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Psychological Society



Division of  
Clinical Psychology

Faculty of the Psychology  
of Older People

# Psychological best practice in inpatient services for older people

Edited by Kate Ross & Sarah Dexter-Smith



November 2017

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# Psychological best practice in inpatient services for older people

Edited by Kate Ross & Sarah Dexter-Smith

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# Executive summary

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## Psychologically healthy wards

The Royal College of Psychiatry accreditation standards for older people's inpatient services currently recommend a minimum of 0.5 wte dedicated clinical psychology time for each ward. It further recommends that there is adequate clinical psychology resource for the size of unit to ensure that all patients have access to detailed psychological formulation and that there is therapy provision for those who would benefit. The Faculty for the Psychology of Older People endorses this recommendation. This executive summary outlines what features of an inpatient service contribute to the psychological health of inpatient environments for older people, their families and the staff who work there, and what clinical psychologists specifically can contribute to services.

- A. Promoting a psychologically healthy environment:** the psychological wellbeing of people using inpatient services is a core component of the service offer and involves clinical staff of all professions. The following factors make a positive contribution to the overall effectiveness and quality of care in inpatient services for older people:
1. *The ward has a dedicated psychologist.*
  2. *The service is committed to the recovery model.*
  3. *Psychological care is understood to be part of everyone's role.*
  4. *The psychologist works in partnership with the ward manager to promote quality of care.*
  5. *The psychologist offers specialist assessment, formulation and intervention directly to patients.*
  6. *The psychologist offers training and models good psychological practice to other clinical staff.*
  7. *The psychologist leads multidisciplinary formulation sessions and complex case discussion groups with the multidisciplinary staff team.*
  8. *Psychological resource on the ward is enhanced by the presence of assistants, trainees and/or interns.*
  9. *People with lived experience and informal carers are involved in service development.*
  10. *There is a broad and evenly distributed mix of workforce e.g. overall quality of psychological care is also enhanced by the significant presence of other therapies staff; occupational therapy, arts for health, physiotherapy, pharmacy, speech and language therapy, dietician, etc.*
  11. *The ward provides patients with information about what to expect of their stay and works to make sense of each person's experience of their journey through the admission.*
  12. *The ward works closely with family or friends of the patient's choice.*
- B. Clinical psychology in older people's inpatient services.** Psychology has the potential to make a significant contribution to clinical effectiveness and quality in inpatient services for older people. The research that accompanies this document indicates that:
- The impact of the psychology resource is enhanced by **clear negotiation with the operational team** about what they hope to achieve from their psychology input. This should clearly map onto what is measured and evaluated about the input provided.

- The psychological intervention that provides the single biggest impact on overall quality and effectiveness of care is **psychology led multidisciplinary formulation** of patients' individual lives, challenges, traumas, strengths and recovery needs.
- Psychologists based within ward teams can make a significant contribution to: the **overall culture of care**; the achievement of **user friendly care pathways** and protocols; developing the service's psychological competency in **communication**; increasing **therapeutic engagement** of staff and patients; **avoiding iatrogenic psychological harm**; and increasing attention to all the small gestures a service can make to increase a person's sense of being **welcome, valued, and cared about**.
- Much of the benefit of psychology comes from working at a team or service level; providing **training and supervision**, promoting **recovery and co-production**, etc. Effectiveness of individual clinical interventions in this context has been shown for **solution-focused** approaches, age-adapted models of **CBT** and **Mindfulness, ACT, DBT, experiential dynamic psychotherapy**. **Risk** assessment, **capacity** assessment, and **cognitive** assessment can also be an effective use of psychology time.

The decision of how much clinical psychology to commission at what banding for each unit will depend on what the service wants to achieve from the employment of psychologists within the team. The following is a broad guide to the added value that could be expected of psychologists at different stages in their career. In order to achieve the maximum impact of psychology described as above in a cost effective way, we recommend a professional structure of psychologists at different bands. Employing psychologists with seniority can deliver improvement across the service, whilst the employment of psychologists at lower pay bands delivers a significant clinical resource. Assistant and trainee psychologists provide valuable extra resources but should not be employed without the appropriate qualified psychologist supervision and do not satisfy the requirement for qualified psychologists recommended by CCQI. The following table is designed to facilitate local conversations about workforce planning within a safe governance framework. As such, it assumes that the psychologists within each band are supported by a comprehensive senior psychology structure in order to safely deliver these elements.

**Kate Ross & Sarah Dexter-Smith**

Input to the organisation	Input to the clinical service	Input with the staff team	Input with family and carers	Input with patients
<p>Band 7-8b</p> <ul style="list-style-type: none"> <li>*Involved in local service/team decisions</li> </ul>	<p>Band 7</p> <ul style="list-style-type: none"> <li>*Carries out audit and research</li> </ul>	<p>Band 7</p> <ul style="list-style-type: none"> <li>*Works alongside psychology assistants (both under direction of more senior psychologists)</li> <li>*Delivers training in psychological therapy models and psychological wellbeing interventions for other staff</li> </ul>	<p>Band 7</p> <ul style="list-style-type: none"> <li>*Liaison work with families</li> <li>*Provides carers' support groups</li> <li>*Helps patients choose how they'd like their loved ones involved</li> </ul>	<p>Band 7</p> <ul style="list-style-type: none"> <li>* One-to-one clinical work with patients</li> <li>*Specialist psychological assessment</li> <li>*Specialist psychological formulation</li> <li>*Specialist psychological intervention</li> <li>*Group therapy interventions</li> <li>* Neuropsychology assessments. Band 7 will need specialist supervision by a senior psychologist</li> </ul>
<p>Band 8c</p> <ul style="list-style-type: none"> <li>* Involved in clinical governance strategy</li> <li>*Acts as principle investigator in investigations and complaints</li> <li>*Supports organisational learning from clinical incidents</li> </ul>	<p>Band 8a</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Selects and designs outcome measures</li> </ul>	<p>Band 8a</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Placements for psychology trainees, assistants and interns</li> <li>*Clinical supervision for other staff members</li> <li>*Reflective practice groups</li> </ul>	<p>Band 8a</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Complex clinical work with families</li> <li>*Develops family and carer communication and consultation</li> <li>*Systemic therapy interventions</li> </ul>	<p>Band 8a</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>* Initiates patient feedback</li> <li>*Leads goal setting with patients</li> <li>*Develops communication of recovery needs across services</li> <li>*Delivers complex risk assessment</li> <li>*Delivers complex formulations involving multiple morbidity and physical and social care needs</li> </ul>
<p>Band 8d</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Leads organisational research and transformation</li> <li>*Operates throughout the sub-structures of the organisation</li> <li>*Contributes to organisational culture</li> <li>*Advocates organisational approach to recovery</li> <li>*Advocates culture of co-production</li> </ul>	<p>Band 8b</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Ensures psychological formulation and psychological needs are an integral part of care pathway</li> <li>*Supports service to be recovery and patient centred</li> <li>*Supports service to be proactive around diversity</li> <li>*Helps service to identify quality indicators for psychological care</li> </ul>	<p>Band 8b</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>*Offers supervision to senior clinical staff including psychiatry</li> <li>*Applies psychological models to other care tasks</li> <li>*Leads multidisciplinary formulation</li> <li>*Designs training and development programmes for other staff groups</li> </ul>	<p>Band 8b</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>* Creates co-production opportunities for carers in ward</li> </ul>	<p>Band 8b</p> <p>As above plus:</p> <ul style="list-style-type: none"> <li>* Delivers complex capacity assessments</li> <li>*Designs and implements clinical protocols</li> </ul>

Input to the organisation	Input to the clinical service	Input with the staff team	Input with family and carers	Input with patients
	Band 8c As above plus: *Leads research and audit and uses data strategically *Inputs to quality and operational processes *Inputs to service vision and service development *Interprets policy and national drivers for other staff *Adapts care models to meet needs of people of diversity *Offers team debrief following incidents *Leads approach to co-production within the service *Contributes at a senior level to overall culture of service *Leads cultural change	Band 8c As above plus: *Offers mentoring and coaching across staff groups * Formally supports ward manager with team culture	Band 8c As above	Band 8c As above plus: * Second opinion *May be responsible clinician
	Band 8d As above	Band 8d As above	Band 8d As above	Band 8d As above

# Introduction

This guidance is intended for psychologists at any stage of their career who work in inpatient services. The emphasis is on services specifically dedicated to older people, in particular mental health and dementia services but the general principles are relevant to all-age and physical health services where these are providing services to older people. For the purpose of this document, the term 'older people' refers to people who use services that are designed specifically for older people or who use services to help them with clinical difficulties that are most commonly associated with ageing. By inpatient services we mean a place where someone is living (short or long-term) for assessment or treatment (not simply social/personal care) based on their mental health needs. This would exclude residential care although some of the principles will easily transfer.

This document arose from a groundswell of clinical interest and need. There has been a huge increase in the application of psychological theory and practice across non-traditional settings and increasingly, this has included dedicated psychology input to inpatient services. Psychologists have a clear idea of what they would aspire to in inpatient services for older people. Surveys of the profession undertaken as part of the development of this document (Ross, 2015)



identify themes of: emotional safety; parity of esteem; person-centred care focused around individual need; the central role of psychological formulation as a representation of the psychological underpinning of human experience; and the fundamental necessity of healthy relationships to enable therapeutic care. Psychologists have whole-heartedly endorsed the improvements to quality of care and patient experience that result from the inclusion of a psychological understanding of people's needs in inpatient services. However, inpatient environments present a clinical context that demands a different range of skills to those developed in community services. Over several years, the Faculty for the Psychology of Older People (FPOP) has worked to bring together an evidence base of published materials, examples of good practice, clinical expertise, and an understanding of the challenges that clinicians experience. This guidance is the culmination of that work. The published evidence base has been considerably enriched by encouraging clinicians from across the four nations to submit examples of what they are doing in their local services and to indicate what approaches they have had success with. This information is available on the website pages via the main FPOP website.

The purpose of this guidance document is to articulate the main areas that psychologists need to consider in order to engage with services effectively. For this reason, the eight chapters are divided into themes that reflect the process of planning psychological engagement rather than therapeutic models *per se*. Throughout the document, there is consideration of ways of engaging at different levels; with individual patients, family members, individual team members, whole teams, and the wider organisation. At different times in an individual psychologist's professional development and an organisation's wider development, psychologists may be involved at any or all of these levels and the document reflects these different ways of working. We hope that this document will:

- Help psychologists to articulate what they are able to offer and what is needed for psychological input to make an impact.
- Enable psychologists to find a voice for psychological work in an environment that can be heavily focused on physical needs and medical interventions.
- Articulate the psychological evidence base and key policies.
- Guide psychologists in prioritising often very limited time to make a noticeable difference and how to evidence that (and to whom).
- Ensure that what psychologists offer to services fits with operational and organisational priorities.
- Enable psychologists to consider the use and governance of psychologically informed interventions delivered by other team members, psychological interventions delivered by psychologists, and the use of psychological theory at a systemic level.
- Identify the barriers that can exist in trying to achieve 'good' and ways of overcoming them.
- Show how to work with/within a team whilst also trying to shape the team's culture and support the wellbeing of all those who use the service.
- Enable psychologists to exercise pragmatism and develop resilience in a clinical environment that is often shifting and unpredictable.
- Guide psychologists in working therapeutically in environments where classic therapy and neuropsychological approaches may be inappropriate.

An executive summary has been produced alongside the main body of the guidance. This is a response to the request of many psychologists for a shorter document that can be used to facilitate discussions with those responsible for designing and commissioning services. The executive summary gives a brief account of the factors that contribute to psychologically healthy wards and outlines what service managers can expect from psychologists at different bandings.

The intention is to help psychologists think about how the core principles of psychological theory and practice apply in inpatient services and to provide a menu of ideas and things to try when the way forward seems opaque. Although the work has been primarily written with clinical psychologists in mind (and funded by the DCP) many of the ideas will be relevant to psychological practitioners more broadly. Psychologists are invited to think about what is immutable and what needs adapting, what the rationale is for their role in the service, how they can best support both the team and the people who use these services, and what the agenda is of the organisation which has placed them there. There are now many examples of services that use psychology to good effect, and the document will help to articulate what the rationale for psychological input might be and what can be asked of psychologists at different stages of their career. Each chapter can be read on its own or alongside the other chapters for a more holistic account.

The chapter authors have drawn heavily on the work of their colleagues across the United Kingdom and have tried to make a broad assessment of the available evidence. Psychology is a broad church which happily includes many different ideas and approaches. The intention is to encourage curiosity and creativity amongst psychologists. The authors have taken an eclectic approach reflecting an openness to the range of perspectives and ideas that have been valuable at different times and places. In producing the document, there have been intense and fascinating discussions and the document is intended to sustain and inform those discussions. We have consulted widely at each stage of this document, with service users, carer groups, other professional bodies and third sector organisations. Their feedback has been supportive and added breadth to the final document.

The authors are also keen that the document should embody the values which are core to psychology. Specific consideration is given in each chapter to issues of difference and to ways in which people who use the service can develop ownership, both of their own care and of the services designed to help them. The editors have also thought at length about the language adopted throughout the document. Language is a powerful medium and The British Psychological Society (2015) has specific guidance on the appropriate style of published information and the appropriate use of health-related terminology. It is perhaps a reflection of the difficulty of genuinely acknowledging the lived reality of people who use our services that the recommendations of these guidelines continue to be debated and contested. The editors support the core principle that people with health needs are experts in their own care and provide invaluable insight into the received experience of using the service. The editorial decision about whether to use 'patient' or 'service user' or 'expert by experience' or 'client' to refer to these people has been very difficult. Wherever possible, we have talked about 'people' and 'individuals' since it is people's humanity that is most important to us. However, there have been instances where it has been necessary to make

a distinction between the people receiving the service and the people delivering it and on these occasions, we have opted to use the term 'patient'. This is a conscious decision to use the language preferred by and most frequently used by older people using inpatient services themselves so that they may recognise themselves and their experiences within this document. We also do not want to gloss over the on-going power imbalance that is currently prevalent in the way that inpatient services negotiate the care that is provided with the recipients of that care.

There is core guidance and other sources of information related to each of the functions that the chapters address. The authors' brief was to build on, rather than repeat, that guidance but we encourage you to read those documents alongside this guidance. The purpose of this guidance is to offer a strategic framework within which those bodies of core knowledge can be effectively applied. A separate document by the British Psychological Society focuses on working age acute inpatient services (DCP, 2012) and is worth reading in conjunction with this guidance.

Finally, we wish you well in your endeavours. The examples of good practice that we have collected and the writing of this document has enhanced our own understanding of how to approach services and we hope that this guidance is helpful to you.

**Kate Ross & Sarah Dexter-Smith**

## References

- British Psychological Society/Division of Clinical Psychology (2015). *Guidelines on language in relation to functional psychiatric diagnosis*. Leicester: British Psychological Society.
- Division of Clinical Psychology (DCP, 2012). *Commissioning and delivering clinical psychology in acute adult mental health care. Guidance for commissioners, service managers, psychology managers and practitioners*. Leicester: British Psychological Society.
- Ross, K. (2015). Inpatient workstream. *Faculty for the psychology of older people, The FPOP Bulletin*. Leicester: British Psychological Society.

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## Chapter 1: The key psychological offer

Inpatient services are complex and multifaceted systems that operate differently to community services. Patients and staff alike report that access to a clinical psychologist is an invaluable aspect of inpatient care. Yet psychologists often feel bewildered when they have their first experience of inpatient services, struggling to know how to engage and operate in a context where there are few of the structures that are familiar to psychology; appointments, clinics, referrals etc. At the same time, psychologists can become acutely aware of the potential scope to influence a critical part of the patient's journey as well as effecting change through the wider workforce. Balancing direct and indirect work can introduce dilemmas, including how to optimise a limited resource in a way that compliments the expertise of the wider team. Psychologists need to think about their key psychological offer to all parts of the system they are working in, whether that is patients, carers/family, individual and collective team members, or the wider organisation.

The purpose of this chapter is to think through strategic issues and the unique contributions the profession can make to address them. The evidence relating to effective use of psychology time is presented and the reader is encouraged to consider what will influence how their time is prioritised and what it is possible for psychologists to offer at different bandings. The values underpinning the use of psychology are identified. The initial consideration of intervening via clinical assessment and formulation and the delivery of training is also considered. Strategies and models of intervention are developed in later chapters.

At the time of writing, the most recent Royal College of Psychiatrist's standards for inpatient services (CCQI, 2017) recommend that each ward should have access to at least a



half-time psychologist, but the actual resource available in services across the United Kingdom is very variable. The potential for psychology involvement is almost limitless. Decisions about where to prioritise the time will depend on how much psychology you have available at what grade, the nature and developmental maturity of the unit, and the organisation's aspiration for what psychology involvement will achieve. The tasks that psychology might typically be involved in are given in Figure 1. Figure 1 also gives a broad brush perspective on what it is generally possible to offer with psychologists at different bandings in terms of both clinical and leadership tasks. For each element, there is an indication of the level of seniority that is most likely to be necessary for the majority of activity at this level. Clearly, this will be dependent to some extent on the individual knowledge and skills of the psychologist in post and the local arrangements for supervision and governance and is intended to be a guide only. Work outlining the leadership elements of a psychologist's role within the NHS Leadership Academy's Healthcare Leadership Model (Dexter-Smith et al., 2015) is publicly available on the North East Leadership Academy's website.

Key questions to ask are:

- Who made the decision to employ a psychologist in the service and why?
- What are the current service drivers that require that things be done differently?
- Where and with whom is psychology likely to have most influence?
- What resources do you have at your disposal? How much psychology time is available? At what banding?
- How much personal resource do you have currently? Who will be your allies in any change?
- Where might the resistance lie?
- How do you position yourself so that you can work with the service but also influence elements of the system?
- What are the service's explicit and unspoken aims and values/the culture and language?
- What is the history of psychology on the ward?
- How will psychology's contribution be evidenced and to whom?

*It may seem like a change in any policy is rare  
 But subtle little changes increase quality of care  
 Because there's more than just pay in which we  
 find rewards. You've got to consider elements of  
 psychologically minded wards  
 And although patients being angry and con-  
 fused is awful  
 We're here to help the team be more compassion-  
 ate and thoughtful*

*Found Poetry, October 2015*

As well as making decisions about the balance of time between direct patient contact, indirect working through teams, staff support and training, culture change etc., it is fundamental to start by considering the values and relationships that the psychologist wishes to embody. Staff working within inpatient services are caring for the most distressed and often physically unwell older people in our society; they work long shifts often in challenging physical environments with historically limited access to high quality supervision. Yet we know that well supported and contained teams are more likely to deliver compassionate and good quality care (Firth-Cozens & Cornwell, 2009). Psychology is often uniquely placed to be able to straddle the position of team member and external observer. Experience suggests

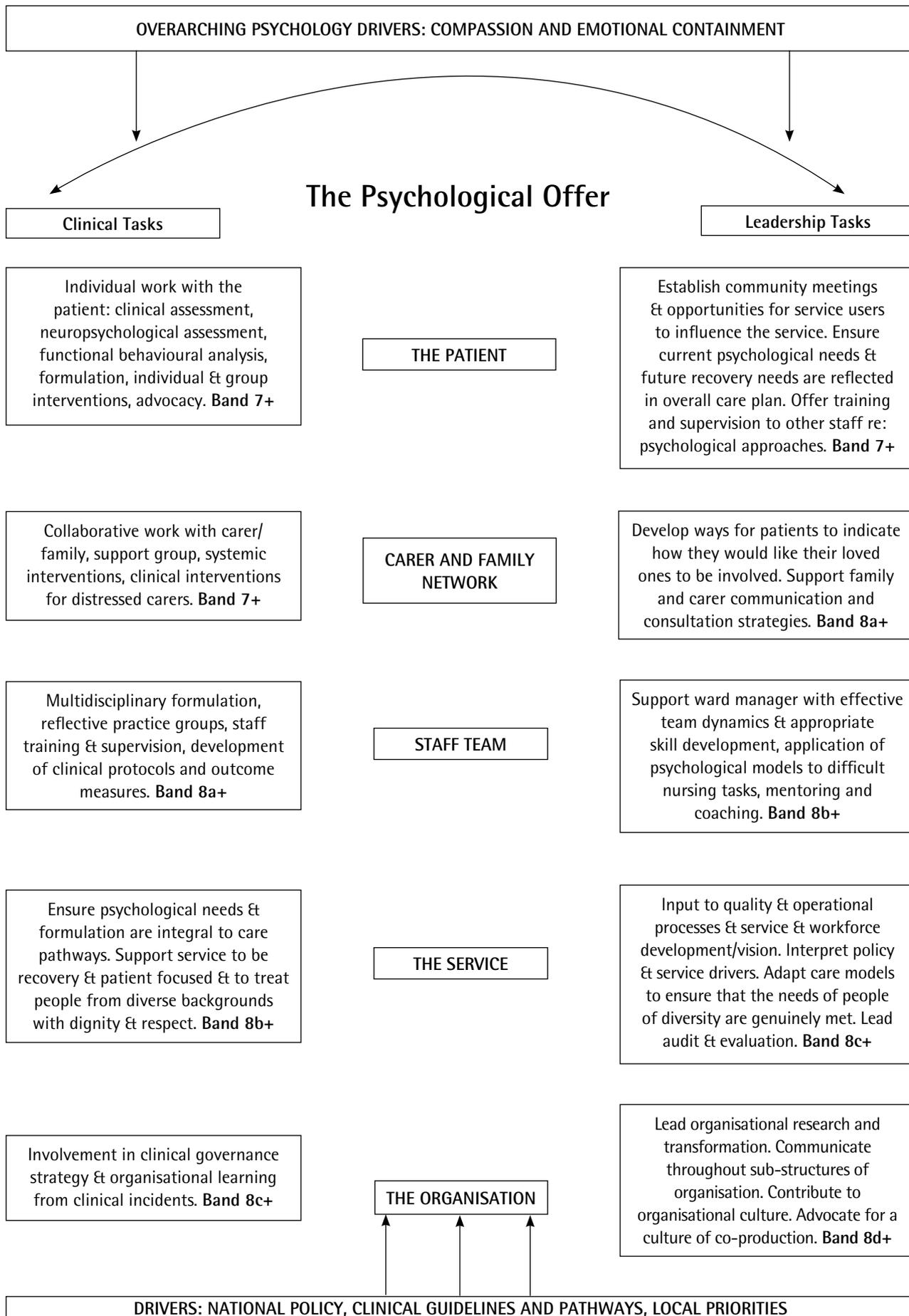


Figure 1: The Psychological Offer.

that enabling teams to recognise, name and actively manage their own emotional responses both to their clinical work and also to the demands of their healthcare system, is an intervention that is highly valued by nursing staff (BPS, 2001). This is covered in detail in other chapters in this guidance. The modelling of compassion towards ourselves and others, and the offer of emotional containment are essential elements that drive the psychological offer.

