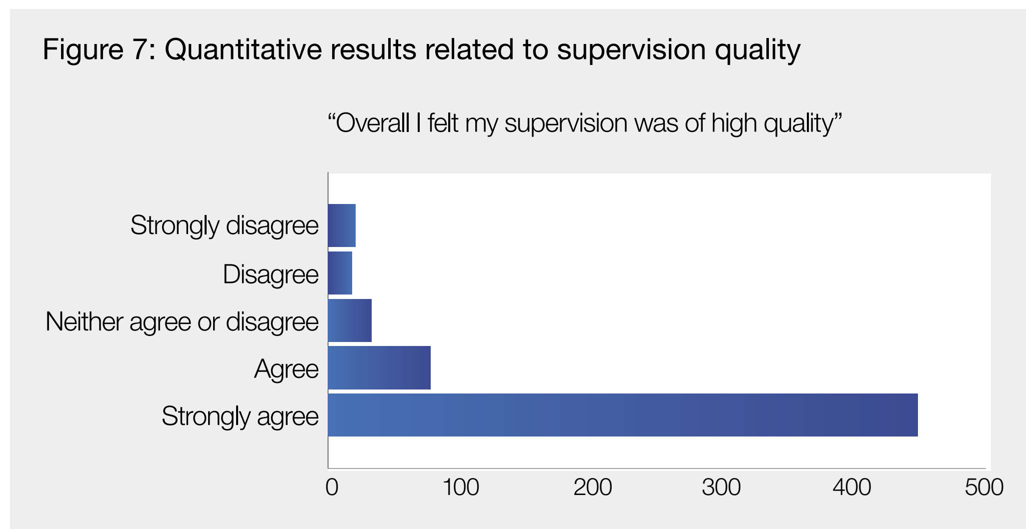
- "Supervisor unaware of other demands of training, e.g. on calls, covering colleagues."
- "The whole thing felt a bit like the blind leading the blind (myself and the patient). I felt grossly underprepared but not sure of the solution to that."
- "It's not always easy to find a supervisor. Trainees were often under pressure to find supervisors and cases themselves."

Quantitative results: Aspects of the PLC that affected the training experience

Factors related to PLC supervision:

A large majority of trainees agreed or strongly agreed that their supervision was of high quality, with 88% of trainees agreeing, 6% rating neutral and 6% disagreeing.

Figure 7: Quantitative results related to supervision quality

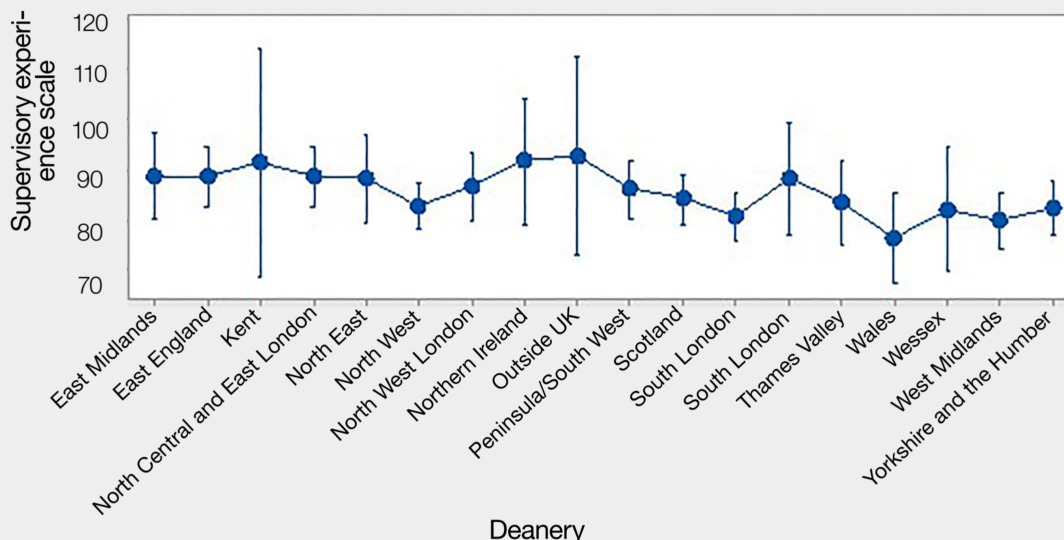


There was a highly significant positive correlation between having a positive experience of supervision and having a favourable attitude towards self-rated improvement in competence as a result of the PLC, $r = 0.639$, $p = 0.000$.

Further analysis was completed to determine factors that contributed to a positive experience of supervision with between group differences calculated with ANOVA on the Supervisory Experience Scale.

While there was regional variation by deanery in mean scores on the Supervisory Experience Scale, there were no statistically significant differences found.

Figure 8: Supervisory experience scale mean score by deanery (95% CI for the mean)