Psychology may be involved at multiple levels depending on the experience of the psychologist in post and the priorities of the service, but all clinical and leadership intervention is motivated by the fundamental need for compassion and emotional containment. The preceding table assumes that the individual psychologists are working within a well governed service and have access to appropriate senior psychology support. The table is intended to support rather than dictate local discussions.

## The overarching concepts of containment and compassion

If compassion and containment are the main drivers for psychology, then what does that mean for our practice? Compassion and containment are the notions of being able to hold in mind the emotional state or situation of another; a desire to alleviate or reduce suffering by offering a thoughtful space while tolerating not knowing, thus allowing a sense of being held and understood. Psychologists are especially skilled in maintaining understanding and compassion for others whilst containing and tolerating highly distressing emotional states. This is a skill that is extremely important in inpatient services both in order to help staff cultivate compassion towards themselves and to maintain therapeutic approaches with patients or family members who elicit strong emotions.

Acute episodes of agitation or aggression can be a particular challenge for the maintenance of compassionate and client-centred care and psychology can contribute to de-briefing from these episodes in a number of ways. Discussions around how to deliver nursing interventions in which staff are facilitated to name and normalise their emotional responses may be a particularly useful way of modelling empathy for all concerned.

Although the way of providing containment may differ, key principles apply and person-centred care remains at the heart of everything. Containment for the patient and family may come through collaborative understandings of their current context and clear communication about how this will meaningfully guide care. Containment to the staff may comprise understanding the pressures of providing clinical care amongst competing clinical and organisational pressure especially at times of change and uncertainty. Containment to the organisation may come in the form of understanding the anxieties that arise from a need to meet performance and financial targets alongside rapidly changing agendas.

The core contribution that psychologists make to inpatient services is this containment. If the psychologist is present and seen as a core team member, the team will trust them with the work that provokes the most anxiety for them. This might be through requests for staff support, risk assessment and management plans, capacity assessments or help understanding the perceived 'stuckness' of particular patients. Containing these anxieties can be overwhelming, especially if the psychologist does not comprehend the dynamics and the purpose underlying these requests. Robust support and a formulation of the system can allow the psychologist to cultivate compassionate containment for the system at every

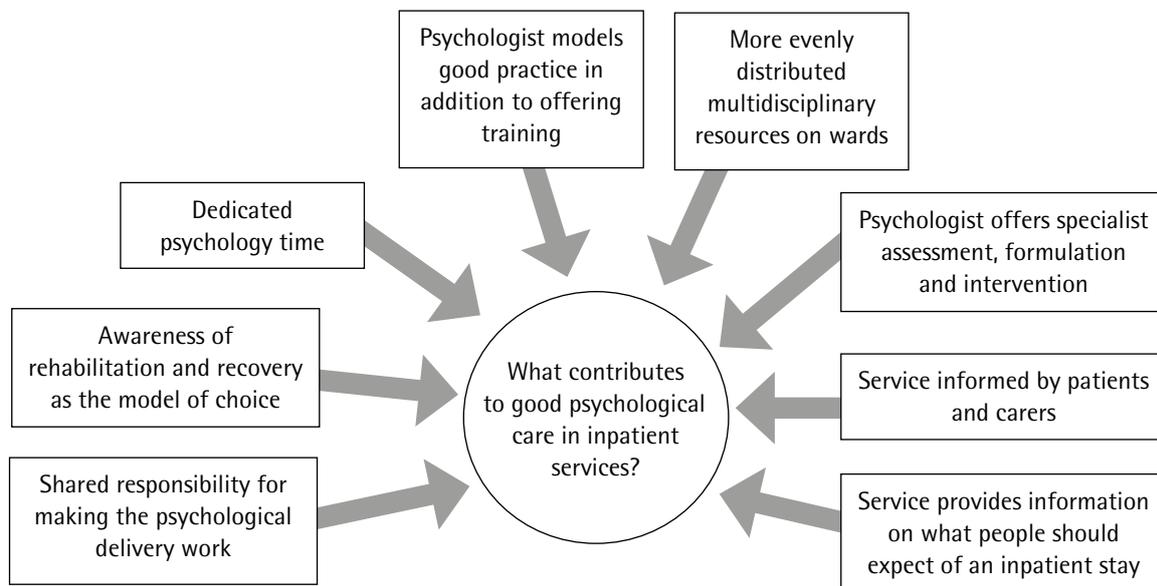


Figure 2: What contributes to good psychological care in inpatient services?

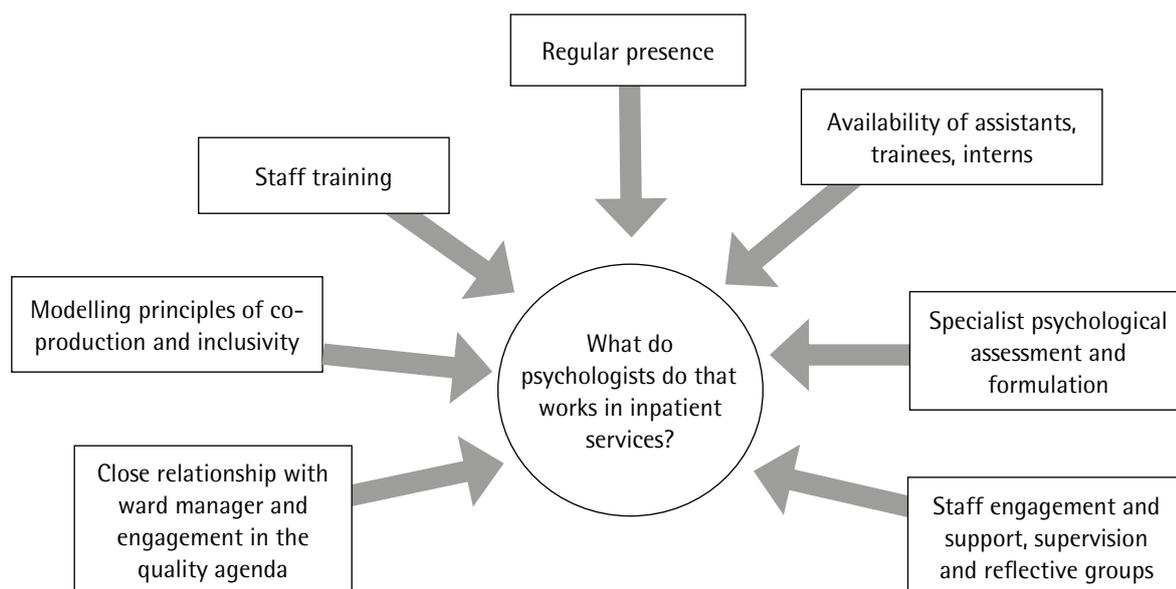


Figure 3: What do psychologists do that works in inpatient services?

level and respond to requests in a mindful way. An additional aspect of compassionate care is the service's ability to embrace the individuality and diversity of all the people who use it. Psychologists have a role in helping the organisation to be mindful of how it achieves inclusion and makes people welcome. The ways in which psychologists can engage with the culture of care are discussed further in chapter 3.

### What works for inpatient psychologists?

As part of the preparation for this guidance, FPOP undertook a series of exercises gathering examples of good practice and looking for a consensus of opinion from experienced practi-

tioners. The full details of the examples that were collected can be accessed via the website that accompanies this document. A summary of the findings is given in Figures 2 and 3.

### Assessment and formulation

Psychologists' highly specialist assessment and formulation skills are particularly useful for guiding care that is responsive to multiple and co-morbid psychological, physical and social needs. Psychologists are regularly asked to contribute to complex decision-making around risk and capacity. Capacity decisions often relate to finances and future accommodation but also, not infrequently, can concern how someone wishes to approach the treatment of their physical health needs. Psychologists in inpatient services often find that they need to acquire a knowledge base in physical health as well as making sure their knowledge of the mental capacity and mental health legislation is current. Of all the ways that psychologists contribute to inpatient services across the United Kingdom, the intervention identified in the examples of good practice with the most consistently positive outcome is the delivery of psychological formulation discussions with staff. Psychologists use a number of theoretical models to structure these (see Dexter-Smith, 2010; James et al., 2010) and the complex issues surrounding this provision are outlined in Chapter 4. Fundamentally, person-centred care relies on the whole workforce making sense of experiences from the perspective of the patients and families we work with. Through training, staff can learn about formulation, what makes it distinct from a purely biomedical perspective and how this biomedical perspective can leave people feeling disempowered. Embedding formulation can offer patients and staff a platform for open dialogues that have the potential to powerfully shape the narrative the organisation holds.

### Interventions

Knowledge and delivery of evidence-based intervention is a further key offer that psychologists can make. Psychological therapy can be beneficial in inpatient settings (Kösters et al., 2006), particularly open therapy groups, which are based on skills learning or distress tolerance. It pays to be mindful of the purpose of intervention in the inpatient context and the potential limitations and a clear understanding of the goals of admission assists this. Recovery can mean a wide range of things to individuals at this stage and often requires subtle and careful conversations to establish expectations. Inpatient admissions generally need to address the following key factors that prevent the person receiving community-based care: a breakdown of care, an acute worsening of what was a stable condition, an acute increase in risk, or a planned change in treatment that itself causes risk. As a compassionate health-care professional, it is tempting to want to provide therapy for the underlying causes and difficulties, but this can be a risky path to tread if you are not able to provide a smooth transition and sustain the therapeutic work once the person is discharged. With limited psychology resource, it may be better to hold therapy in mind for a later date. These decisions should all be informed by your formulation, but a priority is often to consider what will enable the patient to safely receive future care in a community setting. Nevertheless, there are brief models of psychological therapy that may contribute to readiness for discharge and, in some circumstances, therapy is a necessary precursor to safe and successful discharge. During the consultation for this document, solution focused therapy and experiential dynamic psychotherapy were reported as particularly useful. Further information on

specific interventions can be found in the web resource that accompanies this document. Not all interventions need to be delivered directly by the psychologist but the evidence suggests that psychology needs to be an integral part of a team to support the training and continual delivery of interventions that are evidence-based and effective (Onyett, 2007; Murphy et al., 2013).

In addition to formal therapy, psychologists in inpatient services need to be flexible about what they class as a psychological intervention. This may for example involve: psychologists being involved in care tasks to model interactions and communication styles; focusing on the social relationships on the unit; or thinking about the styles of communication of staff. The psychologist needs to have the confidence to design their interventions around their formulation of what the patient and service needs most at that particular moment. Some interventions may not typically be thought of as a psychological skill, but if it is based on a psychological formulation and aimed at a relevant outcome then it is good psychology practice – even if that intervention is as simple as doing a crossword with someone.

## Training

One area of psychological intervention for which there is a huge existing evidence base is the positive effect of providing training to other staff. It is some years now since Moniz-Cooke and colleagues (Moniz-Cook et al., 1998) first began writing about the impact of staff training programmes on staff morale and the confidence of staff to be responsive and innovative about how they manage their patients' needs. There is now a whole raft of literature demonstrating that good quality of care is associated with staff confidence, good leadership, good team working, permission to innovate, and a focus on engagement with patients rather than getting tasks done. Training has a significant role to play in supporting the development of these situational factors and there are multiple examples of training programmes implemented by psychology, which have supported staff to deliver good care (e.g. Barton & Williamson, 2011; Dexter-Smith et al., 2010; Petty et al., 2014). Ward staff often strongly welcome these training opportunities and services may additionally have adopted quality indicators in staff training (e.g. recovery awareness) that psychology is well placed to deliver. Psychologists often have specialist knowledge in areas such as dementia and can develop and deliver training with other agencies and professionals. Training may focus on specific clinical presentations (e.g. behaviour that staff find challenging, relational difficulties), skills (e.g. cognitive screening tools), therapeutic relationships (e.g. communication and managing relational dynamics) or specific approaches (e.g. mindfulness, distress tolerance). Such training will always be more effective when delivered as part of an overall leadership strategy on skills development and supported by a process of on-going supervision, consultation, and renewal.

## Summary

The potential for, and benefits of, psychological work in inpatient settings are vast; for patients and their families, staff teams, services and organisations as well as individual psychologists. The psychology input needs to be driven by compassion and attention to helping others contain and tolerate uncomfortable emotions. To maximise the impact of psychology, the focus at any point in time needs to be thought about carefully and negoti-

ated with those who have invested in ensuring that a psychology resource is available.

**Kathryn Dykes, Clare Hilton & Kate Ross**

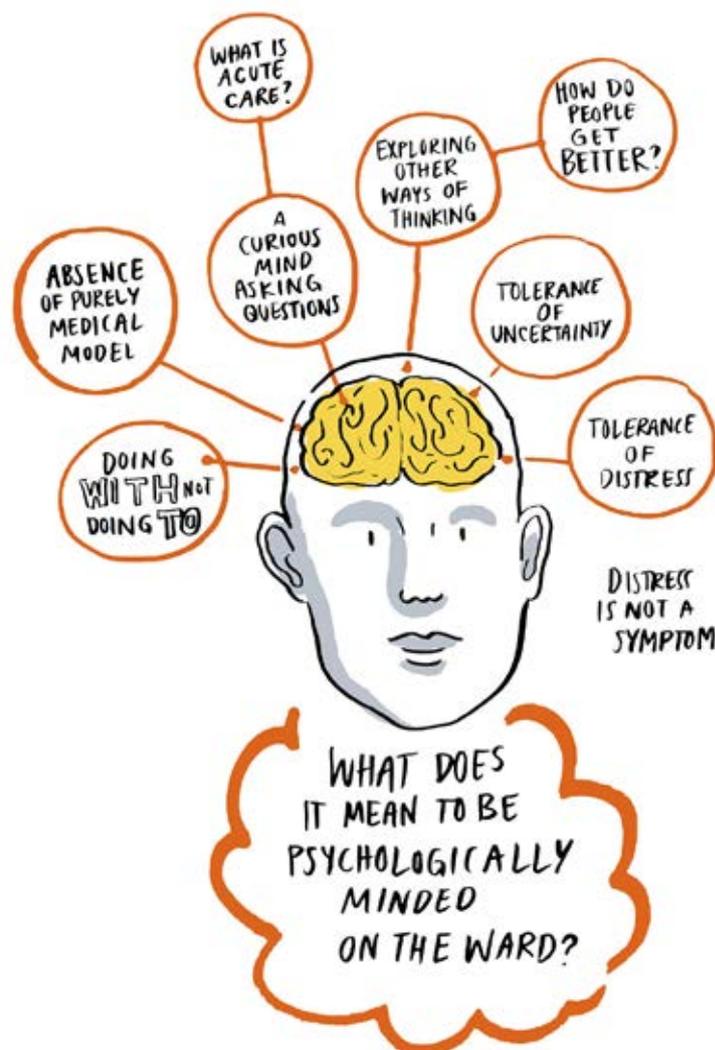
## References

- Barton, K. & Williamson, J. (2011). Psychological formulation as a basis for changing inpatient staff understanding of psychosis. *PSIGE Newsletter*, 117, 38–39.
- British Psychological Society (2001). *Working in teams. A report by the Division of Clinical Psychology*. Leicester.
- College Centre for Quality Improvement (CCQI; 2017). *Standards for inpatient older adults mental health services: Fourth edition*. London: Royal College of Psychiatrists.
- Dexter-Smith, S. (2010). Integrating psychological formulations into older people's services – three years on (Part 1): *PSIGE Newsletter*, 112, 8–11.
- Dexter-Smith, S., Hopper, S. & Sharpe, P. (2010). Integrating psychological formulations into older people's services – three years on (Part 2): Evaluation of the formulation training programme. *PSIGE Newsletter*, 112, 12–15.
- Dexter-Smith, S., Oddy, J. & Cate, T. (2015). Leadership profiles for applied psychologists: Mapping the leadership academy's healthcare leadership model. *Clinical Psychology Forum*, 276, 4–5. Also at <http://www.20cademy.nhs.uk/healthcare-leadership-model>
- Firth-Cozens, J. & Cornwell, J. (2009). *The point of care. Enabling compassionate care in acute hospital settings*. London: The King's Fund.
- James, I.A., Clifford, M. & Mackenzie, A.L. (2010). Trainee guidance on the use of case formulations with older people. *PSIGE Newsletter*, 112, 30–37.
- Kösters, M., Burlingame, G.M., Nachtigall, C. & Strauss, B. (2006). A meta-analytic review of the effectiveness of inpatient group psychotherapy. *Group Dynamics: Theory, Research, and Practice*, 10(2), 146–163.
- Moniz-Cook, E., Agar, S., Silver, M. et al. (1998). Can staff training reduce behavioural problems in residential care for the elderly mentally ill? *International Journal of Geriatric Psychiatry*, (13), 3, 149–158.
- Murphy, N., Vidgen, A., Sandford, C. & Onyett, S. (2013), Clinical psychologists working in crisis resolution and home treatment teams: A grounded theory exploration. *The Journal of Mental Health Training, Education and Practice*, 8(4), 181–195.
- Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams*. Leicester: The British Psychological Society.
- Petty, S., Jones, L. & Annesley, P. (2014). Research update one: Cognitive analytic therapy and a specialist mental health service for older adults: Relationship-centred care. *FPOP Newsletter* 126, 49–50.

## Chapter 2: The patient journey – A psychological examination of the steps and transitions

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The patient's journey started well before they arrived in the ward. Understanding the traumatic events and disrupted attachments, social circumstances and physical health changes that may have precipitated an admission can inform the psychological approaches needed to facilitate the service being experienced as a secure base. While services often speak about care pathways (i.e. procedures and processes), this chapter considers the actual journey of the patient. This may have many stages and may shift between the voluntary and involuntary phases and physical, cognitive, or functional mental health needs. There are key tasks that are fundamental to achieving good psychological care which include; debriefing the process of admission, making the person welcome, agreeing the purpose of the admission, communicating the length and structure of the inpatient journey, planning for recovery, and creating a safe ending. Although the service expectation may be that there is a clear route from beginning to the end of the admission, the 'road to be travelled' is often far from clear to the patient and their family. This chapter



considers the transitional stages of that journey from trauma and attachment perspectives and, where appropriate, other psychological models.

It is important to remember that, for people with cognitive problems, the very task of holding an integrated journey in mind may be problematic. Understanding of and choices about potential future steps, coherent narratives about what has gone before and understanding what is happening in the moment may all be experienced as confusing, fragmented and often contradictory. Extra consideration will need to be given to how to capture the journey in a way that the person can engage with, either by creating an account they can access themselves, or by investing another person with the role of holding a coherent account of the patient's experiences in mind.

## The experience of arrival

The process of admission can have a significant impact on the person's overall experience and recovery.

- Ideally, the inpatient environment is seen as a place of sanctuary where a person can recover from the buffeting forces they have been exposed to and have time to reflect and recuperate. A planned admission may make this more likely. Increased sense of control, collaborative decision-making and the ability to plan for bringing transitional objects are all more likely. Staff are also likely to be better prepared, thereby increasing the opportunity for establishing a safe attachment framework early on.
- Crisis admissions can be more challenging and may themselves be a source of psychological trauma. The level to which the patient understands or feels in control of the decision to admit is particularly, although not exclusively, challenged when the admission occurs as a result of the implementation of Mental Health legislation. Such a rapid response can lead to loss of connection and extra attention needs to be paid by the team to generate a sense of security. The team also needs to work harder to build up a picture of the person's identity and history beyond the labels and description of the crisis situation.
- Alternatively, the journey may start with a medical admission into acute services before eventual transfer into mental health/dementia services. These teams may have worked very differently to your team and the patient may need support to adapt to this. Repeated moves affect the person's sense of safety and belonging and repeats the possibility for their behaviours to be misattributed, leaving the person disoriented and misunderstood and experiencing an impersonal service from which it is difficult to build trust, as the comment below illustrates.

*I had to go to A&E after a fall, I had been waiting three hours and they decided I may have broken a hip. My husband went to move the car and I was anxious he was leaving, he asked them not to move me till he was back but they did. I didn't have my phone on me, I didn't know where I was being moved to, I didn't know if he'd find me. That shaped the rest of my experience in hospital and now I'm reluctant to attend at all.*

Patients commonly report experiencing fear on first arrival; of their own internal state, of the type of service they expect to receive and of the other patients. The initial impression

made by the service (by the nature of the admission process, the warmth of the welcome, the attention to orientation to the unit, containment of initial fears and the establishment of shared expectations) has a lasting impact on the relationship between patients, families, staff and the service. The process of therapeutic engagement and the language used for different conversations is covered in later chapters but there is a critical role for psychology in helping the service to be mindful about the importance of this initial transition. The level to which the establishment of initial goals and tasks are negotiated and communicated in a person-centred way and the care with which the service model is explained, sets the tone for the rest of the admission.

## Key tasks during a stay on an inpatient unit

### Connecting

It is important to think about psychological models that can helpfully support the patient and team to think about the focus of an admission that goes beyond symptom reduction. For example, attachment theory can help our understanding of patients' experiences and presentation. Attachment behaviours are especially evident in times of distress, ill health or loss and become more frequent with ageing (Browne & Shlosberg, 2006) as the person tries to find a way of soothing themselves based on their own learning history. At different times and for different people, this will include the full range of insecure attachment behaviours; aggression, externalising of blame, detachment and avoidance of intimacy, passivity and over-compliance, over-dependence and so on. A compassionate and therapeutic response to these behaviours is more likely if the service understands the role of these behaviours in protecting the person from further emotional harm and sees them as an expression of the person's insecurity and distress. The nature of the relationships developed on the ward (both with other patients and staff) has the potential to become the basis for a further therapeutic relationship on which significant recovery is built. Staff can model and assist patients to develop psychological resources that will help them to recognise and address their attachment needs and develop more adaptive behaviours and responses.

### Goal setting

An essential component of achieving a recovery-focused and patient-centred admission is the early establishment of goals that are based on the patient's own view of what a successful outcome would be. The visioning techniques of solution-focused therapy lend themselves to this and can help in shifting focus from symptom reduction to a recovery orientated approach of hope and optimism. From this stance collaborative goal setting can aid individuals to develop idiosyncratic, meaningful, and achievable goals. Acceptance and Commitment Therapy can also be useful at this stage. Discussions might cover what would improve someone's chances of a valued (for them) future life, the role that perception of risk plays for different people, what support is needed to maintain important relationships, how readiness for discharge will be gauged and by whom.

### Identifying the road to recovery

There is a growing weight of good quality clinical evidence relating to mental health recovery (see, e.g. Leamy et al., 2011) so this section focuses on the psychological processes of

engaging in one's own recovery. One approach to organising the key tasks of recovery is to look at how to address the universal human needs that become more evident during times of distress. Kitwood (2010) defines these as Identity, Attachment, Competence, Comfort, Inclusion and Hope. The pattern and intensity of need demonstrated in each of these areas varies according to personality and cognitive impairment (Miesen, 1992). Recovery may be seen as establishing or re-establishing the fulfilment of each of these needs:

### Maintaining or re-establishing identity

- A person may define their identity in multiple ways (category membership, social role, family and occupational position, etc.) and the task in inpatient services is to enable the person to regain or assert a chosen identity that enhances their sense of self and self-efficacy.
- The person needs to be truly 'seen'. The team needs to know what is important to the person in order to provide a safe space, where the person feels wanted and welcome to express themselves rather than feeling suppressed by a dominant narrative. While formal documents can be a useful starting point to find out factual details, more idiosyncratic information needs to be gathered in order to ascertain the psychological traits of the individual. Superstitions (Moniz-Cook et al., 2001), habits and routines, as well as 'skeletons in the cupboard', need to be considered alongside attachment relationships and trauma. Self-positioning in terms of race, sexuality, gender, disability etc., are all important here alongside what the person makes of being admitted to a place which may be defined by the age of its occupants.
- The experience of receiving a diagnosis can impact positively or negatively on previously established roles and identities. Health psychology models of the process of adjusting to a new diagnosis and forging a new identity that assimilates the new information are of relevance here (Stanton et al., 2007). Advocates, formal or informal, may have an important role in enabling the person to sustain an identity that is not dominated by being positioned as a patient.
- Where admission is experienced as a handing over of control, (either voluntarily, coerced or forced), models of locus of control are a useful framework for considering in what way the person's current psychological position is different to their usual or desired state and for monitoring a gradual return to self-determination. People who have been formally detained have necessarily had a level of control removed from them, although in the best case scenario this can come to be seen as a caring step that promotes their move towards a more self-directed life. Even for informal patients, there is a tendency to assume that the service has more controlling power than it actually does and it can be useful to facilitate both staff and patients to examine their underlying assumptions about whose role it is to make decisions. Critically, a more internal style of attribution is usually associated with better mental health outcomes, so specific attention to how a person's self-determination can be enhanced and promoted is an important aspect of recovery. There is likely to be a gradual process of transition of control between the team and the patient and the appropriate level of care and intervention needs constant and explicit review. The experience of needing others to step in and assume control of your decision-making can be a major

challenge to a person's adulthood. Not being involved in care decisions, perceiving care as meaningless or poor quality, and believing oneself to be an inferior kind of human being can all result from this dynamic (Olofsson & Jacobsson, 2001). Both transactional theory and the reciprocal roles of CAT can provide a framework for discussing the types of relationship the team want to adopt.

## Maintaining and establishing attachment

- Admission often leads to a disruption of attachment relationships for patients and relatives and friends and can be experienced as significant loss, separation anxiety or existential fear of abandonment. However, not all relationships are nurturing and safe and, for some, the ward can be experienced as a safe space. Both advocates and the person's key worker/named nurse can be useful transitional guides who help people to feel they are not on the journey alone. The presence of familiar objects and the maintenance of usual habits and routines may also serve to connect people to their normal lives. When people enter existential crisis, their need for reassurance can be overwhelming and the team may need support to consider how this can be met in a contained way and not to repeatedly reject advances and attempts to be contained.
- Stable attachments are a major protective influence in mental health and consideration of how the person's normal attachments will be maintained and supported needs to be part of the assessment and formulation process. Connectedness – to family and friends, to one's own life, and to the local community – is a fundamental right and need, and it is important to foster creativity and flexibility around how these are achieved. Imaginative and proactive use of a range of technology can support people's ability to remain connected outside the hospital. The establishment of relationships with community mental health staff and the commencement of participation in supportive community activities can avoid further experience of separation and loss when the transition back into the community is made.

*I was admitted into hospital. I was in there for six weeks. I very rarely go anywhere without my wife, so not having her here in an unfamiliar environment was really difficult for me. My wife suggested that I call her at any time and that would be my link. I was to ask the staff to help me use my phone. Every time I did, they would tell me they couldn't and that I shouldn't be using my phone on the ward. I would then get up, get lost, trying to find someone to help.*

## Re-establishing a sense of competence

- Being admitted to an inpatient unit can compound the impact of ageing and lifespan transitions on the acquisition and integration of developmental competencies. In the context of acute ill-health, there is usually a temporary interruption in the person's typical level of competency, which risks having a long-term impact on their capacity for future level of functioning, if previously practiced skills are lost. Patients may also arrive in mental health facilities with the expectation that being in hospital means being cared for, and the team may need support to recognise and be explicit about the important function of activity and involvement in recovery. Meaningful occupation that enhances identity and wellbeing, activities that reinforce a sense

of competence, opportunities to demonstrate individual areas of competence, and support to maintain, develop and rekindle life skills should be an essential element of an admission.

- A particular role for psychology lies in making sure that an assessment of psychological competencies alongside strategies for enhancing and developing these are part of the programme of skill development. This is likely to include strategies for self-soothing as well as relationship competencies.
- It is difficult for a person to retain a sense of competence when they are not fully informed. A frequent complaint from families and patients is that they don't know what to expect, particularly in relation to length of admission. It is commonly the case that services conceptualise distinct phases of admission; e.g. assessment, intervention, identification of future care needs, handover, discharge but this may not match the patient's experience and expectations.
- One source of psychological competence is the social roles a person normally inhabits; husband, grandmother, confidante, etc. Sometimes a break from some of these roles may be therapeutic but this is not necessarily the case and being facilitated to step into role from time to time in a contained way may significantly enhance a person's self-esteem. People may need particular help to think about how to stay in role in their relationships with young children in their family and how to explain the situation and safeguard the wellbeing of children in an inpatient environment.

### Re-establishing a sense of comfort

- The sense of psychological comfort and internal wellbeing can be a helpful balance to the assumption that level of symptoms indicates level of distress or dysfunctionality. This is also in line with a recovery focused philosophy of mental health care where quality of life rather than 'cure' from symptoms of 'disease' is the desired outcome. Models like ACT and DBT may be particularly useful here.
- One model that is especially useful for helping the team to think about the necessary requisites for psychological wellbeing is Maslow's hierarchy of need (Maslow & Lewis, 1987). It is a model that will be very familiar to most of the health care professionals in the team and may map well onto the phases of a person's recovery – the need to re-establish safety and get basic physical requirements met, the key work of developing purpose and belonging, the imagined future goal of achieving individual potential for a satisfying life, as long as the model is not interpreted in an overly simplistic linear fashion. The impact on overall wellbeing of small discomforts and inconveniences (faulty hearing aids etc.) and of missing any of these elements are important elements of psychological comfort.
- One aspect of communal living that patients consistently report as undermining to their wellbeing is the behaviour of others; either because it is experienced as distressing or threatening or because it disturbs the patient's sleep or tranquility. Staff teams equally report struggling to know how to maintain overall therapeutic ambience when there is a lot of noise, distress or disruption. The impact of living in close proximity to others is, to a degree, unavoidable but there is a wealth of literature on the design and use of the built environment that can help to make the

case for specific environmental interventions (e.g. Day et al., 2000) and psychology can model debriefing as an important part of helping patients to process any fears they may have experienced.

- A sense of dignity and a need for personal privacy is an important aspect of comfort that can be difficult to maintain when the person needs a lot of support with personal care. This is particularly true for people with severe cognitive impairment who may misinterpret the motivation of staff who seem to be intrusively interfering with their person. Specific training for staff in approaches to personal care that minimise distress has measurable benefit for both the patient's wellbeing and staff confidence in their practice (Moniz-Cook et al., 2000; Ross, 2012).

### Maintaining and promoting inclusion

- It is essential to recovery-focused care that people be involved in designing their own recovery and psychology can help the staff team to look at how the processes that are used in care planning and care review facilitate or hinder the patient voice being heard. For a commentary on the extension of inclusion to citizenship and the promotion of disadvantaged social groups, see Bartlett and O'Connor (2007).
- The overall culture of inclusion within the organisation will inevitably filter through to how the patient experiences their own presence in the service. Recovery colleges, lived experience consultants who visit the ward, invitations to participate in the processes and structures of the organisation, all speak volumes about whether the patient is seen as a partner in care or a passive recipient. Any approach that blurs the boundaries or reduces the social distance between 'them' and 'us', increases the sense of inclusion. The visibility of older people who are inpatients can be enhanced by taking opportunities to facilitate access to events that are site-dependent (research seminars, carol concerts, open days, etc.).
- It is not unusual for smaller social groups to emerge within the overall community in the ward. Establishing closer, more intimate relationships and friendships can be an important step to recovery for those included in them, but also carry the risk of psychological harm for those who are excluded from them and those who are in a subservient role in the group. Psychology is well-placed to help the team assess the health of ward relationships and to advise on facilitating enhanced communication and inclusion strategies for those whose cognitive difficulties or cultural differences prove a barrier to communication.

### Re-establishing hope (love)

- Kitwood defines the final all-encompassing human need as love and it is fundamental to recovery that a person can retain or establish a love of their own life, something which we have interpreted as hope. Value-based living, solution-focused care planning, and support to develop an individual definition of what recovery means all have a role in supporting a hopeful vision of a future life that is worth living and older people seem to respond particularly well to this type of approach (Eifert & Forsyth, 2005; Weatherall et al., 2015).

- However, older people, families and staff may hold age-related biases that can impact on an individual's hope for recovery. Recognising these and supporting alternative notions that change and adaptation are possible and even common in older age, is a major task for all involved. Offering an opportunity for staff to discuss and reflect on their own experiences, reactions, and values will ensure these perceptions are acknowledged, validated and challenged. Schwartz rounds, Balint groups and peer supervision provide avenues to explore these experiences. Attention to hopefulness and psychological comfort in staff also promotes the team's ability to inspire hope in others (Brooker, 2007).
- One source of hopefulness that is only beginning to be tapped is the encouragement that comes from sharing in and obtaining encouragement from the experiences of others. One way of achieving this is to ask people to leave messages and tips for future patients when they are discharged.

## Moving on

The last step in the journey through admission can be as complex as the first and the attachment issues and need for personal autonomy are just as acute. For some, being discharged home has been top of their agenda throughout the admission but even so, this is a transition to be carefully managed. Relationships and roles will have subtly changed during the period of admission. Patients and families can benefit from trial periods of leave and the opportunities to talk through their initial plans for the first few days at home. The adjustment to being at home again can be complicated by a total change in the care team and it is helpful to consider how handover arrangements between inpatient and community services can facilitate a gradual relinquishing and reforming of relationships.

The decision about when is the right time for someone to leave the ward needs to be based on clear criteria that reflect the person's recovery journey. Services under pressure may struggle to be as client-centred as they would wish to be in negotiating the timing of discharge and the flexibility of this transition. This is particularly likely to be the case when discharge is delayed for non-clinical reasons. The psychologist can help to articulate the potential for relapse and harm where this transition is likely to be challenging. A unilateral decision to discharge can leave the patient feeling without control which may well reflect their experiences of admission. Care needs to be taken to ensure the experience is not invalidating and unpredictable. Loss of control can be experienced by all when a planned discharge is stalled due to the absence of community resources. Both staff, patients and family may need help to identify how this period of waiting can be used so that the person can continue the journey to recovery.

*I went to the MDT meeting and they said Mum is going to be discharged. I didn't realise that this was a decision to be made on her or my behalf, without our concerns or worries being heard. So, you panic and you think about how I'm going to cope, how Mum is going to cope. Before Mum was even discharged my anxiety and hers were sky high. This could've been handled better to help me and Mum understand this was the best decision for her and to support us with our worries.*

The discharge transition is a particularly difficult one to achieve well when the person is moving on to an unfamiliar place. This can compound the admission experiences of having been moved around from place to place and be experienced as rejection when the ward has come to be seen as a place of safety. Coming to terms with giving up one's home can be an additional loss that needs to be addressed. Psychological intervention may be necessary to help people maintain some personal autonomy and deal with the anxiety associated with moving into care facilities. Opportunities for trial periods and a gradual transition that includes being able to start to form new relationships before relinquishing the old ones, are even more important. Involvement in the preparation and handover of detailed care and life story information can help the person to feel that their individuality is recognised.

*I was told I was bed blocking, so they would need to move me into a residential care home that was 15 miles away from home. I felt like I had to agree because I felt so guilty that someone else needed my bed and I was preventing them getting treatment.*

### When death is part of the patient's journey with us

Although death is less common in mental health settings than acute physical health settings, it is not an unusual occurrence. When the staff team feels confident in the care they have given and have had opportunities to deliver compassionate and thoughtful support to both patient and family, and they in turn feel that they have been helped to a 'good' death, it can be a positive experience for all involved. Although our focus is typically on care that enables someone to safely move back into a community setting, it is important that our expectations of a typical patient journey don't blind us to the possibility that death can be an outcome. This blindness can prevent us from supporting patients and their families early enough for this to be helpful. Attention to what is needed to maintain the therapeutic connect between the staff team and the family is particularly important when the death is sudden or unexpected and it is important to articulate the psychological needs of all concerned to have time to achieve this following the death.

When faced with a terminally ill patient, it can be tempting to focus on the practical jobs to be done in an attempt to provide some sense of control but as Payne et al., (2008) reflect, death is as much a social process of letting go as a biological transition. That social process will inevitably reflect the person's current and previous relationships, and psychologists have much to offer in making sense of working with this information. And the authors point out that 'the sheer unpredictability of death can be difficult for the family members, and the staff, to whom you offer support.' This is what we specialise in – being able to tolerate and help others tolerate uncertainty and make personal meaning out of complex and changing situations. We are used to engaging in uncomfortable conversations and we can support the person and their family to talk with each other and the team, about what would make this period a more positive/accepting time for all concerned, so that their death can become a good ending. We encourage you to read about the process of dying and what can be expected – you will be more able to have dignified and respectful conversations if you are not distracted by your own anxieties or lack of knowledge. And it seems obvious, but the impact of a death lasts long after the death has occurred and staff (and you) may need emotional and practical support after the person and the family have left the ward.

The information in the following chapters of this guidance document are all relevant to this stage of someone's life: ask what language people use about death and dying (don't use euphemisms); be aware of the small psychological harms that can damage this phase of the patient's and family's journey; note how the culture of the ward may get in the way of making this experience a positive one (see chapter 6); use your skills to engage in a really human way with all those involved in this process; get your own support; be confident that you have something to offer; and bring all your formulation skills to bear, however informally, on helping people make sense of conflicting emotions.

## The family journey

The fact that their relative has been admitted to hospital, means that the relative is also in a process of transition. They are also on a journey that in some ways will parallel the patient's but in other ways will be unique. They may be going through many conflicting experiences: coming to terms with not being able to cope as they had hoped; shame at the public intrusion of services into a personal situation; relief at someone else taking over the reins; grief at the loss of the other person from their home environment; fear of the future, etc.

*He's being cared for in hospital and then I go home. People say 'enjoy the break' which is extremely frustrating, as if I don't need support to do this, I can't enjoy the break – I get lonely, I've lost my role for that period of time and I don't trust he is getting the same level of care or understanding that I offer whilst there.*

The patient's capacity and decisions about how they want their family to be involved in their care, can create complex situations. Careful consideration and understanding will enable you to support the different individuals affected by the admission and help them prepare for discharge. As with any relationship, understanding what meaning each person is making of the situation is crucial – just understanding each other can ease many of the potential struggles. Teams can find it particularly difficult to know how to manage a situation when relatives disagree with each other regarding the care the patient receives. They often welcome help to negotiate with the patient and their family how their involvement is most therapeutic for everyone. You can also offer clarity of thinking about what is appropriate for the service to offer to the relatives, how the service can engage meaningfully and compassionately with family complaints, and at what point the relatives require support and input in their own right.

When a person living with dementia or in an acute period of distress are admitted to hospital, they may well struggle to communicate their needs with new people in a new environment. Families are vital sources of information in most cases and have a powerful story to share. They are often crucial facilitators in helping the patient to make their own story heard.

In terms of the support that the family needs, inpatient staff should not assume that this has been explored and offered in the community. For many reasons, the point of admission might be the first time that someone has had the opportunity or desire to talk to staff about what they need, how they make personal sense of the situation and their worries and

concerns for the (potential) future/s for them and the patient. Psychologists can have a key role in making this part of the family journey a meaningful experience and one that has lasting impact beyond the period of admission.

Families' notice boards, information booklets, videos about the ward, specific staff who work to support relatives, visitors' bedrooms, drop-in sessions, reclining beds, open visiting hours, and shared activities were all cited as examples of wards trying to find ways of engaging with families. Relatives can feel as disoriented as patients to the culture, processes and unwritten rules of the service and may make inaccurate assumptions. The complexity of the organisational information that families may have to assimilate about the different roles of all the statutory organisations can easily overwhelm. Families too require a guide to get them through this journey.

Working closely with community services and third sector agencies is often vital in making the many transitions safe for everyone. Predictable, regular communication with an identified family member can often prevent many of the problems that can arise when people are frightened, frustrated, and feel isolated from what is happening and out of control. Thinking through some of the cultural assumptions in your service (chapter 6) that create unnecessary barriers to collaboration is important.