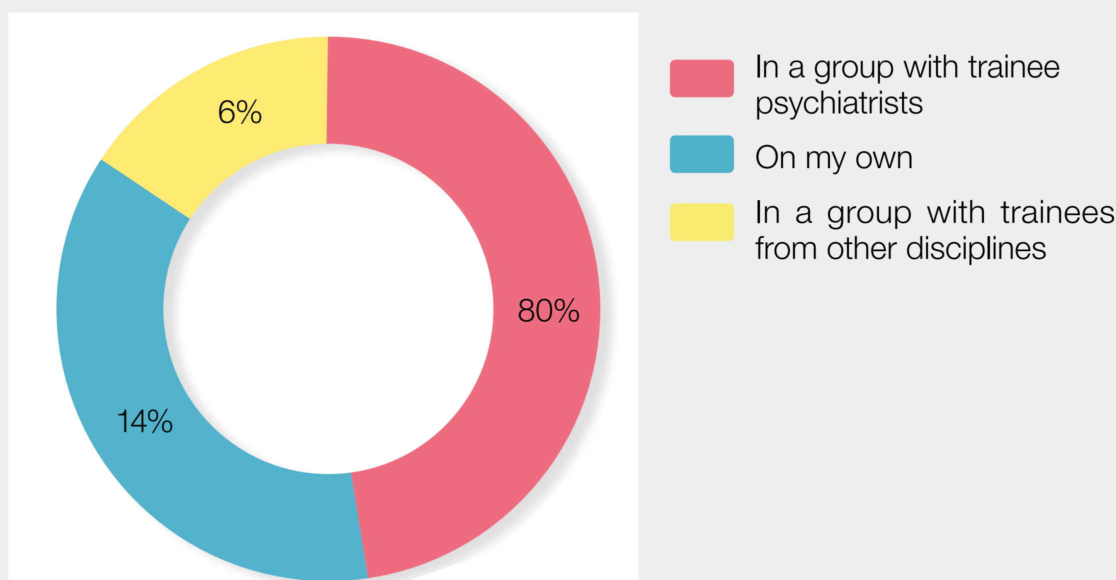


The pooled standard deviation was used to calculate the intervals

Supervision received by participants

The vast majority of respondents (80%) attended group supervision with other psychiatry trainees. There was no difference in mean scores on either the supervisory experience scale or the PLC effect scale as an effect of having attended an individual or group supervision.

Figure 9: Supervision participants



Frequency of supervision

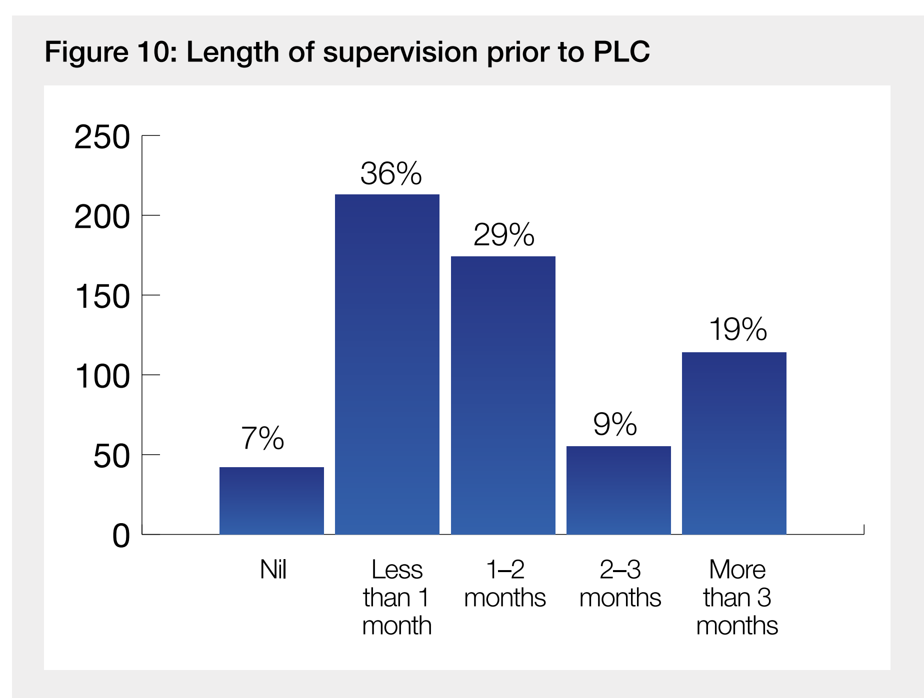
The majority of trainees (88.8%) received supervision at least weekly. There was a trend that did not reach statistical significance that more frequent attendance improved the scores on the supervisory experience scale. This finding is important despite the lack of statistical significance, given that there were very small numbers in some groups and is suggestive of the trainees' experience of supervision deteriorating with reducing frequency, warranting further research.

Frequency of supervision	Number of respondents	Mean score Supervisory Experience Scale (SD)	95% CI
More than weekly	2	96.600 (0.849)	(68.674, 124.526)
Weekly	527	85.343 (19.615)	(83.622, 87.063)
Fortnightly	44	78.71 (22.73)	(72.76, 84.67)
Monthly	10	77.76 (21.42)	(65.27, 90.25)
Less than monthly	3	52.7 (38.8)	(29.9, 75.5)
Other	8	69.2 (29.3)	(55.2, 83.1)

Duration of supervision prior to commencing the PLC

93% of trainees attended supervision prior to commencing the PLC.
57.4% received supervision for longer than one month prior to commencing the PLC.

Figure 10: Length of supervision prior to PLC



There was a highly significant difference in the Supervisory Experience Scale between those trainees who attended supervision prior to commencing PLC and those who did not. The group that attended supervision prior to commencing PLC had a 12-point higher mean score than the group that did not, p=0.000, Cohen's d = 0.52 (medium effect size). This difference was consistent in a more favourable attitude towards the effect of the PLC on the PLC effect scale, with a highly significant difference between those trainees who attended supervision prior to commencing PLC and those who did. The group that attended supervision prior to commencing PLC had a 13-point higher mean score than the group that did not, p=0.001, Cohen's d = 0.45 (small-to-medium effect size).

In the qualitative data, some comments specifically address this topic and highlighted that trainees found supervision prior to starting PLC useful – "Pre-case allocation theory sessions were helpful"; "Attending supervision before having a case helped in learning the theory."

The core curriculum does not specify whether supervision should start prior to commencing the PLC. This survey shows that trainees are not having consistent experiences across the UK and that it is important that this is addressed by RCPsych to allow optimisation and standardisation in experience.