It is also important to be able to see the relative as an individual with their own unique range of expectations and resources. Not all people are confident or competent or want to be described as and take on the roles of a carer. The service can do families and relationships harm by assuming that anyone with a family member therefore has a carer. The patient will also have a view on the degree to which they see different people as being in a caring relationship with them. Friends may be inappropriately excluded from major decision-making when they would be the person the patient would most like to involve. From visiting for tea, to helping to plan care, you can help the ward be flexible in facilitating patients and relatives to opt in and out, thus maintaining a complexity of relationship networks that allow different people to help in different ways and for the teams to welcome these inputs.

## Summary

The experience of the journey through admission is influenced by multiple psychological factors. Throughout the patient's journey, professionals need to ensure that all people travelling with them feel connected, are known and involved at all stages.

With input from Nicola Gawn, DCP Faculty, and Hayley Horton, Alzheimer Society, providing quotes collected from focus groups with patients.

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## References

- Bartlett, R. & O'Connor, D. (2007). From personhood to citizenship: Broadening the lens for dementia practice and research. *Journal of Aging Studies*, 21(2), 107–118.
- Brooker, D. (2007). *Person-centred dementia care. Making services better*. London: Jessica Kingsley Publishers.

- Browne, C.J. & Shlosberg, E (2006). Attachment theory, ageing and dementia: A review of the literature. *Aging and Mental Health*, 10(2), 134–142.
- Day, K., Carreon, D. & Stump, C. (2000). The therapeutic design of environments for people with dementia: A review of the empirical research. *The Gerontologist*, 40(4), 397–416.
- Eifert, G.H. & Forsyth, J.P. (2005). *Acceptance and commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change*. Oakland, CA: New Harbinger Publications.
- Kitwood, T. (2010). The experience of dementia. *Aging and Mental Health*, 1, 13–22. <http://dx.doi.org/10.1080/13607869757344>
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445–452.
- Maslow, A. & Lewis, K.J. (1987), Maslow's hierarchy of needs. *Salenger Incorporated*, p.14.
- Miesen, B.M.L. (1992). Attachment theory and dementia. In G.M.M. Jones & B.M.L. Miesen (Eds.) *Caregiving in dementia*. London: Routledge.
- Moniz-Cook, E., Woods, R. & Gardiner, E. (2000), Staff factors associated with perception of behaviour as 'challenging' in residential and nursing homes. *Aging & Mental Health*, 4(1), 48–55.
- Moniz-Cook, E., Woods, R. & Richards, K. (2001). Functional analysis of challenging behaviour in dementia: The role of superstition. *International Journal of Geriatric Psychiatry*, 16, 45–56.
- Olofsson, B. & Jacobsson, L. (2001) A plea for respect: Involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *Journal of Psychiatric and Mental Health Nursing*, 8(4), 357–66.
- Payne, S., Froggatt, K. & Hockley, J. (2008). *Dignity on the ward. Dying: A guide for hospital staff*. Lancaster: Help the Aged, in association with Royal College of Nursing.
- Ross (2012). *Reducing distress and aggression in people with dementia*, available in the web resource that accompanies this document.
- Stanton, A.L., Revenson, T.A. & Tennen, H. (2007). Health psychology: Psychological adjustment to chronic disease. *Annual Review of Psychology*, 58, 565–592.
- Wetherell, J.L., Petkus, A.J., Alonso Fernandez, M. et al. (2015). Age moderates response to acceptance and commitment therapy vs. cognitive behavioral therapy for chronic pain. *International Journal of Geriatric Psychiatry*.

## Chapter 3: Therapeutic engagement

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The purpose of this chapter is to address those issues which are specific to the quality of the relationship the psychologist has with different elements of the service (individual patients, staff teams, etc). Therapeutic engagement is a fundamental pre-requisite for effective clinical working but can take different forms and serve different purposes. Pereira & Woollaston (2007) define therapeutic engagement as ‘... spending quality time with patients and aims to empower the patient to actively participate in their care’. Clinical psychologists working on inpatient units may be working directly with patients and also with the staff group. So, we may extend this definition to ‘...spending productive time with ward staff and supporting them in the psychological aspects of their care work’.

This chapter focuses on those factors in the relationships within the ward that are likely to contribute to the perception of a good engagement and outcome across different stakeholders. This may, at times, require us to challenge beliefs about the aim and purpose of an inpatient admission and the proposed measures of successful outcome.

Working therapeutically in an inpatient setting with older people presents unique challenges. These are the most seriously distressed of the older population whose care cannot safely be managed at home; often with significant pre-existing physical health conditions, sensory and/or cognitive impairments, many of whom live within an external ‘caring environment’ of family/spouse or care home. In addition the multidisciplinary team may not have had a psychologist on their team before. It is important to be very clear to patients, family members, the inpatient staff team and managers about what we can offer and it is important to bear in mind that the entire time a psychologist spends on the ward is an opportunity for sharing knowledge, modelling and therapeutic engagement. This time also allows for psychologists to learn about the roles, tasks and skills of, as well as the dilemmas encountered by, the inpatient team.



## Engaging the individual

The task of engaging with a patient may vary from the relatively straightforward when the person has good insight and is ready for change, to the more complex when the person's emotional state makes effective engagement difficult to achieve or when their language skills are such that understanding or making their ideas understood has become complex. It is always important to establish the emotional and psychological sense they are making of the situation, their understanding of their distress, their perception of why they are in hospital and what, if any, are their goals for the admission. This may be more complex than a direct conversation with the individual and require time invested in e.g. observation, conversation with those who have known/do know the person, and a more detailed assessment of their communication strategies. Whether the person is there voluntarily or under detention is likely to impact greatly on their engagement. In addition, some people may have no prior experience of psychological thinking. This can make it difficult for people to see the value of interventions and to take the potentially painful risks of engagement.

There may well be practical barriers to engagement, such as difficulty arranging private space, and competing ward or visiting priorities. A further potential complication comes from the amount of time that psychologists have dedicated to working on the ward. There may be limited time for individual therapeutic work and you will need to be careful and explicit about what you are trying to engage the person and the team in (see chapter 1). The principles of good engagement in inpatient units are:

- Respecting and empowering patients;
- Being available;
- Focusing on engagement, not just on tasks;
- Effective therapeutic work;
- Embracing change.

(Pereira & Woollaston, 2007)

These are good principles to follow but may need adjusting when patients are highly emotionally distressed or cognitively impaired. For people who are presenting a high risk to themselves or others, the focus may necessarily be on working with staff to develop care plans which promote work related to safety and stabilisation, preparing the ground for therapy at a later stage and potentially with another team. Psychological formulation can be a key part of this work, as can introductory work on the recovery model and helping the person to begin to make initial sense of what has happened (see chapter 4). Psychologically informed assessments of risk and positive risk taking are also important as is linking this to a coherent formulation of the situation and the future (rather than a standalone administrative exercise). Work on emotional regulation, rediscovering coping strategies, and solution focused work on very short-term goals can all be helpful in setting the scene for later more in-depth work with the person and/or the wider system in which they live.

## Engaging families and other carers

In inpatient services it can be easy to be lured into working with the people that we regularly see (patients and inpatient team) and not give enough attention to those from other teams or the person's family. When the person returns to the community, their relation-

ships with others will inevitably have an impact on their mental health and it is important to actively engage with these significant others to discuss their role, if any, in supporting the person's wellbeing once they leave the inpatient service. See chapter 2 for consideration of the carer's journey. There are specific challenges to engagement for family members, particularly when the family view and staff view differs regarding where the problem lies or what is the nature of the difficulty. It is commonplace, for example, for relatives and informal carers of people with significant cognitive impairment to have a limited or even mistaken understanding of the nature of that impairment. Family can benefit from the sense of containment provided by the service, the offer of a framework to support their understanding, the safety of being able to tolerate anxiety and complexity, and the support that can be provided by the team and the environment. Psychologists can have a key role in helping the wider system/s develop a shared understanding (that tolerates multiple narratives) that is coherent enough for everyone to find some common ground from which to move forward. Often models from core psychological understanding (e.g. social, cognitive, behavioural) can be as, if not more, helpful than clinical models. They also provide a helpful and necessary bridge between wellness and 'illness' and offer support to all the individuals within the system whilst explicitly normalising distress and offering ways forward.

### Engaging the staff team

There are two main tasks required here, first showing a willingness and desire to understand the team's experience and second demonstrating your reliability.

To develop an understanding of their role and the competing pressures they face we could shadow the team members and observe what they do; show interest and concern about their working conditions, the stress they are under and highs and lows of their work lives. Health care staff working in acute settings have been subject to severe scrutiny and criticism, placing accountability at an individual rather than systemic level, being told to 'put their patients first' (e.g. Borland, 2012). Inpatient teams, who may be lacking the necessary capacity and resources to conduct their work, can experience high level guidance as patronising and out of touch. In order to effectively engage with staff, psychologists need to show a non-judgmental approach that appreciates the huge systemic and organisational pressures that may affect front line staff. Our basic counselling, listening and empathy skills will be invaluable here in building relationships of trust and respect.

Demonstrating reliability is achieved by persistence, by turning up regularly, and by 'being there' for the team. Dedicating regular slots so that individuals can be seen at short notice can help, both for staff and patients and their families. These sessions need to be flexible to allow for periods of acute distress or distraction when the person may not be able to engage but these slots can be used for consultation if necessary or for spending time demonstrating a visibility on the ward.

Take advantage of formal and informal opportunities to offer a psychological opinion, for example, contributing to clinical meetings and offering psychological formulation of cases. Inpatient teams may have little experience or knowledge of psychological formulation and may not always understand the value of psychological input as part of a holistic approach to patient care. Be patient; building relationships with teams takes time. The more

experience staff have with psychologists the more they will value your input and you will become an essential member of the team rather than what may feel like an add-on in your first weeks or months.

Staff perceptions of a person and assumptions about their behaviour can impact on engagement sometimes very negatively; this might relate to e.g. assumptions about you as a psychologist, another team member or a specific patient (Hill, 2010). It is important to be able to discuss these perceptions and challenge unhelpful assumptions in a safe space. One way of doing this could be to use the ‘Dual model strategy’ approach from CBT (Wells, 1997) and suggest that while team member A has one idea about the cause of a certain behaviour (Theory A) the psychologist has another idea (Theory B) and how could we go about finding out which is the most helpful in this situation?

### Self-care for the psychologist

As psychologists we hold on to hope and maintain the effort, with sometimes very little feedback that engagement is likely. Maintaining our values of person-centred care is vital. Good professional practice – regular clinical supervision, good clinical governance, structured professional development – will all help to increase your personal and professional confidence. Contact with other psychology colleagues and membership of professional groups and networks is likely to play an important part here, as is the support of people on the ward – you need to find ways of feeling you belong to the service even if that is only in small part initially. Inpatient services can be emotionally demanding for people of all professions and taking time to reflect and actively manage your own stress will both protect you from burnout and model good self-care for others.

### The initial approach

One of the challenges to engagement with staff teams could be the psychologist being perceived as in a peripheral position to the ward team and this can be a problem for both parties. Taking time to explain what a psychologist can offer will be helpful. Actually demonstrating the collegiate, consultative approach that is typically used by psychologists rather than just talking about it may be required as it is, hopefully, different from the rather traditional, hierarchical style that is often common in inpatient services.

A willingness to get involved in working with the ward team and inviting the team to make suggestions of how you could contribute to the team are useful initial steps to engagement. Demonstrating the variety of what can be offered, from debriefing or critical incident support to facilitating team away days, can encourage the team to understand how psychology can make a difference.

### Developing agency

It is important to acknowledge and emphasise the vast reservoir of ‘implicit knowledge’ held by the ward team. This is the intimate knowledge of individual patients, of patterns of interaction, and of services that have been built up over years in addition to their own professional training and knowledge of evidence based practice. The ‘unnoticed professional competence’ (Ahrenkiel et al., 2013) may be poorly articulated (and poorly valued by both the staff concerned and external others) but nonetheless is of great value in face to face

care. To build on this means giving space to teams to express their accounts and acknowledging their narratives of successes achieved through their own agency.

It is also important to endorse more formally recognised skills and knowledge and, as appropriate, to defer to other advice. Therapeutic engagement is not just about ‘helping’ other people come round to our viewpoint. Make sure that the engagement is genuinely two-way.

Showing respect for ward staff’s knowledge and skills will hopefully increase their sense of agency, of confidence in their own abilities and go some way to enhancing their ability to be proactive in difficult situations. One way of achieving this may be through offering spaces in which teams are supported in exploring the learning possibilities from their daily experiences (formulation, reflective groups, supervision etc). These can provide assurance to team members that they’re on the right track, and prevent them from feeling as though they’re floundering in clinical situations.

But don’t forget the day to day small interactions that facilitate engagement within a team. Although we are trained to provide formal interventions and be able to ‘name’ what we are providing, these other more immediate approaches take no more time out of your or their work day but can build into a genuinely engaged relationship (see chapter 8 for some specific ideas in this area).

It is possible to enhance teams’ existing sense of agency by empowering them with new skills and knowledge, and especially by arranging opportunities for success. Teams can be encouraged to take a positive, solution focused approach, to engage in collective endeavour and to set themselves achievable goals (Jackson & McKergow 2007). Measuring change will allow for lots of positive feedback to teams, and to their managers as appropriate.

Many inpatient teams have a range of therapeutic skills that are being underutilised and it will be helpful to find out about these skills and to make use of them. This has to be done in a careful manner to ensure teams are not delegated tasks they feel unprepared for. In general though, this can be a very fruitful approach as engaging people in challenging and meaningful work, often in this case the sort of work many have been wanting to do for a long time, enhances their inner sense of motivation and engagement at work. More straightforward skills teaching may be appropriate at times as long as the teaching is wanted and needed by the service and team members attending understand why it is important and useful for them to give their time to the session. The process of helping the team to identify what its learning needs are will likely be as, if not more, important than the teaching itself. Make sure you also provide literature and produce handouts in key clinical areas, so that staff unable to attend sessions can benefit from them or provide an aide memoire for times when the psychologist is not available. And make these interesting to look at – not huge academic works but attractive and interesting visual formats that inspire people to engage with them.

### **Honour the meaning of the ward team’s experience**

An important part of any psychological therapist’s relationship with their client will be warmth, openness and non-judgemental positive regard. The latter is particularly import-

ant with the staff team as they typically have chronically low morale (e.g. Kleebauer, 2015) which may be partly due to their point of view rarely being acknowledged. Clinical psychologists are in a good position to rectify this by using interpersonal skills they are well versed in.

Understanding staff's lived experience, their assumptions and expectations will help us in tailoring therapeutic programmes, not only to the identified patient, but also to the people who are usually going to have to carry them out.

Sometimes just being there to listen and validate team's tales of their difficulties at work is all that is required. No solutions are sought or are available, it is sufficient for their narrative to be heard and believed, and this allows more positive work to be done.

Part of appreciating the experience of inpatient teams is knowing that therapeutic tasks are only one of a number of tasks that they will be called upon to do. However important they may acknowledge this part of their role, staff will continue to have to attend to other demands, and remaining mindful and respectful of this will ensure we do not add to their feelings of being overwhelmed.

In considering the wider context of the work, it would be important to develop an appreciation of the possible issues the team might be facing, related to the managerialisation of the health service. For instance, there might be pressure to improve performance and efficiency (e.g. evidenced by reduced length of stay) in the context of static or shrinking budgets through local and national budget tightening (Csipke et al., 2016), impending CQC, Mental Welfare Commission, or RQIA inspections.

It may be appropriate to respond to the stress felt by the ward team by using our position to articulate the importance of self-care and negotiate how this might be achieved through providing some clinical leadership in this area (BPS, 2011).

## Validating outcomes

Team expectations about change in the person, their behaviour and their capacity for change, particularly in chronic conditions or dementia, will have a strong impact on therapeutic engagement. It may be necessary to try to combat therapeutic nihilism. In part, this can be done by validating the challenge of working with older people as inpatients. Helping teams to consider how they would know that they are doing a 'good job' can be motivating. It is important for all of us to know that our input is having a positive impact on those around us. Creativity with outcome may be important and may require you to actively identify small changes very quickly rather than waiting for obvious change to become apparent. Specific and person-specific outcome measures could be introduced for this e.g. time spent attending to a conversation, someone flicking through a newspaper or asking about a visitor. Or it may be sufficient to highlight and commend such small, but significant, positive outcomes ad hoc. By directing attention to successes that the ward team have achieved, rather than focusing on failures, mistakes or otherwise unsatisfactory outcomes we can acknowledge the value of the team's work.

## Addressing potential barriers and flexibility

The contingencies of working in an inpatient service are very different from working in, for example, a community team. In inpatient services there will be a large group of staff involved in shift working. The practical consequence of this is variable availability of staff even for predictable regular events.

Consequently, psychologists may need to be adaptable. We may need to consider variable times for meetings, repeating meetings to reach larger numbers of staff, shorter meetings and postponing meetings at short notice with a fallback plan available for how to spend time on the ward. It could be helpful to allocate regular slots for individuals to be seen at short notice as required and it probably won't be possible or desirable to operate a referral and waiting list system in such an environment.

Bearing in mind the importance of therapeutic engagement across the service will help you address potential conflict in a helpful way. There are times when it is entirely appropriate for psychology to question or challenge but it is important that we 'get alongside' and demonstrate that we value the people we work with.

## Engaging with the whole system

There are likely to be multiple views held (by the patient, staff teams, families, informal and professional carers etc.) of the issues and situations which contributed to the patient's admission. In considering therapeutic engagement, it is important to bring these different perspectives together into a coherent narrative so that differences of opinion can be engaged with and worked through. Using a systemic approach can be useful here (see Fredman & Rapaport, 2010 for a useful framework). Appreciative inquiry is another standardised framework for engaging across systems that has had good outcomes in inpatient health services (Scerri et al., 2015).

## Summary

Acknowledging the impact on engagement of the relationships with and between the different elements of the system in the inpatient setting helps inform the necessary conditions for change, such as trust, agency, empowerment and reflexivity. Chapter 5 offers useful reflection about the manner and language you may use to engage with the systems involved and chapter 6 offers a useful framework for thinking about organisational change. However, sometimes, you may experience others in your team as disengaged from or even directly undermining of what you are trying to achieve. This will call for considerable resilience and self-awareness, a willingness to examine your own role in contributing to any resistance, an objective analysis of the competing demands and pressures, and a professional awareness of what is open to debate and what crosses over into poor patient care or staff bullying. Your relationship with the operational team and your professional networks will help to sustain a frank consideration of what action it is sensible to take and what goals you should set yourself in your engagement with the service.

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## References

- Ahrenkiel, A., Schmidt, C., Steen Nielsen, B., Sommer, F. & Warring, N. (2013). Unnoticed professional competence in day care work. *Nordic Journal of Working Life Studies*, 3(2), 79–95.
- Borland, S. (2012). Disbelief as nurses have to be told to put patients first: Staff reminded to treat sick with love and compassion. *The Daily Mail*. Retrieved 4 December 2012 from <http://www.dailymail.co.uk>
- British Psychological Society (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: Author.
- Csipke, E., Williams, P., Rose, D. et al. (2016). Following the Francis report: Investigating patient experience of mental health in-patient care. *British Journal of Psychiatry*, 209(1), 35–9.
- Fredman, G. & Rapaport, P. (2010). How do we begin. In G. Fredman, E. Andeson & J. Stott (Eds.) *Being with older people: A systemic approach*. London: Karnac Books Ltd.
- Hill, T.E. (2010). How clinicians make (or avoid) moral judgments of patients: Implications of the evidence for relationships and research. *Philosophy, Ethics, and Humanities in Medicine*, 5(11). Extracted from <http://www.peh-med.com/content/5/1/11>
- Jackson, P.Z. & McKergow, M. (2007) *The solutions focus: Making coaching and change SIMPLE* (2nd edn). London: Nicholas Brealey International.
- Kleebauer, A. (2015). RCN urges new government to take action on low staff morale. *Nursing Standard*. 29 (36), 7–7.
- Pereira, S. & Woollaston, K. (2007). Therapeutic engagement in acute psychiatric inpatient services. *Journal of Psychiatric Intensive Care*, 3(01), 1–10.
- Scerri, A., Innes, A. & Scerri, C. (2015). ‘Discovering what works well: Exploring quality dementia care in hospital wards using an appreciative inquiry approach.’ *Journal of Clinical Nursing*, 24(13–14), 1916–1925.
- Wells, A. (1997). *Cognitive therapy for anxiety disorders*. Chichester: John Wiley & Sons.

## Chapter 4: Psychological formulation

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This chapter articulates how psychological formulation can be used to develop a shared understanding that supports a person's recovery during their inpatient stay. For overarching guidance on psychological formulation, see Johnstone et al., (2011).

### What is a psychological formulation?

A psychological formulation draws on psychological theory and research to provide a framework for explaining how a problem developed and is being maintained. A formulation is used to deconstruct complexity, to prevent therapeutic drift (Denman, 1995) and to improve outcome (Persons, 1991). Psychological formulations are detailed explanations of why this person (or family or team or service) came to have difficulties at this time and are the summation and integration of the knowledge which may involve psychological, social, biological and systemic factors. It is essentially a series of theoretically driven and testable hypotheses that helps organise often complex and contradictory information about a person. At its heart should be the voice of the individual themselves.

National policy, e.g. the National Service Framework for Older People (DoH, 2001), has



stressed the benefit of psychological formulation in understanding the interplay of physical, social and mental health needs present in older people. Furthermore, the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI, 2017) best practice standards recognise the importance of formulation and recommend that psychologists have sufficient time to provide them.

## Purpose

You may be formulating an individual's presentation and care, levels of risk, the dynamics within a team or a family, or how organisational, team and individual factors are playing out relationally. The key is that you are articulating and bringing attention to the psychological components of the situation being discussed. A psychological formulation is developed where possible with the person that it is about (or family or team or service) and is continuously open to revision in light of experience; feedback on the effectiveness of interventions is evidence of how close the formulation is to accurately explaining the situation.

Formulation's principal purpose, regardless of the model or the theoretical underpinnings, is to help develop a shared understanding and to select and guide the clinical interventions on offer (Johnstone & Dallos, 2013). In inpatient services this is important across the whole multidisciplinary team and should aim to inform and individualise both the overall therapeutic intervention strategy and the day to day offer of inpatient care. This chapter will discuss issues relating to the breadth of formulation (from individual to organisational) although it is likely that the most common format will be with an individual or a care team and about an individual patient.

As a shared understanding is sought about and with a patient, it is also important to think carefully about who information is shared with. Not everyone needs to know everything. There is a balance to be struck between sharing themes, risks and implications with the people who need to know in order to work effectively with the person, whilst also enabling the individual to retain some privacy about things that they would prefer to keep to a more limited audience. Teams can obviously formulate without the patient or family present and should always be formulating their interventions carefully. However, at some point (and this can be in many creative ways), the person themselves should be brought into the process in order to develop a collaborative, shared understanding of the way forward. It can be too easy to get swept along in the sense of urgency and forget to meaningfully include the patient, assess their capacity specifically in relation to this process, and discuss their thoughts about who should be brought into the process (and who should not). The inclusion of the family can be complex to think through. It is often vital but the patient's decision about their involvement is crucial unless they do not have the capacity to decide; and in this case the relevant processes need to be gone through in order to make an informed decision about the appropriate course of action.

## Benefits of formulation and reflection on work

Psychological formulation has been found to be effective in three broad areas that are relevant to inpatient care:

1. Shared recognition and increased empathy for the person (e.g. Kennedy et al., 2003).

2. Enhancing the quality of the interventions and care planning (e.g. Moore, 2007; Murphy et al., 2013).
3. Increasing capacity within the staff team for safe unknowing and reflection; the ability to tolerate a position of uncertainty in regard to a patient rather than impose a framework or decision that is inadequately developed (e.g. Schon, 1987).

Before introducing psychological formulation into a service you need to be clear on the purpose of doing so and how the impact will be measured (and by whom).

- To reduce length of stay?
- To obtain a better understanding of the person and their difficulties?
- To inform relationships between the person and the team?
- To provide more focused interventions?
- To improve the long-term prospects for recovery?

There are also practical decisions such as:

- What are appropriate things to be shared e.g. with the patient present is probably not the time for the team to be reflecting on their own emotional reaction. Make sure the purpose and therefore content and boundaries are clear from the start.
- Who will the formulation be shared with/in what format?
- When will it be reviewed and by whom?
- What level of detail will be entered in the person's notes?
- How will conflicting opinions be articulated?
- How will the person hold a copy safely (e.g. not accessible to family if this is not appropriate or wanted)?

### Theoretical model, focus and process

It is easy to conflate the model, process and content/focus of a formulation but they all need careful thought (see Table 1 for examples). The theoretical model that you choose needs to be able to articulate the problems that are under consideration, be accessible for everyone involved, and have a strong theoretical integrity. You also need to consider whether you are going to use one theoretical model across situations or use various models. As described above, the focus might be at an individual, team or organisational level. The process might be with one person, in a group, around a table and paper, up on a 'live screen' etc. A number of the services who demonstrated examples of good practice during the development of this document use an overarching formulation model to guide the team case discussion in some way and details of these can be found on the website. They all bring their own dis/advantages so time spent thinking this through is worth the investment.

Figure 1 demonstrates a formulation of current interaction style from an integrative perspective. Other more linear models lend themselves more clearly to the process of planning the steps of a person's recovery, e.g. see Laidlaw et al. (2003) or James (2011).

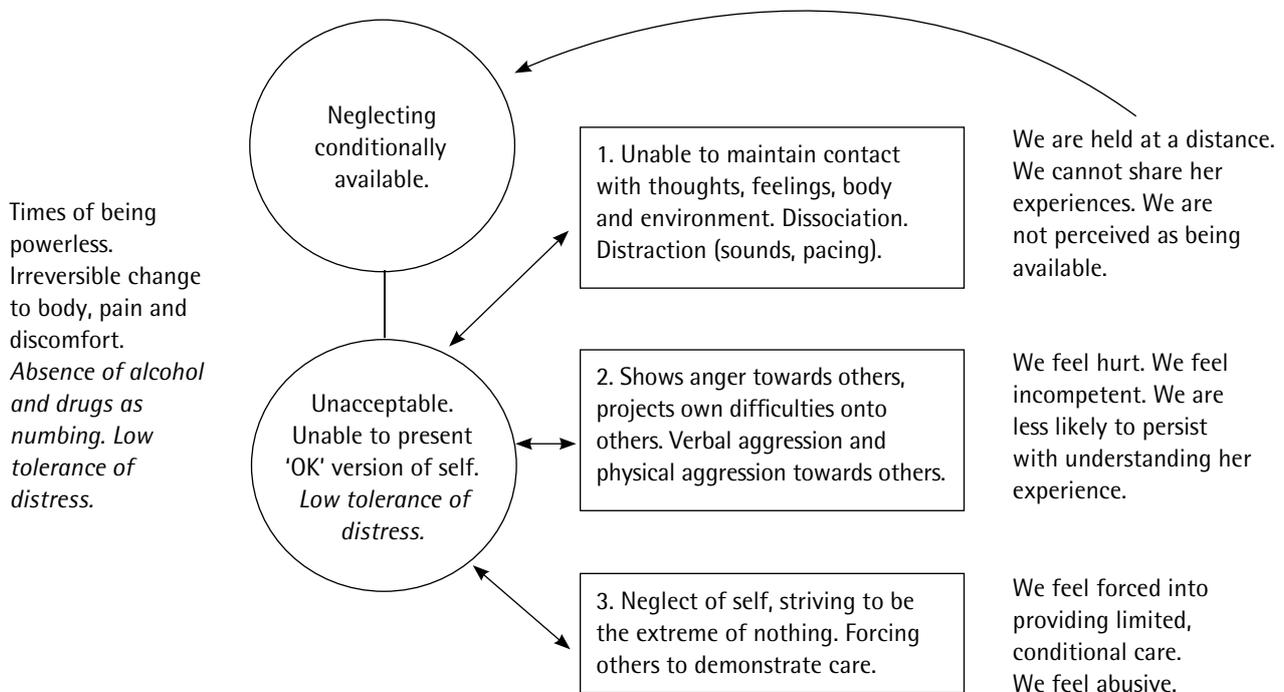


Figure 1: Example of a diagrammatic integrative formulation, drawing upon CAT for the main structure.

Regardless of the theoretical model you choose, it is important to ensure that any formulation in inpatient services provides space for the following:

- The person's identity beyond the presenting problem to be heard.
- The meaning of the current situation for them and for others to be apparent.
- Inclusion of other problems that the person is experiencing such as physical illness, housing problems, finance, some of which may get lost with the immediacy of 'risky' factors.
- A very clear link to the interventions/person's own strategies that will follow from the formulation. Things move quickly on wards and a well-meaning formulation that was helpful in the moment can rapidly get lost amongst other urgent issues.
- A clear strategy for communicating this new understanding to the people that weren't in the room in a way that is respectful to the individual and helpful to those reading it.
- An understanding of whether there are people that won't be given access to this formulation – information can be too easily seen as available to all when teams work this closely together.
- A plan for how it will be translated into the person's care record. Don't assume that others will or can do this, the detail of the wording of a formulation is often critical. And don't be afraid to be very specific about what you mean the intervention to be following a formulation. When done well, a care plan can move from reflecting policy and risk to reflecting the person at the heart of the discussion (Hull et al., 2015).
- The impact of the team on an individual's wellbeing. These are intense environments where small frictions can have a significant impact. Use the formulation session to

Table 1: Reflecting on the focus, aim and examples of formulation.

Focus of formulation	The aim	Examples
<b>Individual formulation</b>	<p>To ensure the person's voice is heard.</p> <p>To formulate the needs of the individual.</p> <p>To consider the reciprocal relationships between the patient and their immediate environment.</p> <p>To enable individuals to make meaningful changes to their own behaviour.</p> <p>Consider accessing an advocate for people who are struggling to make their views known.</p>	<p>Understanding a presenting difficulty; considering 'alternative' understandings to diagnosis; providing an individualised understanding of 'triggers'; to understand anxieties or obstacles to change within the immediate care setting.</p> <p>People living with dementia whose stress and distress presents as resistance or aggression; a person who is experiencing high distress and cannot articulate this verbally.</p>
<b>More than one person</b>	<p>Formulating the needs of the patient within their family or with the inpatient team (American Psychological Association, 2014).</p> <p>To enable collaborative relationships between individuals and key working relationships.</p> <p>To influence conditions that are conducive to change for the patient.</p> <p>To enable change to occur within relationships.</p>	<p>Meetings with nursing team to use an understanding of a person's attachment style to plan a strategy for the delivery of nursing care.</p> <p>Meetings with families to enable a clearer understanding of the family issues that are contributing to the current difficulties.</p>
<b>Systemic/organisational formulation</b>	<p>Formulating the needs of the team, the service and the organisation. In turn this will inform understanding of individual needs.</p> <p>To influence the conditions of working and resources available to enable the unit to provide therapeutic care.</p> <p>To minimise unhelpful patterns of behaviour at all levels of the system.</p> <p>To influence transitions of care.</p>	<p>Understanding your own role and approach within the system; understanding how distress or difficulty has been conceptualised within the system; formulating barriers to change (Hickman &amp; Crawford-Docherty, 2010); formulating how the system is responding to anxiety.</p> <p>Working on the relationships between different parts of the organisation (inpatients, community, safe-guarding, crisis) to improve the psychological quality of the whole care pathway.</p>

discuss these and bring them out into the open so that you can also plan a way of dealing with them.

- Difficulties that the team may experience in processing and responding to the individual patient's presentation of distress and attachment style.
- Remember that formulation is inherently a process not an event and you have the ability on a ward to meet with people on a more ad hoc basis. Use that to your advantage to build up a narrative that works for everyone and with which everyone is involved. The process does not have to be the same for everyone. For some people, meeting with their family member and the named nurse will be very stressful but they will value the chance to share ideas. Others will not want to be in the room at all but will be happy to send very strong messages via you on their behalf (and want to see a draft of the resulting formulation as soon as the meeting is finished). And some people will want their whole team there in one go. You should always be tentatively thinking about the meaning of each decision for each person and trying to

respectfully balance the needs of all parties. Ultimately what you want is not the big meeting with all concerned, but a shared, theory driven and personalised narrative about what has happened, and what needs to happen to move forward.

## Potential problems and ways to overcome them

Facilitating a psychological formulation in this setting can be complicated. A large number of people are involved in an admission but having them all there with the individual and the family is rarely appropriate. It is important to think about who does (not) have the right to be included in the information gathering and sharing. Although the team do need to be formulating the person's needs and their own interventions, the inclusion of other people such as family members needs careful consideration, especially in light of capacity and consent from the patient.

When formulation takes place as a group discussion, the facilitator also needs to be confident in dealing with multiple emotions in the moment (their own included) as this is often the first time that individual stories have been reflected on and shared. This may also be the case in the context of potential recent traumatic experiences, recent discoveries of information that challenge established family stories and disrupted attachments.

Research into the impact of team/group psychological formulation on the patients and carers that were involved made for some uncomfortable reading (Tarran-Jones et al., 2016). When it went well the process was recovery orientated and inspired hope, offered shared meaning for the first time, helped people see that there was a way out and what they could do themselves. But there were instances when patients and carers reported that the meetings perpetuated an authoritative and powerful professional team that they felt 'in battle' with and judged by.

The factors that made the meeting more likely to be a positive experience are a useful framework for any meeting where patients and carers are involved and worth bearing in mind and sharing with colleagues as this is often the dominant way that teams engage with patients:

- Make sure the room is confidential and that there is a sign indicating not to be disturbed. If someone does disturb you, be proactive in protecting the meeting. Tolerating disturbance indicates a lack of respect for the meeting.
- Don't have the staff sitting in there waiting for the patient to be 'brought in'. Ideally, let the patient and their representative arrive first and get comfortable in the room and let the staff come into the patient's space.
- Use a small, preferably round table – you are aiming for safe and intimate not big and exposing. Round tables help reduce hierarchy and enable everyone to see each other.
- Keep the group small and relevant. Only people who have something to contribute should be there and the patient should have consented to them being there. Make sure the team are briefed on what you expect of them before and during the session (especially that they are there to contribute, not to watch). Silent observers (even if they are introduced at the start) create an audience rather than a collaborative presence.
- At the start of the meeting make sure everyone is introduced, the purpose of the meeting explained and everyone's role made clear.

- Make sure everyone has a drink (all the same – not that staff have tea and others have water unless that is their preference).
- Make sure all the chairs are the same. The service user sitting on a small chair can feel vulnerable but sitting on a higher chair can feel like ‘being in court’.
- Think carefully about the use of laptops/computers etc. in the meeting – they can make things go faster from our point of view but tend to reinforce the power differential in the room and reduce the level of engagement from participants. Flip charts and pens are much more engaging.
- The team obviously need to meet at times without the patient or family present. However, it is uncomfortable to leave a room of people who are staying behind to talk about you. Could you all leave and come back together in five minutes?

## Outcomes

The examples of good practice that were gathered during the development of this document (available on the website) often included psychology-led multidisciplinary formulation or case discussion sessions. When wards engage in team formulation sessions, the following outcomes are observed:

Staff report changes in their own practice:

- Greater psychological understanding
- Improved recovery focused care
- Compassionate therapeutic alliance
- Increased staff confidence
- Improved ability to provide a consistent approach
- Positive management of complex problems

Measured reductions in:

- Average length of stay
- Readmission rates
- Harm and falls during admission

## Summary

Formulation is core to putting the individual needs of the patient at the heart of care planning and must, above all else, produce a map of how to improve the psychological wellbeing of the patients and carers who are making use of the service. That is, how therapeutic change can occur; how things can be better than they currently are and how can this be sustained? The question of ‘who is formulation for?’ should be kept alive and continually revisited. It is helpful to maintain that the patient is not a by-product of a system, but a person around which a system is built. Therefore, the outcome of any formulation must be better individual care; it must be a plan for possible change. The inpatient context is a setting offering great potential for therapeutic change, or a reduction of further harm, which is a worthy aspiration.

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## References

- American Psychological Association. (2014). Guidelines for psychological practice with older adults. *The American Psychologist*, 69(1), 34.
- College Centre for Quality Improvement. (CCQI; 2017). *Standards for inpatient older adults mental health services: Fourth edition*. London: Royal College of Psychiatrists.
- Denman, C. (1995). What is the point of a formulation? In C. Mace (Ed.) *The art and science of assessment in psychotherapy*. London: Routledge.
- Department of Health, (2001). *National service framework for older adults*. London: Department of Health.
- Hickman, G. & Crawford-Docherty, A. (2010). Ward C: A formulation-based service development programme. *PSIGE Newsletter*, 112, 46–54.
- Hull, A., Dexter-Smith, S. & Prescott, T. (2015). *The impact of psychological formulations on care plans in older adult mental health inpatient units*. Unpublished doctoral thesis, Teesside University.
- James, I.A. (2011). *Understanding behaviour in dementia that challenges: A guide to assessment and treatment*. Jessica Kingsley: London.
- Johnstone, L., Whomsley, S., Cole, S. & Oliver, N. (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: British Psychological Society.
- Johnstone, L. & Dallos, R. (Eds.) (2013). *Formulation in psychology and psychotherapy: Making sense of people's problems* (2nd edn). London: Routledge.
- Kennedy, F., Smalley, M. & Harris, T. (2003). Clinical psychology for inpatient settings: Principles for development and practice. *Clinical Psychology Forum*, 30, 21–24.
- Laidlaw, K., Thompson, L.W., Dick-Siskin, L. & Gallagher-Thompson, D. (2003). *Cognitive behaviour therapy with older people*. West Sussex: John Wiley & Sons.
- Moore, P. (2007). Formulation diagrams: Is there more than meets the eye? *Clinical Psychology Forum*, 174, 9–12.
- Murphy, S.A., Osborne, H. & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging and Mental Health*, 17(4), 441–448.
- Persons, J.B. (1991). Psychotherapy outcome studies do not accurately represent current models of psychotherapy. *American Psychologist*, 46, 99–106.
- Schön, D.A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.
- Tarran-Jones, A., Dexter-Smith, S. & Muncer, S. (2016). *'It was almost like an awakening'. An interpretative phenomenological analysis of service-users' and carers' lived experiences of team psychological formulation*. Unpublished thesis, Teesside University.

## Chapter 5: Speaking the ward's language

Language includes or excludes, facilitates or disempowers, joins or separates and defines membership of groups, whether intentionally or not. Linguistic research has long highlighted that the language we use shapes what we think about things (Biner, 2017; Boroditsky, 2009). When you join an inpatient team, it's worth spending time working out how information on the ward flows, between who, and about what. You might also spend time working out when communication occurs.

*Language is a uniquely human gift, central to our experience of being human. Appreciating its role in constructing our mental lives brings us one step closer to understanding the very nature of humanity.*

Lera Boroditsky  
*Professor of Psychology at Stanford University*

There will be formal meetings and handovers but there will also be key unspoken methods of communication that you need to make use of. And each context will change what is said. There are complex decisions to be made about what language you adopt at different times, when you embody separateness for the sake of modelling and when you join, and how the language that is used defines the purpose of the activity and the position of the people in it. It can be demoralising to realise that we are struggling with communication when we arrive in an inpatient service. But working in semi-closed, fast moving environments that are, by their nature, often focused on other high priority agendas, can be bewildering. Com-



munication processes learnt from community services don't always translate effectively to inpatient environments: inpatient services are more direct and immediate; staff communicate in less formal ways; and it is often harder to choose the membership and timing of a conversation than in the community. What you need to communicate and to whom will dictate where you aim your message e.g. in one service nurses read care plans, managers read risk registers, psychologists and psychiatrists read letters. Inpatient teams may have a very strong group (rather than individual) identity which has formed over many years and can be hard to break into. Don't waste time trying to change processes of communication if the pre-existing ones can be made to work for you. Think broadly – research the different languages of policies, clinical records, meeting structures and operational processes; remember that these are all communication strategies that you could tap into. You should also be familiar with our own professional guidelines on the use of language (BPS, 2015).

Everything you do communicates your values about the service, your colleagues, and the people they are trying to help, so think carefully about how you communicate and don't underestimate the complexity in this system structure. Until you understand the stakeholders and existing culture you can't make useful decisions about sometimes fraught choices: do you go to that meeting you perceive as unhelpful and challenge what is happening, or stay away?; what are you communicating to whom with each decision? There is an inherent tension between:

1. the seeming simplicity of communicating with a team that is always in one place, share an environment, have a strong identity, and whose patients are nearly always 'available';
2. the reality of shift working (you will only ever be able to talk to a small proportion of the team at a time), disparate group cultures, the speed of turnover (sometimes of staff as well as patients), and the rapid nature of decision-making by the team that often change day to day and don't match your working hours.

There are many languages we need to speak as psychologists in inpatient environments and Table 1 outlines key things to bear in mind. Some of these are the formal languages of social care, mental health law, physical health, 'bed management' etc. Others are much more subtle unwritten communications of how that ward team engages in emotional processing with each other. Is this a team where it is OK to say that a particular individual frightens you or that you are irritated by someone and need some space? The emotional demands of being in a relationship with the same group of patients for a whole shift must be communicated and processed somehow e.g. is it by a level of dissociation, the development of heroes, or collaborative peer support? The language that you use can provide a sense of containment for yourself and those around you, or conversely increase levels of anxiety and distress.

National guidelines can add an external 'objective' rationale for tackling problematic language that may be so engrained it is hardly noticed (DEEP, 2014; BPS, 2015).

Cultural assumptions and inequalities are unwittingly perpetuated by the way the dominant discourse pervades general information, e.g. the assumption of heterosexuality. Ageism is unfortunately part of this dominant discourse and it is important to be alert to it; it is so widespread that it is easy to overlook and can form part of the discourse of patients,

Table 1: The languages you may speak.