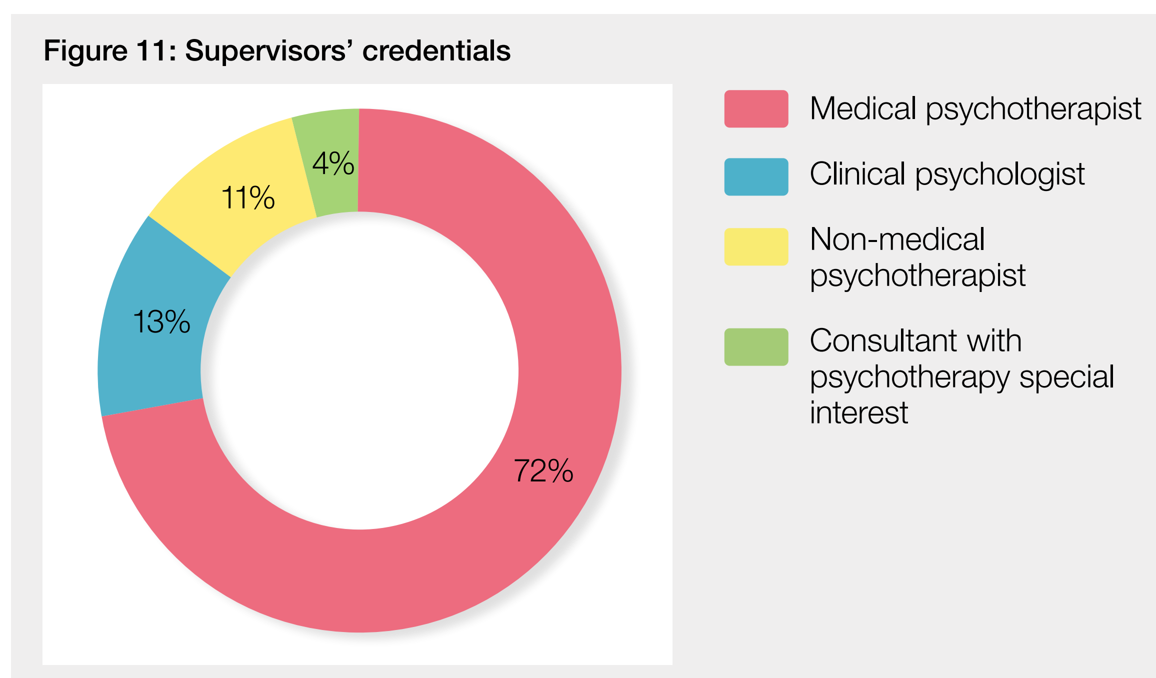
Factors related to PLC supervisor

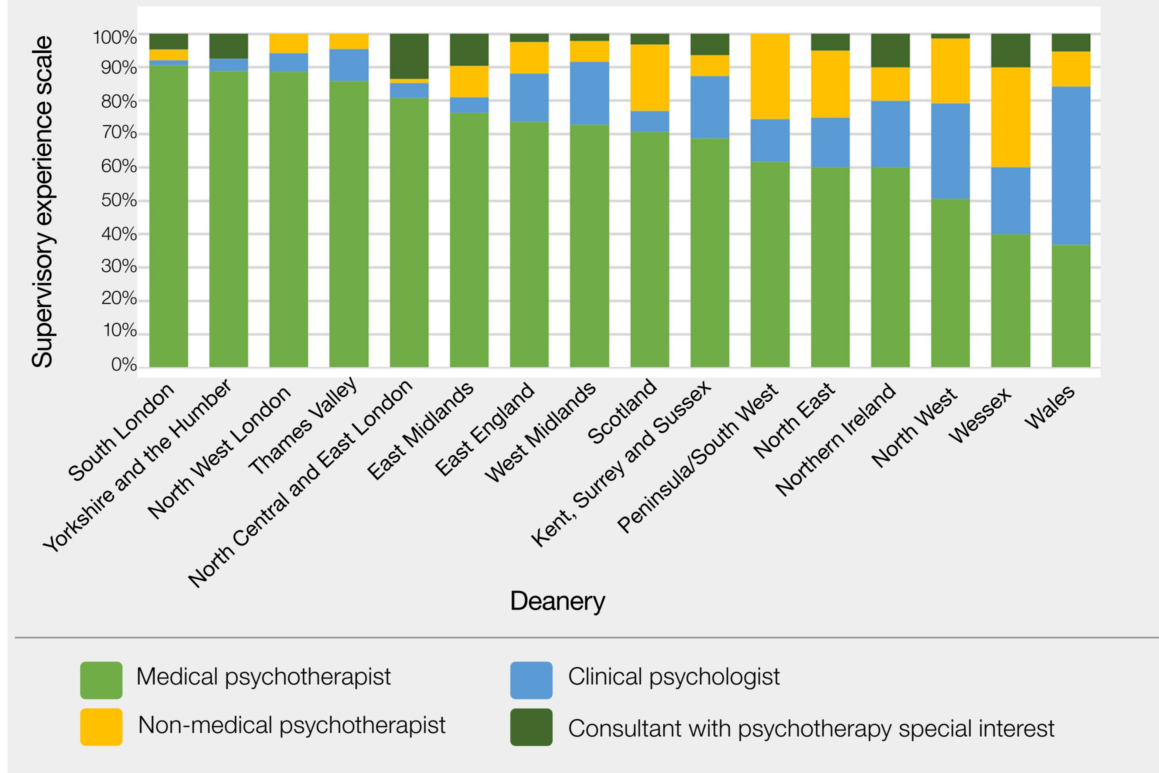
87.2% of respondents reported that the psychotherapy scheme was under the governance or run by a medical psychotherapist. Trainees in a scheme led by a medical psychotherapist scored significantly more favourably in the supervisory experience scale (mean 85.1 vs 77.6, p=0.026), with a small effect size, Cohen's d = 0.35.

Supervisors' credentials

The majority of trainees, 71.9%, were supervised for their PLC by a medical psychotherapist.

Figure 11: Supervisors' credentials





This graph demonstrates the differences in how the PLC training is supervised across different deaneries. For example, in South London, 90.6% of trainee responders were being supervised by a consultant medical psychotherapist, compared with Wales, where only 36.8% of trainees were supervised by a medical psychotherapist. In Yorkshire and Humber, there were no trainee responders who were being supervised by a non-medical psychotherapist and three deaneries had no trainee responders who were being supervised by a consultant with a special interest in psychotherapy. Wales was the only deanery where clinical psychologists delivered the majority of the PLC supervision to trainees.

There was a trend, which did not reach statistical significance, of more favourable attitudes towards the experience of supervision with medical psychotherapists and clinical psychologists compared to a non-medical psychotherapist or a psychiatry consultant with special interest.