DO	DON'T
Be aware that what you say and how you conduct yourself is constantly communicating your core values.	Insist others learn your language in order to understand you. Don't expect operational colleagues to speak a clinical language.
Use the language of recovery and talk about people's lives, preferences, personal goals and what gives them joy or satisfaction.  Express useful psychological ideas in plain speech.	Mistake the processes of communication for the purpose of communication.
Adapt the pace of your communication to the context – inpatient services are fast moving. Be ready to give an imperfect or half-finished opinion if it provides a useful starting point.	Dress statements up as questions. Learn to notice when people just want to be told what your opinion is.
Consider 'acting the solution' in teams where power is very unbalanced: as though everyone is a valued member and opinions are already welcomed and listened to.	Ignore the powerful ways that the environment communicates factors such as the worth of patients and staff, however inadvertently.
Think carefully about when it is helpful to mirror the language style of the person you are communicating with and when it isn't.	Fall into communications that reinforce the stereotype that older people are a homogenous group and that issues of difference and exclusion are for the young.
Be aware that you are embedded in the norms of psychology. Spend time investigating what others have been taught to value and prioritise.	Forget the huge range of people who may be contributing to the experience of care – family, medical specialties, physiotherapy, SALT, dieticians, activity coordinators, advocates, research team, safe-guarding, infection control, advocacy, police, support workers, volunteers, housekeeping, students, chaplaincy, administrative staff, social workers, mental health office.
Learn the language of physical health. You need to be able to understand and communicate about blood pressure, kidney failure, diabetes, infection etc. in order to understand the complexity of the problems other team members are grappling with.	Ignore what might be happening when people tell jokes – these are often the times when the uncomfortable emotions get discharged or moral judgements get made.
Make thoughtful decisions about how to communicate dissent and dissatisfaction. Is this a situation that requires formal reporting? Consultation with the ward manager? Direct confrontation? A private word behind closed doors? Curious questioning?	Ignore the powerful communications staff make to each other about hierarchy and the value of people's opinions.
Talk about psychological ideas, especially those which can help the service to deliver high quality nursing care: Mindfulness, attachment, locus of control etc.	Stop reviewing the language you are using yourself and the message it is giving.
Consistently reference the variety of human experience and identity (sexual, cultural ...) in your own communications and ask questions about the provision for people with protected characteristics.	Under-estimate the cultural differences between the 4 nations. Language impacts on how people think and Welsh is a national language alongside English.

families, and staff. Look critically at the information your service provides. Do your pamphlets, signs, and environment actively acknowledge difference or are issues of difference invisible until individuals self-identify as outside the norm? This can be particularly difficult in services for older people where there is typically a generation or two gap between the

staff and the patients, and often a generation gap between patients themselves. Language is incredibly fluid and changeable; different age cohorts use language differently in ways that reflect the different philosophies and ethical dilemmas that people have needed to attend to at different points in history. Look at models of co-production and think with patients and families about how they can support a change in language and communication on the ward.

Go back to basics. Remember all the ways in which you, the patient, team and organisation are communicating: email, conversations, patient records, policies, body language, what you prioritise when meetings clash, what you challenge, the built environment etc. What are you doing that promotes or hinders genuine understanding from the wider team? Our experience is that there is a very powerful relationship between the use of language and 'acting the solution'. If *you* begin your conversations with an account of the patient's concerns and priorities there is an impact on team discourse. People get used to talking and thinking in certain ways and you can initiate cultural change by kick starting changes in the style and content of conversation.

### Who are you communicating with?

This is heavily influenced by whether you and other stakeholders have clear roles and a clear 'point' to the person's admission and the maturity of the relationships that you have with each other. It's important to understand what roles are being acted out and what roles you are being 'invited' into or to witness/condone (passively or overtly). Cognitive Analytic and Transactional Analysis models might be particularly useful here. Make a conscious decision about what you're taking on/taking part in etc. Communicating your commitment to team membership happens via many tiny acts and gestures. Making tea and having a chat are not acts that require psychological technique but the decision about what to (not) take part in might be part of a sophisticated and well-thought out communication strategy that is based on psychological formulation. Table 2 summarises the key people with whom we might be communicating.

### What are you communicating about?

All systems, (especially closed systems) have both overt, dominant narratives and more subtle narratives along with rules about which narratives are silenced or discouraged. Mapping the dialectics in play can help you to identify what is being said, what is (not) being given thinking time, and where you might find ways of creating common ground whilst also creating space to create change within the team. Words such as 'us and them', 'ill and well', 'diagnosis and formulation', 'patient and service user' all carry strong meanings and can be difficult to reconcile with the pressure to move to more recovery orientated ways of working. Keeping the impact on the patient at the centre of all communication can prevent some of the dehumanising/distancing process words (beds/delayed discharges etc.) coming to stand for the individuals who need care.

A strength of our training as clinical psychologists is our ability to draw on multiple models to inform assessment, formulation, and intervention in relation to individual care, team dynamics, and organisational processes and to embrace uncertainty. But in communicating

Table 2: Who you communicate with.

<p><b>Patients</b></p>	<p>Depending on the cohort and cultural mix of the local population, several different languages will probably be spoken, particularly in Welsh services. Some Asian languages have quite different linguistic ways for talking about mental health and this can frame the patient and family understanding of the difficulties they experience.</p> <p>Also look out for: behavioural communication; use of the physical space; the degree to which people socialise; how physically active people are, ways in which their appearance may be communicating something, and whether they exercise their freedom to leave the ward. Interpreters are important in helping staff understand not just the language spoken but also the meaning that is being communicated by cultural stories, 'symptoms', and descriptions of distress.</p>
<p><b>Families and carers</b></p>	<p>Don't assume that close family will identify themselves as carers. Our blanket use of this term can exclude and distress or burden people with a sense of responsibility that they are not willing or able to fulfil. The psychological contract in even close relationships does not necessarily include caring for the other person. Think with families and patients about the ways they have communicated between themselves (style, words etc.), what isn't comfortably said or heard, what is within the capacity of different relationships, and what is given priority?</p>
<p><b>Clinical staff/teams</b></p>	<p>Formal/informal meetings, documentation, supervision forums, training processes. Who attends and speaks, where, how are people addressed (verbally and in writing), how are 'things' (keys/ uniforms/offices etc.) allocated? Is the language between teams supportive or confrontational? How are transitions between teams communicated to everyone?</p>
<p><b>Wider organisation</b></p>	<p>What is given priority/measured/funded (including the built environment)? Who sees what reports (think broadly)? What processes get talked about most (serious incidents, talent management etc.)? What gets into the business plan/who is given responsibility and accountability for what? What accreditation and regulatory standards are prioritised?</p>

with other staff, there is a balance to strike in how you use those multiple perspectives. In a fast paced, high hazard environment, people (patients, staff, managers etc.) need some containment in how you communicate your professional opinion. That doesn't mean buying in to false certainty but it's not always helpful to 'show all your working out' or refuse to make a decision. This can be difficult especially if you are new to the profession or to inpatient work. So use supervision or a mentor to help you think through who needs to know how broadly you can think and who needs some more concrete advice.

### Find a way in

There are some key factors to hold in mind when thinking about how to structure your own language:

- There is a careful balance to be achieved between using language of concern and telling stories of success and it is important that you are thoughtful about the timing, context, purpose, and audiences for your message.
- However, telling stories of success is incredibly valuable. As long as you are telling stories of the *team's* success, you contribute to improved morale, increase self-belief in their ability to make change, and positively influence external narratives about the team. You also start to contribute to a shared understanding of what 'good' looks like and specific ways in which each person can contribute to that.
- Make sure you communicate safety and predictability by: your time keeping; your

emotional reactions (being congruent and predictable rather than emotionless); following through on promises; a stable focus on what is important; and how you talk about other people especially when things are contentious (all your conversations are 'professional' and are being noted by others).

- All cultures have a dominant narrative and older people's inpatient units are no exception. Feedback from the FPOP membership clearly articulated concerns about how to find a voice for communicating psychological messages in a world of 'ECT, ketamine infusions and TMS'. Medical language often dominates for many reasons, not least because a lot of the people using the service are physically unwell. But there will always be a way in – look for what is worrying key stakeholders in their conversations and bring in an alternate perspective.
- Groups form in all environments; usually we're a single psychologist. What, if any, groups do you join? What stories will people tell about that? Think about e.g. where your photo goes on the ward board, where you sit, where you have lunch, how is your (and others') title (not) used in conversation/minutes/introductions etc.
- You might need to communicate differently with different groups. People understand that. But make sure that, even if the words/format/vehicle of communication differ, the core message and values of your communication don't – people will rapidly see through that and lose confidence in you.

We encourage you to think widely: stories of successful communication have often come from the multitude of ways in which we communicate whether we value the patients, team and organisation as much as we value ourselves and psychology. Do you:

- Join the team for coffee breaks/offer to make coffee sometimes.
- Keep your door open and actively move into the spaces on the ward that have traditionally been avoided.
- Stand up for 'silenced narratives' or go with the dominant flow.
- Work on clinical or operational policies or service reviews – shaping them can alter the communication flow of a ward for years.

## Summary

Pick some key messages and keep repeating them in as many places as you can. Relentlessly communicate that you want to be there and want to help make the unit a more therapeutic place for everyone. Use your psychology skills; build relationships, take time to make sense of communication, challenge appropriately, and have well thought through opinions. Above all, remember that your communication in all its forms portrays your respect for the other people on the ward. When you get it right it goes a long way to making your work more effective and your job more enjoyable.

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## References

Biner, B. (2017). *Does the language I speak influence the way I think?* Linguistic Society of America. Retrieved 23 March 2017 from [www.linguisticsociety.org/content/does-language-i-speak-influence-way-i-think](http://www.linguisticsociety.org/content/does-language-i-speak-influence-way-i-think)

Boroditsky, L. (2009). *How does our language shape the way we think?* [www.edge.org/.../lera\\_boroditsky-how-does-our-language-shape-the-way-we-think](http://www.edge.org/.../lera_boroditsky-how-does-our-language-shape-the-way-we-think)

British Psychological Society/Division of Clinical Psychology (2015). *Guidelines on language in relation to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Dementia Engagement and Empowerment Project (DEEP, 2014). *Dementia words matter: Guidelines on language about dementia*.

# Chapter 6: Culture change

## Introduction

The treatment of psychological distress and dementia has historically been shaped within a biomedical framework. Cultures of care for older people have been described to us as ‘task-focused’ and lacking hope in their approach to those with ‘incurable’ conditions or those who have not responded to medical treatment. However, social context, expectations of patients and staff, and models of care have all changed in recent years. There are many examples of innovative practice which have addressed some of these historical approaches and this is a fruitful time to negotiate change in healthcare settings. The increasing multidisciplinary sign up to the recovery model, the shift in operational focus towards quality, and the investment in leadership development reflect this emerging climate of new possibilities.

Health care practice and policy highlight the fundamental role of organisational culture in enabling good mental health care (Rafferty et al., 2015) and this chapter outlines how you might begin to think about the culture of care in which you work. It brings together themes from other chapters (particularly the key offer, therapeutic engagement, and speaking the ward’s language) and considers them at a systemic level. There is enormous



interest in leadership and change methodologies within the NHS and recent examples of systemic poor care have created a welcome shift in emphasis to what enables healthcare organisations to work collaboratively and compassionately (e.g. Berwick, 2013). This chapter focuses on applying the psychological models that form a core part of a psychologist's toolbox within the specific context of older people's wards but these models can be enhanced by a broader reading of the literature on leadership and organisational change. The King's Fund and the NHS Leadership Academy produce regularly updated resources and information in this field.

An important starting point for you and the wider service is to consider what a healthy culture of care looks like? At the broadest level, the principles of dignity, compassion, competence, safety and choice are seen as essential to good quality care (Department of Health, 2015). A healthy culture of care is also one which develops the employee's capacity for hope, resilience, optimism and self-efficacy (psychological capital) and in doing so maintains good performance, wellbeing and satisfaction (Luthans et al., 2008). Within mental health services, a good culture of care would be one which endorses an understanding of mental health from a range of perspectives, with each patient's unique needs at the centre. Both recovery and person-centred approaches are often referred to as aspirational frameworks for mental health and dementia services. These two approaches share much common ground, both emphasising the role of hope, identity, connectedness and purpose as fundamental to emotional wellbeing (Slade, 2013; Perkins et al., 2016). Both also recognise the importance of the individual's relationship with their socially prescribed identity through e.g. issues of gender, ethnicity, sexuality, and ageism. The way in which these identities are supported is often an important indicator of the health of a culture (for patients, staff and families).

Spending time specifically thinking about the inpatient culture in which you work is critical in helping services move towards recovery-based psychologically informed care. The principles of culture change draw on many core psychological models familiar to all applied psychologists as well as on the critical influence of processes, practices and structures in underpinning culture. For clarity, this chapter will use cognitive behavioural theory as a framework for illustration as this is, to some degree, familiar to all psychological practitioners and mental health professionals. This does not suggest that CBT is the only model through which this work can be developed; rather, any psychological model which is appropriate and preferably familiar to the service in which the psychologist is working can be applied within this framework.

This chapter will focus on how to support the development of a psychologically healthy culture through assessing, formulating and intervening in the domains of individual sense-making and behaviour, and the organisational systems that hold these in place. It begins by defining culture and presenting a theory and framework for understanding cultural change. It contrasts a CBT approach to Schein's (2010) model of culture to support those psychologists who are beginning to move from individual work to organisational interventions. However, it is important to recognise that other psychological models, especially systemic theory, will have equal validity in thinking about this process of cultural change.

## What is culture?

Culture is defined by the *Cambridge English Dictionary* as ‘the way of life, especially the general customs and beliefs, of a particular group of people at a particular time’. Within organisations, culture comprises both subjective elements of life (individuals’ thoughts, feelings, beliefs and values), and the more objective or observable structures and processes that support and strengthen those subjective elements.

According to Schein (2010), there are three levels to culture, which in many ways provide a parallel to CBT’s levels of schemas, conditional assumptions/‘rules for living’ and accessible automatic thoughts and behaviours. These are outlined in Table 1.

In reverse order, the observable level of culture, (the equivalent of thoughts and behaviours), are called *artefacts*. These are visible, for instance, the environment, the routines, the meetings, the clothes worn, or the words spoken and written. These elements are straightforward to observe but trickier to interpret. Their interpretation relies on accessing the next or deeper level of the culture.

The next level of culture is that of *espoused beliefs and values*. Following our CBT analogy, these parallel ‘rules for living’ are the shared values and beliefs of the group. These have been developed over time through a process of successfully applying them to problems and dilemmas, thereby establishing their place in the espoused ‘way we do things around here’. Needless to say, there may be contradictions between different sets of espoused values; for example, those that promote a value of being person-centred with the associated artefact of spending quality time with patients, with those that promote the value of safe care as practiced through effective and thorough record-keeping. These values each require different sets of behaviours or artefacts which, when time is scarce, presents a potential conflict.

The consistency we see in resolving this conflict is produced through the deepest level of culture; *basic underlying assumptions* or, in CBT terms, schemas.

Basic underlying assumptions are taken-for-granted, invisible ‘theories-in-use’ (Argyris & Schon, 1996). They are unquestioned, indeed their presence is unacknowledged, the culture equivalent of breathing air; any alternative way of thinking and its associated way of behaving is inconceivable. They tell team members what to pay attention to, what things mean, how to react or feel, who they are, what they value, what to feel good about. If such assumptions are inadvertently challenged, confusion may result through a failure to understand or even through the misinterpretation of situations or events. As in CBT, these assumptions protect the individual and group from the anxiety that derives from people’s needs for certainty in an uncertain world. Change provokes anxiety. ‘To change a team culture, people have to unlearn beliefs, attitudes, values and assumptions and relearn new ones. This causes anxiety because people tend to like order and consistency in what they do. To avoid this anxiety, people tend to think about events around them as in line with the way they currently do things. This may mean distorting, denying, or falsifying to themselves what is really going on’. (NHS Institute for Innovation and Improvement, 2007, p.25). It is also worth referring to Menzies’ (1975) paper on organisational defences against anxiety. This provides another way of formulating a task-driven culture and considers why staff might use dehumanising labels or why there may be a motivation to distance psycho-

logically or physically from the patient, making meaningful relationships more difficult.

To go further, not only does effective culture change involve unlearning at an individual or group level, but also unravelling and redesigning the systems and processes that hold the current cultural beliefs, values and assumptions in place, that positively reinforce and support some behaviours and artefacts and undermine others. Culture change initiatives that focus purely on values, beliefs and behaviours and fail to address this reflexive relationship by which they are reinforced will fail to achieve lasting change.

Note that the dichotomy between traditional and recovery models of care is intentionally created to exemplify the point. Typically there will be elements of both in a healthcare environment.

## A framework for culture change

The most familiar framework for change for psychologists is that brought to individual clinical work; assessment, formulation, intervention and evaluation. When we are talking about culture change the 'client' becomes the service and this might offer a good opportunity for patients and families to take an active role in co-producing the assessment, formulation and intervention with the service.

A period of pre-assessment is important when thinking about potentially wide scale change. This might include the reason for the assessment (your reason and others'), the scale of agreement on the goal, thought about the relevant stakeholders, and the potential use and distribution of information that the project uncovers. You will also need to consider readiness for change and the resources available to the service to effect this change, in order to decide when to intervene. Prochaska and DiClemente's (1983) trans-theoretical model of change with its emphasis on the stages of pre-contemplation and contemplation is as applicable to organisational systems as to individual people. Indeed, organisational development professionals have developed this model for use with teams as evidenced in the work of the NHS Institute for Improvement and Innovation and the Division of Occupational and Organisational psychology (Tate et al., 2014).

In order to assess culture, you need to develop a hypothesis about what artefacts or indicators are relevant. The formulation can then be derived from the observations and the conversations you have with team members about how and why they do things. The dynamic relationship between these elements and the positive and negative reinforcement schedules that support them would comprise the intervention plan. For example, when considering the presence of a psychological culture in an inpatient team for older people, the assessment would collect data identifying the artefacts congruent with this culture and the formulation would put them in the context of the underlying 'rules for living', schemas and reinforcement schedules which hold them in place (Hickman & Crawford-Docherty, 2010).

Artefacts could include:

- The way tasks are described e.g. helping a patient to have a meal vs feeding a patient.
- What team members recognise as a legitimate 'task' e.g. is social interaction regarded as a legitimate task in the same way as personal care or drug administration.

Table 1: Levels of culture mapped to cognitive behavioural theory.

Schein's levels	CBT translation	Real world examples: traditional care	Real world examples: recovery, person-centred ethos
Artefacts	Automatic thoughts and observable behaviours	<p>Environment e.g. minimal space for personal belongings.</p> <p>The way tasks or problems are described e.g. 'feeding a patient', 'kicking off', 'attention-seeking'.</p> <p>Staff-patient interactions i.e. professional-led and task focused.</p> <p>Routines that just meet needs of service e.g. meal times, ward rounds, medication rounds.</p> <p>Audit programmes/what the service is measured on reflect service rather than patient goals.</p> <p>Reliance on agency staff and high level observations to manage risk/agitation.</p> <p>Fixed visiting time and rules about what visitors can/not take part in.</p>	<p>Patients' identity represented in their personal space.</p> <p>Language that supports patients' strengths and recognises distress/unmet need.</p> <p>Rich informal staff-patient contact evidencing knowledge of life of patient, staff engage with patients between tasks etc.</p> <p>Care routine tailored to patients' preferences and needs.</p> <p>Targets that promote a recovery/person centred ethos e.g. are care-plan objectives person-centred and meaningful in context of patient's life story.</p> <p>Use of appropriate therapies to enhance wellbeing.</p>
Espoused beliefs and values	Rules for living/conditional assumptions	<p>'If the patient has dementia, then s/he is unaware of what happens around him/her'.</p> <p>'We only need to know about health needs' (brain scans and blood tests).</p> <p>'There's no point talking with them, they don't understand'.</p> <p>'If they aren't motivated, it's because they're old – what do you expect'.</p> <p>'We are responsible for their safety/have an overriding duty of care'.</p> <p>Protocols that drive passive, containing, risk-averse practices.</p>	<p>'Patients are people with rich life histories – I need to use that in my care'.</p> <p>'If I help my patients feel relaxed and happy, I am contributing to their quality of life'.</p> <p>'It must be so scary for my patients to not be able to remember where they are'.</p> <p>Protocols that drive person-centred care.</p>
Underlying assumptions (theories-in-use)	Schemas	<p>'Good nursing is about meeting all of your patient's physical needs'.</p> <p>'Caring for them'.</p> <p>Ageist myths e.g. 'you can't teach an old dog new tricks'.</p> <p>Disease fantasy in patients and staff e.g. 'the doctor will sort it out'.</p> <p>Biomedical assumptions about mental health/dementia.</p> <p>Organisational policies that promote risk-averse, passive care.</p>	<p>'Good nursing is about caring about my patients as people, adapting my practice to meet their individual needs'.</p> <p>Organisational policies that promote person-centred, recovery practice.</p>

- How specific tasks are carried out e.g. the presence or absence of conversation during personal care or during one-to-one observations.
- What information is deemed relevant for handing over between team members or recording in notes e.g. incidents and medication or what has worked well with a patient and what has been learned about their life.