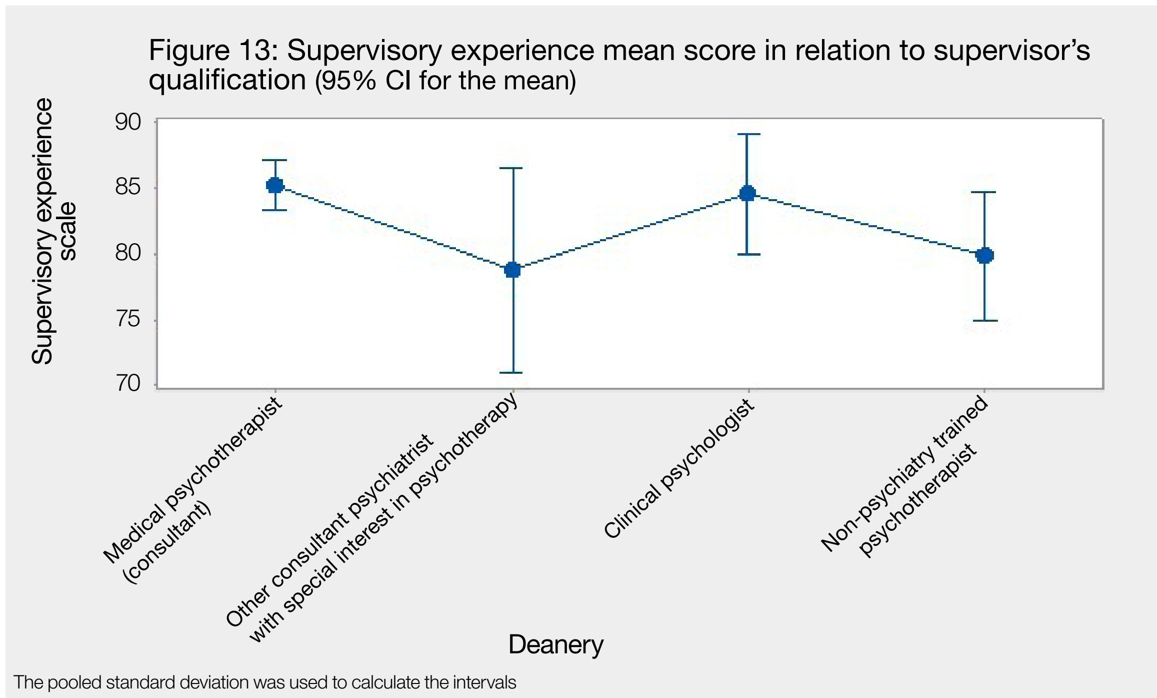


Figure 13: Supervisory experience mean score in relation to supervisor's qualification (95% CI for the mean)

The pooled standard deviation was used to calculate the intervals

Barriers to completion of the PLC:

50.3% experienced barriers to completing the PLC.

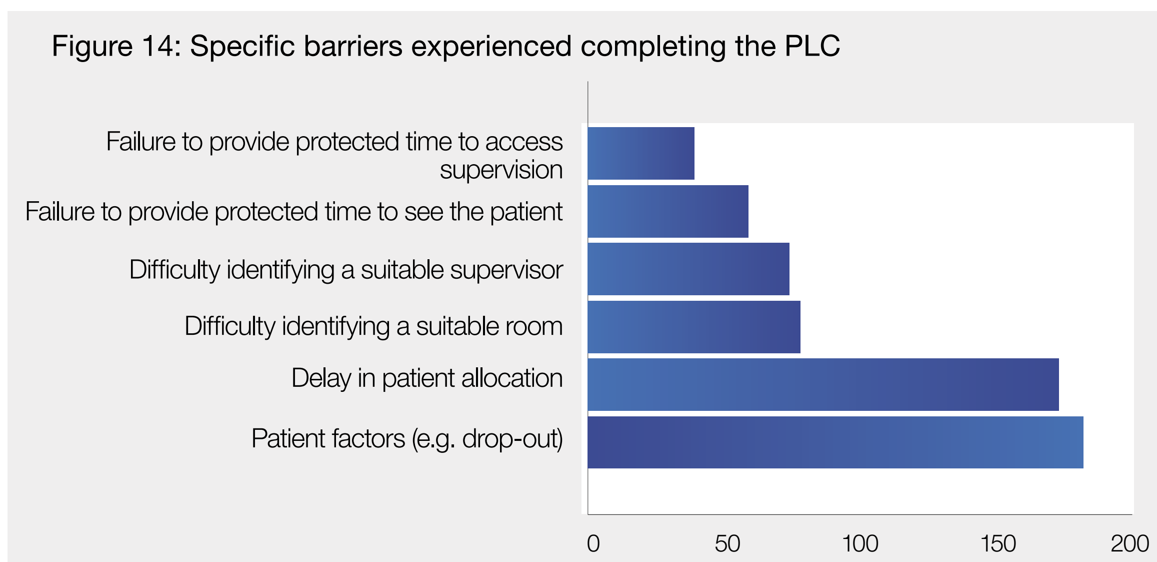


Figure 14: Specific barriers experienced completing the PLC

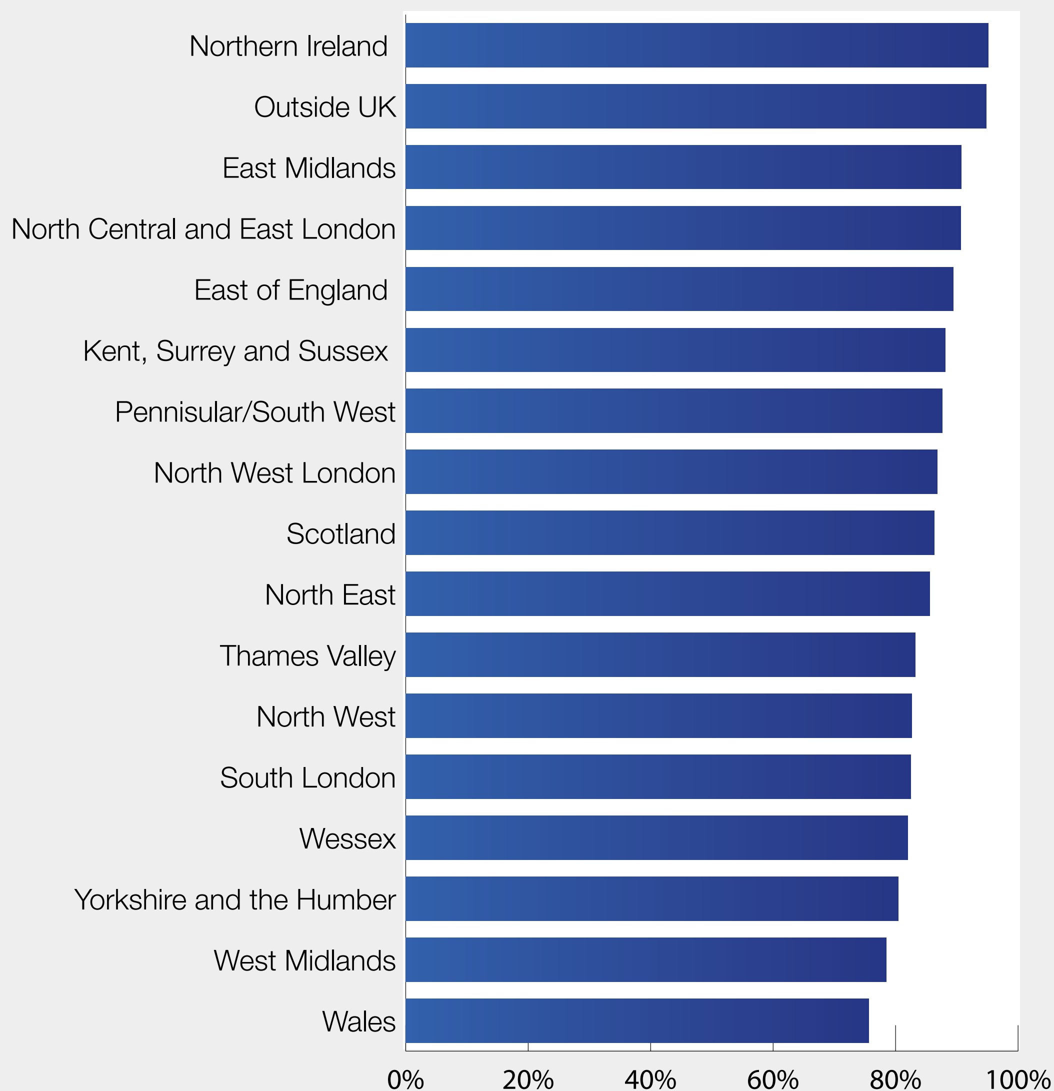


Figure 15: Deanery breakdown of respondents facing barrier to completing the PLC

Respondents in Peninsula/South West faced the fewest barriers to completing the PLC, with 27.7% of trainees identifying barriers, and trainees in Yorkshire and Humber reported 37% of trainees faced barriers. The deanery where the most trainees identified facing barriers was Northern Ireland, with 80% of trainees reporting difficulties, then North West, with 68.8%, and then West Midlands with 66.7% of trainees. The specific barriers faced in each deanery are included as graphs in the appendix (item 2).

The majority of deaneries showed that 40–60% of their trainees faced barriers to completing their PLC. This is a significant and concerning finding from the survey which requires further attention from the RCPsych.

Through use of ANOVA, comparison was made between the groups who did and did not face barriers to completing the PLC to determine whether facing barriers impacted on the overall attitude to the PLC on the PLC effect scale. There was a highly significant

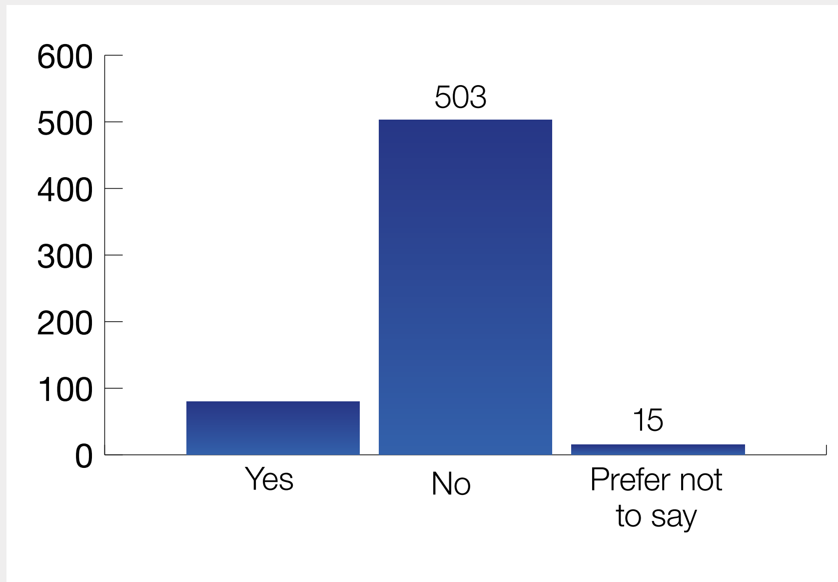
difference between groups with those who faced barriers showing a mean score of 65.71 on the PLC effect scale compared to those who did not face barriers showing a mean score of 78.43, p=0.000. The effect size was medium, Cohen's d =0.52.

Facing barriers to completing the PLC was associated with having a negative trainee experience of supervision. Those who faced barriers showed a mean score of 79.9 on the Supervisory Experience Scale compared to those who faced no barriers (mean score of 88.7, p=0.000). The effect size was small to medium, Cohen's d = 0.44.

Qualitative and quantitative results related to personal therapy

13.4% of respondents had personal therapy while completing the PLC, 2.5% preferred not to answer and the remaining 84% did not have personal therapy while completing the PLC.

Figure 16: Quantitative results showing whether respondents undertook personal therapy during the PLC



32 trainees (5.35%) commented that personal therapy could be beneficial during the PLC. Whilst undergoing personal therapy is not a training requirement, it was interesting to note that a small number were undertaking this, and there were reports that this was helpful, for example:

- "Affording individual trainees more insight into their own psychological make up would greatly improve our ability to engage in this type of work."
- "It also brought up very difficult feelings and personal therapy before starting case would have been useful."
- "There seems to be an artificial and unhelpful divide between patients and doctors in medicine that doesn't exist in the same way in other professions. I think engaging with psychotherapy as a recipient would help break down this barrier."

Those respondents who had personal therapy during the PLC scored significantly higher on the PLC effect scale (mean difference of 12.76, p=0.000, with a medium effect size, Cohen's d = 0.56). There was no significant difference in the experience of supervision scale based on whether or not respondents received personal therapy during their PLC.