In assessing the ‘rules for living’, explanations would be sought from team members on their rationale for the behaviours and systems identified as artefacts, with schemas identified through the presence of underpinning themes that are pertinent to the philosophy underlying different models of care. An assessment would also include the processes by which the desired behaviours are triggered and reinforced. That is, how the processes would produce behaviours and sense-making congruent with the psychological ethos and how they would be ‘held in place’ through the positive reinforcement provided in the form of clinical supervision, reflective practice, audits, reporting and patient feedback systems. It is also important to understand with the team the developmental history of the ward culture, using systemic practice to understand multigenerational legacies of risk, loss, control, crisis, hope, recovery etc. The impact of wider societal experiences, power and beliefs about care are also important to take into account.

Culture change at a team and service level is predicated on producing differences in sense-making and behaviours on the part of clinical and operational staff. The articulated and observable differences in behaviour and other artefacts are achieved in much the same way as any behaviour change enterprise is embarked upon in the domain of psychological therapy. Common elements of a generic theory of change underpinning any therapy model (Evans, 2013) are equally critical to culture change. The elements of change are relationships, commitment to change, new sense-making and behaviour change. Thus a relationship with the other members of the team is an essential pre-requisite to any change work, just as it is with a client entering therapy. Such a relationship provides a foundation of trust and containment, which are both critical in helping colleagues along the emotional journey towards making changes in their thinking and behaviours and adopting different care models (Weisbord, 1987, 1989; Emery & Trist, 1973; Schein, 1999).

Therapeutic models are equally powerful in this context for helping you consider who is defining the change that needs to happen and who has identified the need for change. For example, if the desire is that the ward staff should behave differently or adopt a different set of beliefs or approaches, who will define what change is needed or what the desirable outcomes are? Are you in a client-centred situation where the set of people who will enact the change are empowered to develop their own vision of a preferred future or are the people defining the goal and the people who are supposed to be changing their behaviour two different groups? Solution focused (McKergow & Clarke, 2005) and transactional models (Mountain & Davidson, 2011) may provide useful frameworks alongside systemic models for considering these dynamics.

Similarly to one-to-one therapy, the relationships between the people involved in cultural change bring power to the interventions. Helping the team identify ‘what’s in it for them’ through clinical techniques such as motivational interviewing produces the catalyst for, and commitment to, the changes to come. Commitment to change is influenced through

identifying the need for change, eliciting the self-belief in a team that they have the ability to produce the required changes, and helping them identify what they will gain for themselves. This motivational work also needs to include other stakeholders such as managers and clinical leaders who indirectly influence the operation of the ward. Experience shows that change is much easier to achieve and embed when the psychologist works closely with the team and service managers. How you have positioned yourself within the team will inevitably influence this. Co-production can also be achieved by inviting patient and carer representatives into this process of negotiating a shared goal.

The development of new sense-making and behaviours are common interventions delivered by psychologists within inpatient settings. Skills development programmes comprising training, skills practice, and supervision or reflective practice are common offers from psychologists working within inpatient services. They are more likely to be successful if they are designed in accordance with the overall formulation of the culture change required within the setting, as well as the strength of the relationship established with the team members. This should inform decisions regarding length, format, style (e.g. didactic vs coaching), the need for further support to translate to practice (policies, paperwork, supervision), and reinforcement systems that demonstrate to colleagues that this matters (e.g. operational management conversations, audits of behaviours, reporting systems).

Evaluating the impact of organisational change work can be complex but illuminating. You will need to work to ensure that the changes required by different elements of the system are considered and woven together into a meaningful narrative e.g. balancing cost savings, workforce changes and increased presence of person centred conversations and care plans. Culture change that does not address the needs of each stakeholder won't be maintained and so planning for the evaluation of each element from the start is imperative. Working out how those elements will fit together in the new culture will also have been part of your formulation in the planning stage.

As a real world example, Schein's model of culture was used by Shaw et al. (2016) in understanding the way in which organisational culture impacts on the way medication is prescribed to older people in nursing homes. They used a questionnaire based on Schein's three levels to divide culture into traditional, person centred or ambiguous and found that these characteristics influenced the prescribing of antipsychotics. They also found four potential areas for interventions (characteristics of the setting, characteristics of the individual, relationships, and decision-making) that could shift culture towards a more flexible, resident-centred culture with the possibility of reducing use of psychoactive medication.

## Summary

Effective culture change involves the application of core clinical psychology competencies and frameworks but applied at the level of the team and organisational unit. And, just as in individual work with patients, the societal influences of e.g. power, isolation, poverty, historical and current trauma at a group level, need consideration. Culture operates and is maintained in much the same way as an individual's thoughts, feelings and behaviour. The artefacts that are visible to the observer are underpinned by beliefs and values and

taken-for-granted assumptions, much like thoughts and behaviours are underpinned by rules for living and schemas. These cultural artefacts and belief systems are maintained through a system of reinforcing processes such as monitoring systems, audits, and supervision which strengthen the organisation's desired behaviours and allow the undesired ones to fade and extinguish. Thus, the enterprise of culture change within older people's inpatient services has many parallels with individual or family work; assessing and formulating the current position, defining the desired change, designing interventions and maintenance mechanisms, and facilitating their implementation. This framework provides the skeleton upon which many of the organisational aspects of the work of the inpatient psychologist can be hung.

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## References

An evidence-based framework for designing skills development to ensure maximum transfer into practice can be found on the Health Education England website within the PROMPT online tool. Further examples of the use of this change framework are included in the accompanying web resource.

Argyris, C. & Schon, D. (1996). *Organizational learning II*. Reading, Mass: Addison-Wesley.

Berwick, D. (2013). *A promise to learn – a commitment to act: Improving the safety of patients in England*, available at <http://www.gov.uk/government/publications/berwick-review-in-to-patient-safety>.

Department of Health (2015). *The NHS Constitution: The NHS belongs to us all*. London: The Stationery Office.

Emery, F. & Trist, E. (1973). *Toward a social ecology*. London: Plenum.

Evans, I. (2013). *How and why people change: Foundations of psychological therapy*. Oxford: Oxford University Press.

Hickman, G. & Crawford-Docherty, A. (2010). Ward C: A formulation-based service development programme. *PSIGE Newsletter*, 112, 46–54.

Luthans, F., Norman, S.M., Avolio, B.M. & Avey, J. (2008). The mediating role of psychological capital in the supportive organisational climate – employee performance relationship. *Journal of Organisational Behaviour*, 29, 219–238.

McKergow, M. & Clarke, J. (2005). *Positive approaches to change: Applications of solutions focus and appreciative inquiry at work*. Cheltenham: SolutionsBooks.

Menzies, I. (1975). A case study in the functioning of social systems as a defence against anxiety. In A. Colman & W. Bexton (Eds.) *Group relations reader* (pp.281–312). Sausalito, CA: Grex.

Mountain, A. & Davidson, C. (2011). *Working together: Organizational transactional analysis and business performance*. Farnham, Surrey: Gower Publishing Ltd.

NHS Institute for Innovation and Improvement. (2007). *Improvement leaders' guide: Personal and organisational development – building and nurturing an improvement culture*. Coventry:

NHS Institute for Innovation and Improvement.

Perkins, R., Hill, L., Daley, S., Chappell, M. & Rennison, J. (2016). *Continuing to be me: Recovering a life with a diagnosis of dementia*. Nottingham: ImROC.

Rafferty, A., Philippou, J., Fitzpatrick J.M. & Ball, J. (2015). 'Culture of care' barometer: Report to NHS England on the development and validation of an instrument to measure 'culture of care' in NHS trusts. London: King's College London.

Schein, E. (1999). *Process consultation revisited: Building the helping relationship*. Reading, MA: Addison-Wesley.

Schein, E. (2010). *Organizational culture and leadership*. San Francisco, CA: Jossey-Bass.

Shaw, C., McCormack, B. & Hughes, C.M. (2016). Prescribing of psychoactive drugs for older people in nursing homes: An analysis of treatment culture. *Drugs – Real World Outcomes*, 3(1), 121–130.

Slade, M. (2013). *100 Ways to support recovery: A guide for mental health professionals*. London: Rethink.

Tate, L., Donaldson-Feilder, E., Teoh, K., Hug, B. & Everest, G. (Eds.) (2014). *Implementing culture change within the NHS: Contributions from occupational psychology*. Leicester: British Psychological Society.

Weisbord, M. (1987). *Productive workplaces: Organizing and managing for dignity, meaning and community*. San Francisco, CA: Jossey-Bass.

Weisbord, M. (1989). Re-designing non-routine work: The key is involving more people sooner. *Productive Workplaces*, 1, 1–4.

## Chapter 7: Psychological harm

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Our aim for this chapter is to raise the profile of psychological harm for all who use the services we work in. We start from the premise that a psychologically healthy workforce is needed in order to provide safe care. We have selected frameworks that help make sense of the work environment so that you can articulate problems and suggest solutions. We have not detailed how to respond to harm when it occurs but encourage you to look into this, particularly as some experiences, such as being sectioned under Mental Health Legislation are common and potentially traumatic. We have looked to concepts of harm in other 'high hazard' workplaces as well as healthcare. Failures in care are more likely when the best approach remains uncertain and multiple professionals are involved in the care provided (Runciman et al., 2007): we hope that this chapter helps you and your teams to think through the uncertainty you have to deal with in a more coherent and informed way.

We have specifically focused on those elements that we have found important in older people's mental health services. This quote is worth repeating in full, replacing 'customers' with 'patients':

*'It has been recognised that there are unique risk factors associated with providing customer services [e.g. in] ... healthcare. In this type of work the expectations and behaviour of customers represent an additional source of work demands. The self-control required to manage emotions when dealing with difficult situations results in what researchers call 'emotional work' and may cause strain for employees. In addition to the strain of emotional work, customer behaviours that threaten employees' sense of control or self-esteem, which prevent employees from developing good relations with their customers and/or which make employees feel insecure during interactions with their customers are important sources of stress. These situations tend to deplete the individual's personal resources, and emotional exhaustion, job dissatisfaction and ill health can result.'* (Dollard et al., 2003).



Traditional definitions of psychological harm often focus on actively abusive harm. These are important but enable us to separate ourselves from the potential to be part of this dy-

namic. Harm also occurs in other ways and care can be experienced as potentially hurtful or abandoning, preventing access to significant others, humiliating, blaming, controlling, and intimidating. It often includes isolation, and reduced access to support networks, all of which can contribute to psychological harm (NHS Choices, 2017). This may be compounded by the beliefs of patients, staff and families that restrict their dignity and self-efficacy. For example, believing that they cannot leave the ward despite being an informal patient or being excluded from decision-making about their own care/omitting to place value on the patient's own views of the situation. Harm may be mundane or catastrophic and acts of omission, delays and inconveniences can all have a significant impact on wellbeing (Runciman et al., 2007).

It is important to note that *'Iatrogenic harm is the natural outcome of the way healthcare is designed and delivered. Indeed, the healthcare system has not really been designed at all, but instead evolved haphazardly over time, and continues to do so'* (Runciman et al., 2007, p.65). Iatrogenic harm is not limited to the patient or staff groups. It can cause very real harm to the self-efficacy, hopefulness and wellbeing of the families and people that are close to them. And it is important to note that there is emerging evidence that psychological interventions can also be a source of iatrogenic harm, even when interventions are carried out appropriately (Crawford et al., 2016).

Psychological harm can be caused by and occur in the ward team, patients, visitors and members of the wider organisation. It is a significant enough problem that the Australian government has produced guidance on strategies to reduce the risk of this type of harm (see Comcare, 2008). Yet psychologists, and healthcare staff in general, are not necessarily familiar with these models or frameworks. We are familiar with clinical models of distress and fundamental human processes but other 'high hazard' industries deal regularly with how to organise work based systems to support the psychological wellbeing of those who use them. In clinical settings we are often good at reacting to signs of distress but this can distract us from noticing systems that seem designed to create it. A prime example of this might be the impact on health and wellbeing of people who regularly work through the night.

A helpful broad overview is provided in the Institute of Occupational Safety and Health (IOSH) guide *Promoting a positive culture: A guide to health and safety culture* (IOSH, 2015), which outlines an overview of the foundations of 'positive safety culture' and ways in which to improve it.

The IOSH model is made up of three parts; working environment, systems management, and people and organisation (Figure 1). It is important to remember that 'people and organisation' covers patients, team members and visitors and, although there are often specific issues for each group, there are enough commonalities that we have grouped them together. Often the experience of one group is mirrored in the experience of the other. Team members who are new or only periodically work on the ward, visitors, staff who respond to emergencies and then leave, and patients who stay for a very short time may be particularly vulnerable as they have less opportunity to share those experiences with other members of the group or to develop relationships which support help seeking.

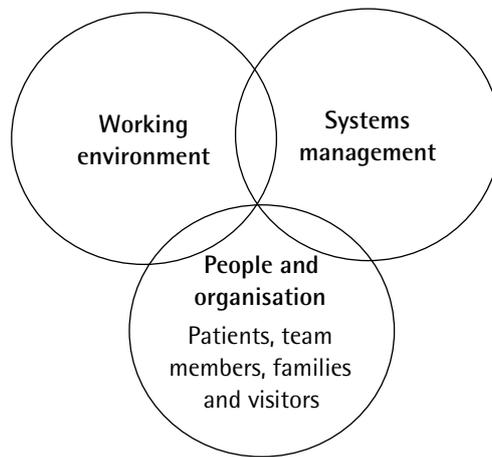


Figure 1: Health and safety risk management: managing the risks associated with interactions between the working environment, the management systems, the organisation and its people, (IOSH, 2015).

Table 1 articulates some of the factors in each area that are worth considering. Obviously, the divide is arbitrary at times but it highlights the broad range of factors that might contribute to situations that lead to harm, in order to begin to address them.

The Australian government (COMCARE, 2008) make another useful distinction in the difference between harm from the work *context* and the work *content*. The content is inevitably interspersed with high emotion, precarious relational interactions, making decisions in fast paced, uncertain and hazardous situations, shift working and unsociable hours. But the context (covered in Table 2) does not need to exacerbate this. Too often in mental health care, especially in acute care, the two are conflated and the distress perceived as inevitable. This stops people noting what could be changed and removes a sense of agency which is in itself damaging. Issues of work context as outlined in Table 2 are very open to change and we all contribute to how those contextual factors are implemented. Up front conversations about the items in this table can help to quickly address some of the factors and increase the team's sense of agency. The following advice from the IOSH highlights the need for practical guidance around working practices that is articulated in behavioural terms and many of the contributors to the development of this guidance have also commented on the need to be explicit about what actions and behaviours are needed to achieve ethical and compassionate care.

*'It's hard to change the attitudes and beliefs of a workforce by direct persuasion, but by acting safely workers can start to think safely. This belief has led to the development of 'behavioural safety' approaches. Remember that culture often develops slowly, and that fundamental change requires time.'* (IOSH, 2015).

It's also important not to be complacent as the risk of harm is ever-changing. Teams that have received positive feedback can miss signs that their culture is changing. *'Abuse and neglect can occur in many types of institution, including those that seem to provide high-quality care to patients. A key finding from an examination of inquiries into scandals in residential care suggested that an acceptable or good regime of care could be transformed into an abusive one relatively easily and quickly, with little detectable change in the outward situation'* (Clough, 1999). And whilst compliments are hugely important, they can also be an acknowledgement of good care 'in spite of' the evident problems in a ward (Runciman et al., 2007).

Table 1: Mapping the IOSH model to older people's inpatient services.

Working environment
<ul style="list-style-type: none"> <li>■ Overcrowding.</li> <li>■ Lack of privacy.</li> <li>■ Lack of purposeful and rewarding activities/inadequate sensory stimulation.</li> <li>■ Noise.</li> <li>■ Financial restraints.</li> <li>■ Physical restraints (e.g. locked ward).</li> <li>■ Unpredictable or aggressive behaviour of others in the environment.</li> <li>■ Challenging narrative in the media.</li> <li>■ A clinical environment where multiple and often long-term medical issues mean there is little hope of a 'cure' and therefore 'heroic' interventions are unwarranted and gratification at a 'job well done' is more subtle.</li> </ul>
Systems management
<ul style="list-style-type: none"> <li>■ Erosion of individuality in care.</li> <li>■ Inadequate nutrition.</li> <li>■ Use of restraints.</li> <li>■ Low status given to working with older people.</li> <li>■ Information not being readily available to support understanding and choice.</li> <li>■ Supportive others not having easy access to the patient.</li> <li>■ Pressure from outside sources.</li> <li>■ Changing structures and pathways.</li> <li>■ Is there an agreed 'limit' to workload/stress/flow etc. as there is in other high hazard industries? Who is this communicated to and is a response guaranteed?</li> <li>■ The degree to which risk management and recovery are balanced/promoted.</li> <li>■ Lack of or inadequate training.</li> <li>■ Degree to which mandatory elements of the work day e.g. 'paperwork', are perceived as supportive of the individual's ability to provide good care.</li> <li>■ The organisation's approach to booking leave and rotas and the amount of control that the individual has over this (and the impact on ability to attend training).</li> </ul>
People and organisation
<p>The following factors apply to all the people who work in, use or visit our services.</p> <ul style="list-style-type: none"> <li>■ Intimidating meetings where people are pushed into accepting certain actions.</li> <li>■ A sense that patience has run out with the progress being made.</li> <li>■ Building a culture of relational security (e.g. through staff training, reflective practice groups, ward round, influencing management processes, role modelling).</li> <li>■ Inadequate attention given to individuals' identity, development, needs etc. and little time given to reflect and heal.</li> <li>■ Intergroup conflict – 'us and them' across professions, professions and patients, managers and clinicians. Groups often hold positive views of themselves at the expense of belittling the outgroup, particularly when one or more group/s feel under threat.</li> <li>■ Disgust: there are often situations that can trigger this reaction in everyone who uses and visits the ward. Disgust has been shown to have 'strong moral content' on a cognitive level, which when left unmanaged can easily become disdain.</li> <li>■ Conflicting social values/ageist beliefs/confronted by fears of own ageing and morbidity.</li> <li>■ Fatigue.</li> <li>■ Feeling undervalued.</li> <li>■ Loss of control – helplessness and frustration.</li> <li>■ Misuse of power to encourage passivity.</li> <li>■ Not being meaningfully involved in intervention or discharge plans.</li> <li>■ Exposure to traumatic events. The ripple effect and loss of a necessary sense of safety for everyone can be destructive.</li> </ul>

Table 2: Work context and associated risk factors for psychological harm (COMCARE, 2008).

Working context	Risk factors
Organisational culture and function	Poor communication, low levels of support for problem solving and personal development, lack of definition or organisational objectives.
Role in organisation	Role ambiguity and role conflict, responsibility for people.
Career development	Career stagnation and uncertainty, under-promotion or over-promotion, poor pay, job insecurity, low social value to work.
Decision latitude/control	Low participation in decision-making, lack of control over work (control, particularly in the form of participation, is also a context and wider organisational issue).
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors. Interpersonal conflict (including harassment and bullying), lack of social support.
Customer related	The need to hide negative emotions during interactions with clients/customers, unrealistic customer expectations, and/or verbally aggressive clients/customers.
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems.

The Health and Safety Executive (HSE, 2009) cites strong evidence linking risk factors associated with demands, control and support to health outcomes. This links to employee health but could just as usefully be considered with patients and families.

- **Demands** – Workload, work patterns and working environment; Pressure to get well, accept multiple interventions, or negotiate relationships with multiple new people.
- **Control** – How much say the person has in the way that they meet those demands. This can be very obvious for people who are held under mental health legislation but subtly pervasive for many other people within the service.
- **Support** – The encouragement, sponsorship and resources provided by the organisation and peers for example.

Distress is associated with facing demands and expectations that are beyond the person’s skills, abilities and coping strategies. Acute stressors are often more immediately obvious but chronic stressors, whilst often overlooked, are pernicious. Taking the number of psychological injury claims as an indicator of the degree of damage done, it is the interaction of a number of factors over six months or more that causes the most psychological harm (COMCARE, 2008).

The impact of pressure on staff, patients and visitors cannot be overstated. 50 per cent of psychological injury claims come from workplace pressure (COMCARE, 2008). That pressure then becomes inherent in the system. Staff pressured to meet expectations that they feel unable to fulfil will struggle to keep that pressure from having an impact on their colleagues and patients. Pressure to be able to provide a bed for everyone that needs one means pressure to discharge someone else. When we asked during our initial consultation event about psychological harm, we heard about staff hiding in the office and patients and families not receiving a proper welcome to the ward. Ultimately this invalidates the people who come into contact with the ward at a time when they are often at their least resilient.