Discussion

Overall, more than 80% of trainees felt that the PLC was an important part of core training and the PLC was found to significantly increase psychiatry trainees' self-rated competence in a range of domains, including empathy, managing boundaries, listening skills, managing difficult clinical interactions, recognising the value of continuity of care, recognising one's emotional response to a patient, formulation skills and understanding how this impacts treatment plans. These skills are fundamental to the practice of psychiatry. Our study lends further evidence of the educational value that trainees put on the PLC in developing these. In addition, trainees felt that the PLC improves resilience and that working psychotherapeutically adds to their enjoyment of work. These are important points for recruitment and retention of psychiatry trainees and add further weight to the importance of maintaining high-quality psychotherapy training. Those trainees who had experience of the long case had more favourable attitudes about psychotherapy training. One possible explanation for this is that completion of the PLC has a greater impact on trainees' self-reported competence in a range of professional domains than they anticipate that it will have before they complete the PLC.

The majority of trainees were supervised by a medical psychotherapist and rated their supervision as high-quality. There was a clear association with having a positive experience of supervision and self-rated improvements in skills as a result of the PLC. It is therefore clear that high-quality supervision is important in determining the trainee experience. This survey highlights the importance of supervision starting prior to the PLC, being regular and being conducted by a supervisor who is aware of the curriculum requirements and trainee's other commitments. There was a highly significant difference in the supervisory experience and attitudes towards the effect of the PLC on skills between trainees who had started supervision before the PLC and those who had not. There is no current guidance, however, whether supervision should start prior to commencing the PLC. It was also noted that trainees who were supervised by a medical psychotherapist or whose PLC supervision was under the governance of a medical psychotherapist, had significantly more positive experiences of supervision. No significant differences were found in groups of trainees supervised by clinical psychologists, non-medical psychotherapists or consultants with a special interest in psychotherapy, once the scheme was led by a medical psychotherapist. This finding however should be carefully interpreted due to small numbers in those groups of respondents who were not supervised by medical psychotherapists.

This survey identified a number of factors that impaired the effectiveness of the PLC. Facing barriers to completing the long case and not attending supervision prior to starting the long case negatively impacted on the experience of supervision and of the opinions about the effectiveness of the PLC in improving skills. It was found that around half of trainees experienced barriers to completion of the PLC, with termination of therapy by patients and delay in patient allocation being the most common difficulties. This is a significant and concerning finding from the survey which requires further attention.

There was a highly significant difference in trainees' attitudes of the PLC on the PLC effect scale between those who had faced barriers to completing the PLC compared with those who hadn't. Therefore, there facing barriers to completing the PLC has a clear association with a less favourable trainee experience of supervision and self-rated improvement in clinical skills and attitudes as a result of the PLC. It is possible that attending less than weekly supervision also reduces the benefit, however the survey had insufficient power to conclude this.

The survey also highlighted that a small number of trainees are already undertaking personal therapy and that more are interested to do so, recognising the value to psychotherapy and wider psychiatric practice. Undertaking personal therapy while completing the PLC was associated with more favourable opinions of the effectiveness of the training intervention, although this cannot be taken to be a causal association as it is possible that those trainees with an interest in psychotherapy were more likely to undertake personal therapy. This is an interesting finding as personal therapy is not a requirement in core training. Trainees may start personal therapy for a variety of reasons, including to manage difficult emotions brought up by the PLC, increase their self-reflective capacity, to increase their understanding of the patient experience and for reasons independent of psychiatry or psychotherapy training. Undertaking personal therapy is a requirement for higher trainees in medical psychotherapy due to the knowledge that personal therapy is essential to act as a psychotherapist. Personal therapy is not currently a requirement for other higher trainees or for those undergoing core training in psychiatry. It is interesting nevertheless, that some trainees felt the need and benefit of having arranged this themselves. It may be appropriate to consider whether access to funded personal therapy for wider numbers may be helpful in strengthening reflective practice and resilience within the speciality.

Limitations

There are a number of limitations that need to be considered. Overall, the generalisability of the study was limited by the low response rate of 14.3%. Caution should also be taken when comparing deaneries due to the considerable differences in deanery sizes and response rates.

The use of the RCPsych database of trainees' email addresses was a limitation due to the difficult nature of keeping an up-to-date list. Some people who were contacted may not have been current trainees, for example those who had recently left or completed training or those who had not updated their contact details. It is estimated that the error rate was smaller than5%.

Responder bias may have influenced the results, as trainees with extreme experiences may be more likely to respond and write comments. The self-rated trainee competencies are a subjective measure, and therefore, future research with objective measures of core psychiatry skills is suggested.

The study was designed to include higher trainees, who would provide a different perspective following reflection on the value of the PLC to core training. However, although the survey questions were asked specifically regarding the value of the PLC to core training, it is possible that higher trainee responses could be influenced by later psychotherapy experience.

Conclusion

The results of this trainee-led national survey indicate that the psychotherapy long case (PLC) is a valued educational experience. Trainees reported that it increases their skills in a range of domains including empathy, managing boundaries, listening skills, managing difficult clinical interactions, recognising one's emotional response to a patient and how this influences treatment plans. This highlights that the PLC experience is likely to be important in creating reflective, empathetic, person-centred and emotionally intelligent psychiatry consultants of the future. The study found that trainees reported that undertaking the PLC improved their resilience and enjoyment of work.

The negative comments in relation to the PLC were mostly due to the barriers faced in completing the PLC and concerns about this impacting on progression of training. Around half of trainees reported barriers to completing the long case. The obstacles reported were a lack of suitable identified patients, lack of supervision opportunities and time not being protected. As a result, some trainees reported concerns that they may not be able to complete the PLC due to factors outside of their control, and that progression through training may be delayed as a result.

Trainee responses within this study also emphasise the importance of ensuring consistent ARCP experiences and training opportunities across the UK, with clear expectations which have been previously highlighted[13, 14]. Guidance is clear that the medical psychotherapy tutor should use their discretion, and make a qualitative assessment of the trainee's development alongside the expectation of the minimum number of sessions for the PLC being 20. Some trainees worried that this flexibility to triangulate evidence could be inconsistently applied. The findings of this study support the requirement for the psychotherapy tutor to be registered as a Medical Psychotherapist on the Specialist Register.

The findings of this survey support the need for training schemes to protect time and continue to provide suitable training opportunities to enable completion of PLC. Where this is not consistently happening, medical education systems need to ensure that remediating this is prioritised. Heads of Schools (or their equivalent) must work with local education providers through local Quality Assurance mechanisms to ensure that this is recognised and valued as a fundamental and non-negotiable aspect of training. The influence of expanded psychotherapy training in developing resilient psychiatrists with higher levels of work enjoyment and therapeutic impact requires further investigation.

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Appendices

1. Qualitative themes

Positive attitude towards the importance of PLC as a training experience

There are eleven themes relating to positive attitude towards the importance of PLC as a training experience. They are described in additional detail below:

Doctor–patient relationship
For example: maintaining boundaries, improving dynamics, recognition of unhelpful interactions, understanding psychological processes:
• Psychodynamic module has helped me to be a patient person overall. It has helped me in understanding the other person's views without being judgemental. • This enables trainees to consider how… the doctor patient relationship may be influenced by interpersonal factors as well as an individual's psychological development. It also encourages one to consider how our own development and ways of relating may be contributing to doctor-patient dynamics. • Not understanding self and how we alter based on our doctor–patient interaction will impair out ability to treat patients. • …to tackle the stirred emotions while maintaining the boundaries between patient and doctor. • The ability to acknowledge transference and counter-transference is immensely helpful in clinical practice.
Approach to psychiatry
• The experience of working in a psychodynamic model has informed a lot of my work with young people since then and added enormously to the richness of my training. • Improves greatly the understanding of patients' presentation even in a more generic psychiatry environment. • This fundamentally changed my approach to treating individuals. • (It) has made me a better psychiatrist.
Developed formulation skills
• Helps to structure a way of thinking about all patients. • It's equipped me with tools to think about my patients in a psychodynamic way.
Transferable skills
For example: transferable to working with patients or in psychiatry in general.
Learning about different modalities in psychotherapy
For example: valued learning about the modality in its own right

Biopsychosocial approach
To protect a more holistic and open-minded view of mental illness against the dominant biomedical constructs of present-day psychiatry.
Managing patients
• Helped with confident risk management of cases as better understanding core issues. • It allows learning of (psychotherapy skills) and how to use them to inform clinical judgment and decision making.
Teaches about supervision/experience of supervision
For example: learnt about leading groups, learnt supervision skills
Communication skills
For example: improved communication, talking or listening skills
Inspired future psychotherapy work
For example: medical psychotherapist training or special interest • I was very grateful for my long case experience without which I would not have had the exposure to psychotherapy which allowed me to go on to higher training in medical psychotherapy. • I would like to make it a part of my professional activity in the future.
Helps with work in organisations
For example: working with individuals, groups and managing difficult team dynamics • Psychology is a big factor in group issues in organisations. • Important for developing my ability to work with others and be more thoughtful about why conflicts arise within team.

Negative attitude towards the importance of PLC as a training experience

There are eight themes relating to a negative attitude towards the importance of PLC as a training experience. They are described in additional detail below:

Challenges at ARCP
For example: additional time being added to training/barrier to completing training/ minimum ARCP requirements of 20 sessions: • It hindered in my ARCP and… I could not apply for ST4 in time. • May be ideal to initiate this process much sooner in CT2 rather than CT3. • …it puts tremendous pressure on trainees who are fearful of their ARCP outcomes. Myself and colleagues frequently came in on nights and annual leave to see our patients who did not always turn up. I know other trainees who did not apply for ST jobs because they couldn't guarantee psychotherapy would hold them back at their final ARCP. • Should be less rigid and punitive, could be offered as an experience instead of forming part of ARCP. • My deanery will not sign off pace unless 40 sessions completed which makes sign off tough when someone drops out. • I'm aware that (the long cases) are the most common reason for extending core training. • Trainees' careers and progression are bound to the whims of a reliably unreliable population whom are expected to keep coming every week for a year.
Lack of suitable patients
For example: no suitable, available patients and no support to find them or severe delays in finding them [The long case] should not be a requirement, unless trainees will be allocated cases… the stress and anxiety associated with trying and struggling to find a case and fearing that you will fail your core training is not worth it. It turns the whole thing into a tick box and makes you resent the whole process.
Not clinically relevant
• I do not use the model in my day-to-day practice now, nor are there many opportunities to refer my patients for this. • The provision in the NHS for psychotherapy appears to be ever dwindling and I have reservations as to whether it should remain an essential requirement.
Lack of supervision or medical psychotherapists
Unfortunately, the way it is now is like a postcode lottery, depending on if you get a good supervisor or if you do get anyone at all.
Skills can be learnt elsewhere
29 trainees (4.85%) For example: Balint or short case

Not able to offer safe/effective practice for patients
[Psychotherapy] should be left to the experts. I personally felt out of place throughout the process – it was such a traumatic experience – and so did the patient who deserved better.
Takes trainees away from other experiences
• Extremely time-consuming (2 sessions per week for nearly a year), difficult to find the time to complete other work/competencies as a result. • There can be substantial "opportunity cost" to trainees [where] their time could arguably be better spent developing their interests in other areas further.
Difficulties in cooperating alongside other commitments
For example: alongside rotations, on calls, study leave, exams, sickness, maternity. • Managing attendance of groups around night shifts and on-calls has been a challenge, and managing to attend enough sessions to keep up to speed with my patient has required me to go in on a lot of days off. • Coming in on rest days after night shifts was an expectation and no changes were made to job plan to help achieve it. Frequently left tired/fatigued as a result.