It's easy to think about how others inflict this on us and the teams we work in. It's less comfortable to think about how we might also be contributing to those factors. We have all certainly fallen into this; do take time to think about the way you might be either passing on your own stress or undermining team members in one of these areas (however important your end goal is). Plan for the outcome of the assessments you do especially if it is likely to be negative: how will this be communicated safely and by whom and what support will be put in place to enable people to move forward constructively?

## Taking things forward

Noticing these factors in your workplace is one thing. Having the confidence to work towards addressing them relies on a number of factors; your own resilience, the support provided by your networks, the clarity of your role in the service, and understanding the evidence base to help your thinking and conversations.

There is increasing scope to talk to your team about the opportunities to actively measure harm and acknowledge that harm can occur despite benign intentions. Duty of Candour legislation can be used to support this discussion and using emerging outcome measures of harm, and including harm indicators in service audit, evaluation and research is key to putting harm firmly on the agenda.

Make sure you have a supportive peer group and substantial links with operational or professional leads as outlined in other chapters so that you have somewhere to discuss any concerns. It is important that you are not isolated and can work with others to understand and address any broader issues. It also ensures that you are not rushed into acting unsafely and that the roles of other people in keeping the environment safe are reinforced.

Access to relevant knowledge has a vital role in keeping an organisation healthy (Runciman et al., 2007) and you can play a strong part in this. Interpret publications, organisational data, and clinical information. Help people make sense of what is happening, including gathering new information, and suggest ways of keeping things psychologically sound. Find and model safe ways of exploring complaints and asking for genuine feedback so that stories of harm can be heard and *acted on*.

Healthcare systems revolve around people – understanding people is your profession. Don't forget all the models of human experience, stress, coping, groups etc. that you learnt in your undergraduate degree. Support other people to make sense of their own and others' distress. In this way you can help work out which situations are concerning but can be dealt with within the team and which are serious enough to need raising more formally, including to people outside of the service.

Linked to this, support the organisation and your team to think about how organisational language might be received by the people who have been harmed. Martin, Chew and Palsler (2017) warn about (organisationally) useful analytical terms such as moderate and low harm being assumed to also represent a patient's experience. Your psychological skills will help the team and patient bridge those potential gaps in both understanding and experience and potentially prevent further harm being done.

Psychologists also have a key role in understanding and facilitating teams' decision-making and it might be useful at this point to look at the table in chapter 1 outlining suggested levels of responsibility for psychologists. When you consider that 'more than half the harm caused by healthcare results from a failure to deliver appropriate care or deciding on courses of action which are inappropriate' (Runciman et al., 2007) it becomes clear that this is an important but often unnoticed part of how things can go wrong. You understand the cognitive and emotional elements of decision-making; have the confidence to name when this might be going astray.

One of the most direct things you can do is to become comfortable with your role as a clinical leader in a way that is appropriate to your setting and your role. The HSE include the presence of an effective ('supportive') leader as itself a factor in reducing the likelihood of psychological injury, as well as increasing performance and productivity (Cotton & Hart 2003). The Healthcare Leadership Model produced by the NHS Leadership Academy (2013) has been mapped to the different bands of applied psychologist and is built on the observable behaviours through which leaders demonstrate ethical and value driven practice (Dexter-Smith et al., 2015). The Scottish Model of Healthcare Leadership (NES, 2014) also outlines the behaviours and 'personal qualities' that contribute to 'service excellence' and is worth becoming familiar with.

And when harm is done, support the team to maintain good communication with each other and the patient/family to ensure that further harm is not done in the aftermath, either to the people directly involved or the others who have witnessed the event. Knowing the team well, will help you find ways of learning from mistakes and hearing concerns in such a way that you can safely, not reactively, respond to it.

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## References

- Clough, R. (1999). Scandalous care: interpreting public inquiry reports of scandals in residential care. In F. Glendenning & P. Kingston (Eds.) *Elder abuse and neglect in residential settings: Different national backgrounds and similar responses* (pp.13–28). Binghamton, NY: Haworth Press. Cited in World Health Organisation, World Report on violence and health, chapter 5 (2002). Geneva: WHO.
- Comcare. (2008). *Working well: An organisational approach to preventing psychological injury*. Canberra: Author. [www.comcare.gov.au](http://www.comcare.gov.au)
- Cotton, P. & Hart, P.M. (2003). Occupational wellbeing and performance: A review of organisational health research. *Australian Psychologist*, 38(1), 118–127.
- Crawford, M.J., Thana, L., Farqharon, L. et al. (2016). Patient experience of negative effects of psychological treatment; results of a national survey. *The British Journal of Psychiatry*, 208(3), 260–265.
- Dexter-Smith, S., Oddy, J. & Cate, T. (2015). Leadership Profiles for Applied Psychologists: Mapping the Leadership Academy's Healthcare Leadership Model. *Clinical Psychology Forum*, 276, 4–5. Also at <http://www.nelacademy.nhs.uk/healthcare-leadership-model>

- Dollard, M., Dormann, C., Boyd, C., Winefield, H. & Winefield, A. (2003). Unique aspects of stress in human service work. *Australian Psychologist*, 38(1), 84–91.
- HSE: Health and Safety Executive. (2009). *How to tackle work related stress: A guide for employers on making the management standards work*. Suffolk: HSE Books. <http://www.hse.gov.uk/pubns/indg430.pdf> retrieved February 2017.
- IOSH: Institute of Occupational Safety and Health (2015). *Promoting a positive culture: A guide to health and safety culture*. [ww.iosh.co.uk/freeguides](http://www.iosh.co.uk/freeguides).
- Martin, G.P., Chew, S. & Palser, T.R. (2017). The personal and the organisational perspective on iatrogenic harm: Bridging the gap through reconciliation processes. *BMJ Quality and Safety Online*. <http://qualitysafety.bmj.com/content/qhc/early/2017/07/26/bmjqs-2017-006914.full.pdf>
- NHS Choices. (2017). Retrieved 25 January 2017 from <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/vulnerable-people-abuse-safeguarding.aspx>. NHS Education Scotland (NES) (2014). NHS Scotland Leadership Qualities Framework. [http://www.nes.scot.nhs.uk/media/3399300/scottish\\_leadership\\_qualities\\_framework\\_-\\_guidance\\_notes\\_july\\_2014\\_-\\_copy.pdf](http://www.nes.scot.nhs.uk/media/3399300/scottish_leadership_qualities_framework_-_guidance_notes_july_2014_-_copy.pdf) (accessed 10 August 2017).
- NHS Leadership Academy. (2013). Healthcare Leadership Model. <https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/> accessed 14 August 2017
- Runciman, B., Merry, A. & Walton M. (2007). *Safety and ethics in healthcare: A guide to getting it right*. London: Ashgate Publishing.

# Chapter 8: Tips from the coalface

## Introduction

The role of a psychologist in an inpatient setting can be very different to working in the community. Whilst the aims of reducing distress and increasing psychological thinking are similar, being within a largely medical team presents different challenges.

We asked colleagues working in inpatient services across the UK what they wished they had known when they started their work in inpatient services. The request was an open one and went out through existing groups and social media. The chapter is intended to be read in the spirit of messages of support and guidance from colleagues in similar services and we are grateful to colleagues for the response we received. The comments we received are presented verbatim to retain the intent of the sender.

Three core themes emerged:

1. Relationships with colleagues.
2. How to be effective in your role: what does and doesn't help.
3. Self-care and resilience.

Themed, verbatim responses are available in the online resources.



## Relationships with colleagues

Build effective working relationships. If this is the only rule of thumb you follow when working in inpatients you will be effective, enjoy your role more and maintain your own and others' resilience. Build constructive, respectful relationships with colleagues of all levels, patients and carers alike.

Ward teams can be very close given the time they work side by side in a highly emotive environment; you never know where relationships lie and who will talk to whom. The more effective your relationships, the more likely your aspirations will filter through and become permanent.

Foster strong personal relationships with colleagues that allow you to focus on a client's needs and to sustain differences of opinion. There is an ideal emotional distance to aim towards with colleagues. Relationships that become too close are vulnerable to instability and an overemphasised personal component is not always conducive to objective reasoned debates about clinical issues.

Be aware of tribal loyalties; your actions have both a clinical and a political impact. If you are a lone psychologist then your advantage is that you are less threatening and can be an associate member of every other tribe.

Don't make your only interactions clinical ones, ensure you get to know colleagues as people first.

Take time to understand your colleagues' roles and their experiences. For example, support workers spend the most time with and know the patients really well. They can also be present during very stressful times on the wards. Offer your support and take time to value their experience.

Nurses have multiple duties on wards; one frustration can be the amount of paperwork they have which reduces their face-to-face contact. Again, value their knowledge and experience, be sensitive to the pressures of their role and highlight how your work can help them.

Understand what provokes anxiety in team members e.g. increasing workload or being made responsible for something that might go wrong. The first sign is often a focus on short-term and 'concrete' (typically medical) tasks, probably in an attempt to create a sense of control. MDT meetings become like a ward round in an acute hospital and the patient as a person can get quite lost. Look closely at what might be going on in the system and think of ways to support the team.

Enthuse your colleagues; they can feel disempowered by the system and many additional responsibilities which may detract from therapeutic contact or innovative practice.

Psychiatrists often have the pressure of leading clinically on the patient's care. Get to know their professional preferences and concerns. Respect their expertise, and recognise that psychiatry and psychology can build an effective synergy to treatment.

Operational colleagues are increasingly open to the importance of good psychological care. It's much easier to effect change if you are working with the support of the operation-

al team, so spend time finding out what problems they need to solve and show them what psychology can offer in relation to these.

Get a balance between being objective and part of the team. A psychologist's systemic view is what enables change to drive quality in care, so becoming too engrained in the ward may inhibit this. You might not be everyone's friend all of the time, especially when you are challenging a method of practice which has been habitual, but if you have built solid working relationships this makes the seas of change a little less rocky.

Make sure your values are transparent and consistent in your various relationships. People may not always agree with you but they will respect you and allow you to challenge them (and importantly, feel able to challenge you).

The more effective your working relationships, the more you can maintain your resilience, as you are nurturing a caring and cared for reciprocal way of relating, which is extremely important on those days where the wards may be particularly challenging.

### What helps?

To change the culture of a system takes a minimum of 2 years. Give yourself and colleagues time and note each success.

Humour is a good tool to defuse tension.

Remember the power and importance of being able to say I don't know. No-one expects that you will know everything – people are admitted because their difficulties are so complex that community treatment has failed. It's really important to be able to discuss the need to do nothing sometimes so that inappropriate treatments are not attempted when there is no obvious way forward.

Try talking and behaving as though the world is already the way you would like it to be. Talk to people with whom you would like to have a respectful collegiate working relationship as though you already do. Talk to managers and strategists as though you are expecting them to have an interest in what you say – i.e. model the solution.

More than any other setting, your personal and professional reputation is paramount. There are a huge and diverse group of colleagues, most of which will have to form opinions about you based on limited first-hand contact. Take time to make sure you always behave in a way you would be proud for anyone to see.

Be flexible in your approach to client work. Consider therapeutic conversations with patients as important as, or more important even, than therapy as such. Recognise 'moments' that are significant/informative/important, rather than using models where you have 'sessions' of up to an hour. Don't expect people to give you all the information you need; challenge stories about individuals, read old notes, have lots of conversations, look for what's missing and be prepared for meetings to go in directions you haven't anticipated.

Providing a psychological formulation for several patients as opposed to several sessions with one patient can increase your input and offer something useful to more people, rather than the gold standard to fewer people.



Just as in therapy, the team need to own the approach or model that you are using. The nursing team often have a much better understanding of good psychological care and a greater personal commitment to holistic care than it might appear – help them utilise this.

Ask questions about all the medical and physical health care you don't understand – it's a real education which will help you to make better assessments of your patients and shows that you credit others' knowledge and models others to reciprocate curiosity.

Psychology input may be novel to some ward teams. Be clear in what your role involves. Becoming credible can be achieved by doing a piece of work with a patient and sharing this with the team. An early win can be very useful. You can be a powerful asset and resource to colleagues who use you appropriately. By demonstrating how you can help colleagues you make it apparent to other members of the team how you can help them.

Muck in and be present – help colleagues, make cups of tea, offer support, don't be a bystander if there is an incident. Visibility leads to accessibility; a great quality to develop in improving the psychological impact of your work.

Attend MDT meetings. You can impact multiple patients' care in a short period of time, will understand others' assessment methods and outcomes, and integrate into the team more effectively.

It is useful to be aware of stereotypes regarding psychologists which you may encounter. Counter stereotypes by consciously demonstrating positive values in the direction opposite to that predicted by the stereotype.

Challenge where appropriate. Psychologists often bring a different perspective and this is crucial to patients receiving person centred care, so ensure your focus is the patients' care and offer a different perspective when necessary. Be patient, push where it moves and recognise the intense and rapidly changing dynamics on wards in a context of very limited resources.

Offer training – there are lots of opportunities to enhance the knowledge of the team in psychology and this is often requested. Running training on wards can be a challenge; be flexible, offer shorter sessions at times that work around the ward schedule.

The word 'supervision' means different things in different professions. When you offer supervision, ensure there is a shared understanding of what you are offering.

Know your policies and guidelines and provide a clinical rationale to your recommendations. This can be very effective if you're driving change or challenging a suggested treatment.

Recognise where your competencies lie and how these can be utilised by other disciplines. Also know your limitations and ask your colleagues from other disciplines for their advice.

If you are not based on the ward itself, but enter it and exit it, be sensitive to this and what it might feel like to others who are not free to do this (patients and other members of the team) at the times they wish, or for those detained.

One way to approach the perception that diagnosis is explanatory (and bring others on board) is to frame diagnosis as part of the assessment that then leads into formulation which is about creating hypotheses based on patient need and admission goals.

When considering change, Prochaska and Clemente's stages of change model is a useful reference point. Ask yourself questions such as i) is the team ready to take on board a change in the way they collect/record data or to shift to a more obviously bio-psycho-social model? ii) If not, what might be helpful in terms of bringing about readiness in terms of scaffolding and support.

Where a team are accustomed to working within a medical model they can feel anxious and under-confident about implementing a more psychological approach not least because it can trigger difficult personal emotions precipitated by a more self-reflective response. Taking time to support colleagues individually or more practically setting up reflective practice groups can be invaluable. Even though we know that to formulate in a more bio-psycho-social way is good practice, anxieties of individual team members can get in the way of this becoming a reality.

Be confident in your discipline, you are championing psychology and you need to fly the flag for what psychology can offer. Psychologists understand formulation, relationships, group dynamics, effects of stress at work, reflective practice, emotional containment, and debriefing. Make sure others know this repertoire of skills you could offer.

Be mindful and sensitive to different needs and how others identify themselves; single sex wards can assume various prejudices in gender identity and sexual orientation.

For a team to work psychologically, significant psychology time needs to be invested. Use the national guidance available to you to highlight why this matters, and point out the

problems of only providing reactive, rather than dedicated, psychology input to the team e.g. increased length of stay, increased use of antipsychotics and so on. Don't just be grateful for being given any time on the ward, regardless of how limited it is. Make sure you and key others are realistic in what you can offer in the time that's funded.

Join FPOP! There are a bunch of supportive, similarly minded professionals out there, along with useful documents and a bulletin that you can draw on in everyday work.

Develop some sort of record (e.g. a ladder or diary) so that you can record the small gains that you notice and their relevance and hold on to them at times when you (and others) feel overwhelmed by the scale of the task. Consider sharing this with others so that there is a degree of transparency about your role and the master plan!

The intensity and bubble-like nature about inpatient work can make it easier to be sucked into the existing culture of underlying assumptions/espoused beliefs and values than in other teams. Make time to step back (escape the shared office for a coffee or a walk outside at least once a day). Place yourself in a formulation of what's happening on the ward. Regular supervision to assist you in this is essential. In your formulation include who is and is not being given space to be heard: patients, carers, professional groups etc.

Recognise that some/much of the work you do will not look like what you've been trained to do. It doesn't make it less valid. Brief doesn't have to mean 'quick and dirty'. Drawing out the theory-practice links in your thinking/actions will ensure that you stay true to your professional training and practice guidelines.

Do offer therapeutic interventions. These short interventions can act as a taster of what is possible and provide a useful springboard for later interventions.

### What doesn't help?

Do not silo work. Working in a uni-disciplinary way will not work. Your colleagues will not understand your work, you will not be adjusting your approach to what other disciplines are doing and the service the patient receives will be inconsistent and lack quality.

Be cautious about having a formal referral process and try and promote a conversation. This often develops into more of a consultation and you can decipher whether direct work with a patient is appropriate. Promoting conversations will allow you to educate your colleagues around what is most appropriate for psychology. Attendance in MDT meetings can be useful in this regard as you will hear an overview of the patients and recognise those who may benefit from psychology.

Don't be shy about using your title of Doctor. You might find that Junior Doctors call you Doctor and you are introduced as such in meetings with families. These dynamics can be helpful in highlighting the prominence of psychology in inpatient work and your input may be heard more as a consequence. However, be aware of power dynamics within the team and the way your own actions affect how you are perceived. These may include subtle hierarchies such as clothes worn, accepted seating arrangements in meetings or whether you are referred to as Doctor. Realise a balance between respecting yourself and your profession with confidence, being down-to-earth and practical, and not overreacting to perceived slights in a hypersensitive way.

Challenge but don't argue. Be patient and model emotional regulation and appreciative styles of communication to your colleagues and patients. Instead of public confrontation it is often more effective to speak to individuals in private where they won't feel humiliated or threatened and likely safer to express their true fears or thoughts behind clinical decision-making.

Do not see psychiatry as the villain. It is not. More and more trainee psychiatrists are requesting supervision from clinical psychologists to improve their knowledge of psychological models and thinking. A respectful working relationship will enable true MDT working and this is when the patient really benefits.

Don't try to do everything at once. Inpatient work can be overwhelming with how much you might want to support and take on; see pieces of work through to the end rather than having too many open ended projects.

Don't rush in without thinking through the support needed to follow through with a project. Nurture colleagues adequately and understand the barriers they face before you challenge their practice. Techniques like dementia care mapping can be experienced as punitive if the team experiences the exercise as highly critical and doesn't feel it is empowered or resourced to change.

Don't rely on other people to record what you mean in the notes. Other colleagues might not be familiar with the distinctions we make and the wording of what you intended might be very important.

### Tips from our service user consultation group

'It can be daunting and frightening when you are first admitted and you can feel separated from your normal self.' 'It really helps if staff can take time to know you as an individual. I would have liked to be able to talk to a member of staff every day.' Make sure that you support staff to be able to help people who are in distress to begin to rebuild a meaningful sense of who they are and who they want to be. This isn't always easy when distress levels are high for various people within the service (ourselves included sometimes) but it is the foundation of what a psychologically health ward should facilitate.

'The most helpful input is one-to-one'. Don't let the administrative processes and procedures cause you to lose sight of the importance of building relationships in person; with patients, their families and your colleagues.

'I would have liked to learn how to get around problems.' This probably applies to everyone on the ward. Don't get so hung up on feeling the need to produce some very detailed 'big' intervention that you fail to offer the low level, basic psychological input and advice that can help people feel contained and show them a possible first step towards a way forward.

Patients felt that people staying on an older people's mental health ward should have access to a clinical psychologist.

*'It's a better feeling altogether when you see a psychologist.'*

*'I would have liked to see a psychologist to discuss issues at the time.'*

*'It would be useful to have dedicated psychology time, and that it would be helpful for psychologists to model good practice and offer training to support with the pressures facing front line staff.'*

Use comments like this to remind those around you of the need for psychological input to the wards and the positive reaction from patients. Don't be shy about promoting the good work you are doing and pointing to the people who value it.

Help the team to think about how to support families to make the best use of their time on the ward to maintain the relationships that support the person's wellbeing, identity and role. Consider the preferred style of visiting (private room/public area/outside) and remember that many families will feel anxiety when preparing to visit an inpatient unit. This may be related to their relative's distress but also fear of the unknown environment. Building up family trust is important.

### **Self-care and resilience**

Inherently, every inpatient has been deemed too unwell to be helped to recover with standard community interventions. Therefore, anticipate feelings of impotence when you approach clinical work. Though much is possible, it is an area that can lack clear empirically defined guidance and therefore requires practical and innovative application of valid knowledge and principles.

Ensure you have clinical supervision with a supervisor who is a specialist in your area and has an understanding of inpatient work. You will likely take more of a supportive role to team members, so regular clinical supervision is crucial to maintaining your wellbeing and confidence.

Keep in touch with your local network of psychologists and peer professional development networks. The supportive and different points of view offered are invaluable in maintaining your identity and enthusiasm and can be a cathartic forum to offload!

Remain reflective and take time to understand how the distress present on the ward is impacting on you. Additionally, acknowledging feelings of frustration can prevent you acting on those impulses.

We can be great at looking after others but self-care is crucial in being effective, so nurture interests outside of work.

Finally, take time to enjoy it. Inpatient work is an area where many of us have been part of significant positive change and been able to work creatively to demonstrate the value of our profession. So can you.

### **Leila Eccles**

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