Positive supervision comments

The seven themes relating to positive experiences of supervision are described below:

Quality of supervision
For example: interesting, explorative, helpful feedback or practical advice • These supervisions were completely different from anything I had experienced and so were a unique opportunity. They were not a chance to feel supported or even to reflect on my practice. Instead, I was challenged and forced to think about interactions with patients in a new way. I was encouraged to take risks. It was a good space to discuss issues and concerns and get feedback both from the consultant and other trainees. Thoughtful and educational discussions. • Really useful for reflecting on the previous session and for giving ideas about which direction to take future sessions. • Useful arena for discussing any psychological concepts. • Good mix of theory and practical aspects of how to manage the case
Good/skilled supervisor
For example: supportive, experienced, helpful • My supervisor had a clear in-depth understanding of psychodynamic therapy and she was so opened and understanding and willing to explain the processes. • Supportive and flexible supervisor. Encouraging and was a psychiatrist so understood the tension between managing risk and building rapport with the patient/developing a therapeutic relationship. • Fantastic supervisor. She was a traditionally trained psychoanalytic psychotherapist and had very high standards. Very skilled and knowledgeable. • Non-judgemental supervisors who encouraged me to enjoy the process and not to demand too much of myself and my patient. • We had both a consultant psychotherapist and a clinical psychologist in supervision which enhanced learning and enabled trainees to openly discuss difficulties. • I found the supervision with an experienced medical psychotherapist more helpful as she could understand my psychological knowledge and skills better and could provide me with the right level of support. • She liked working with junior doctors and it was a mutually valued relationship.
Group feedback/learning
• The opportunity to participate in supervision for my colleagues was a privilege. It afforded even greater insights into the process and I felt closer to these colleagues for having gone through the experience together. • Helpful [because] others could notice things that I had not. • Being with other trainees in the group made it a more comfortable experience as we were all new to psychodynamic psychotherapy so had similar worries and concerns. • The opinions of other trainees enriched the supervision experience, but could prove a barrier when the therapy brought up difficult issues in myself (and it would have improved my experience to have the offer of individual supervision with my supervisor.

Structural issues
For example: reliable, consistent, emphasised its importance • The regularity of supervision was essential
Safe space
For example: safe, containing, could talk openly • It was helpful to have a space where I could feel listened to and supported. • Emotionally safe space to grow. • Space to think creatively and reflectively on a person's situation and problems
Availability of supervisor
For example: approachable, available, contactable • I felt confident that I could approach my supervisor when I needed it. • The supervisor was always contactable if there were urgent concerns, so I never felt out of my depth. • The opportunity for 1:1 supervision, in addition to regular group, helped me feel supported. • Email or telecom contact was also valued in addition for more pressing occasions.
Training - before or during supervision
For example: • Simultaneous study and discussion of relevant journal articles was enriching. • Pre-case allocation theory sessions were helpful. • Attending supervision before having a case helped in learning the theory. • Good at signposting to relevant reading material.
Negative supervision comments
The four themes relating to negative experiences with supervision are described in additional below:
Group feedback
For example: stressful/uncomfortable/time constraints • Often there was not enough time to discuss the case due to the number of trainees in the group. • Sometimes input from other trainees was helpful, sometimes it felt a bit critical. • We were videoed delivering therapy sessions and this was played back to the group and discussed during supervision. This often felt uncomfortable and certain people were singled out. • It does make me self-conscious about revealing when things produce feelings in me that may be, in part, related to my personal life and own mental health issues. • Criticism in front of a group is particularly hard.

Poor supervisor
For example: forgot details, hard to understand, didn't think trainees should be doing this therapy, focused more on number of sessions rather than quality, poor relationship, potential for abuse/bullying • My supervision was not medically trained and therefore thought that trainee doctors should not be doing psychodynamic psychotherapy. I would frequently be told 'you need to have therapy to give therapy,' which was not constructive when I was reflecting on my case. • Unhelpful over analysis of lateness and absences beyond our control, such as rushing from teaching and needing the toilet, queuing for the lift, on calls, night duty. • My supervision was overly confrontational and the supervisor would forget details about me and the patient. In addition, the supervisor assigned me a patient based on incorrect assumptions. • The supervisor was very quick to correct both my actions and my feelings about a situation without any apparent curiosity or room for discussion, I was just told I what I said was wrong and I did it because I was feeling X and that was the end of the discussion. Unsurprisingly this was not very helpful from either an educational or inter-personal standpoint. • Trainees have to complete this process to the satisfaction of one supervisor whom you are bound to for a year. Clearly this opens up all sorts of potential for bullying/abuse. • My supervisor appeared to enjoy supervising white British trainees. I seemed like a burden. • Supervisors counted the number of the sessions to sign us off and didn't take into account the effort of the trainee throughout the whole process
Physical availability of supervisor
For example: nil available, available late in post, only available via telephone, left post and delay replacing them. • It's not always easy to find a supervisor. Trainees were often under pressure to find supervisors and cases themselves. • It was telephonic which was not helpful.
Quality of supervision
For example: not engaging or interesting, lack of exploration, lack of helpful feedback or practical advice: • Subject has not been delivered in an interesting or engaging way. • Whenever I asked for help with a particular issue, I was given vague suggestions with little practical value.

2: Deanery breakdown of barriers faced to the PLC

Deanery	Any barriers (%)	Difficulty identifying a suitable supervisor (%)	Failure to provide protected time to see the patient (%)	Failure to provide protected time to access supervision (%)	Delay in patient allocation (%)	Patient factors (%)	Difficulty identifying a suitable room (%)
East Midlands	47.6	0	9.5	4.8	28.6	28.6	14.3
East of England	47.6	7.1	9.5	2.4	25	26.2	16.7
Kent, Surrey and Sussex	56.3	6.3	0	0	18.8	43.8	6.3
North Central and East London	46.7	6.7	17.8	11.1	17.8	27.9	15.6
North East	40	5	0	0	30	15	15
North West	68.8	28.6	16.9	11.7	45.4	46.8	13
North West London	51.4	8.6	14.3	8.6	17.1	28.6	2.9
Northern Ireland	80	60	0	0	60	50	30
Pennisula/South West	27.7	0	2.1	2.1	23.4	23.4	10.6
Scotland	43.1	4.6	4.6	6.2	15.4	20	7.7
South London	48.4	16.1	10.9	3.1	28.1	28.1	14.1
Thames Valley	61.9	9.5	14.3	9.5	38.1	28.6	14.3
Wales	57.9	36.8	21.1	21.1	36.8	42.1	31.6
Wessex	40	30	10	0	40	40	20
West Midlands	66.7	25	4.2	6.3	50	37.5	18.8
Yorkshire and the Humber	37	3.7	9.3	5.6	20.4	24.1	18.5