



Advancing Practice in Bedfordshire



Editorial Group: *Advancing Practice in Bedfordshire*

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Editorial

by John Butler – Chair of Editorial Group

As someone who has spent the last few years promoting the practice of psychosocial interventions (PSI), I am particularly pleased to introduce two examples of practice contributions within this edition: Kelly Perkins and Carolyn Martinez discuss their planning and implementation of a carers education and support group programme within the community mental health setting; Verone John reflects upon her initial practice of PSI with a service-user in the Assertive Outreach setting, enabling the service-user to achieve and realise change as an outcome of a structured, focused and collaborative approach. At a time when the Trust is promoting a greater emphasis upon the provision of talking approaches, as shown by the forthcoming establishment of the Centre of Talking Therapies, my hope is that their work will encourage and inspire others to both move forward their own practice and share their experiences.

To complement this work, I am pleased to introduce a second paper from a guest contributor, Bruce Wallace – this time providing a thought-provoking review of the literature on the impact of service-user suicide on the healthcare professional. This is likely to strike a few cords with many practitioners, and especially with those who have direct experience. Complementing his review of the literature from the previous edition, Bockarie Sesay provides a summary of his qualitative exploration of working relationships at the interface between the Crisis Resolution and Home Treatment Team and the established Community Mental Health Teams. Through using a focus group approach, Bockarie perhaps confirms many of the expected issues and identifies some potentially helpful solutions aimed at achieving more effective team working and practice – the challenge is now the implementation of change, in the context of a more efficient pathway through care.

To complete this edition, Terri Dorman provides a summary report of the recent Trust Conference on positive interventions for those with Autism Spectrum Disorder, Bernie Harrison summarises the policy guidance on changes to the Care Programme Approach, and Daisy Bogg offers some initial thoughts on personalisation in mental health care, in the context of new ways of working. Some of the work show-cased in this edition certainly connects with and demonstrates this important theme.

Promoting Positive Interventions with People who have Autism Spectrum Disorder: conference report

Terri Dorman

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Conference Report

Services for People who have a Learning Disability (SPLD) hosted a one day conference at Silsoe Conference Centre in Bedfordshire on Monday, 31st March 2008.

The opening address was given by Alison Davis, the Trust Chair-person, who welcomed around a hundred people to this exciting and informative event. Alison chaired the first part of the morning programme, which included an overview of the Autism Service currently provided within SPLD, further illustrated by two case presentations focusing on two individuals with very different needs who had been supported by the service.

Following the morning coffee break, Paul Groom, Commissioning Manager with Bedfordshire County Council, took the chair for the mid-morning session. Invited speakers from Autism Bedfordshire gave emotional presentations exploring the family viewpoint of those in receipt of services, and the support that they offer as an organisation to people who have Autism Spectrum Disorder and their families and carers.

As the second presentation for this part of the day, two representatives from The Liverpool Aspergers Team gave an overview of the team and the work they had been engaged in since the team was formed. The morning concluded with questions being put to all the morning presenters.





After lunch, conference delegates had the opportunity to participate in two seminar sessions. The three available seminar options included: Practical Approaches; the Liverpool Aspergers Team Workshop; and, Offending and Autism Spectrum Disorder.

The afternoon session was chaired by Dr Michael O'Rourke, Clinical Director of SPLD, during which a Vision for the Future presentation outlined the directions the Service could take in order to address the needs of people who have Autism Spectrum Disorder living within Bedfordshire, and in particular those people whose needs are not currently met by the Trust. Following the presentation, questions that had been put forward by conference delegates regarding future service provision, were put to the panel by Michael, who was joined by Paul Mullin, the Trust Chief Executive, who led the responses, inviting contribution from members of the audience where appropriate – *as shown in Table 1.*

Table 1: Q & A Session

Q	Who will provide training for the Police, Prison Staff and members of the local community?
A	<i>In order for us to fulfill our responsibilities regarding Valuing People this is a key part of our role. As a service we need to forge links with the Criminal Justice System and local communities in order for us to take this forward in conjunction with the Trust Learning and Development Department, and develop training programmes tailored to meet specific needs.</i>
Q	How will the Trust ensure there are coordinated care planning systems with the voluntary sector?
A	<i>This conference was the starting point for future working with Autism Bedfordshire and similar organisations. We promote the importance of Communication Passports and Life Plans and advocate these aids are used with individuals in all aspects of their life, where appropriate, in order that the person is supported in the way which makes sense to them. This will be further explored within the Autism Clinic, in order to set up robust person centred procedures.</i>
Q	How will the Trust support people who have Autism Spectrum Disorder but who do not have a learning disability?

A	<i>The future service discussed in the 'Vision for the Future' Presentation highlighted the areas of need. In order for a service to be developed by the Trust it has to be commissioned. The Bedfordshire Commissioning Manager agreed to take these issues back to the Primary Care Trust and Local Authority. However, if a person had Aspergers Syndrome and a mental health issue, they would be accessing mainstream Mental Health Services.</i>
Q	How will the Trust support people who have Autism Spectrum Disorder to access Acute Hospitals and Mental Health Services?
A	<i>We currently employ two Access to Acute nurses within Services for People who have a Learning Disability, one in Luton & Dunstable Hospital and one in Bedford Hospital. Their role is to support all people who have a learning disability to access acute care, be it an emergency situation, planned admission or out-patient appointment. In the Business Plan we have included plans to increase support within Primary Care and mainstream Mental Health Services. This will provide more support for carers and multi-disciplinary services, which will facilitate an increase in information and training packages specific to meet the needs of other professions, and ultimately support service users.</i>

Paul Mullin provided the closing address in which he summarised the day and concluded discussions regarding future service development, thanking all of the presenters and delegates.

The general feedback from the day was very positive, with several delegates making a request for an annual event.

The Incidence and Impact of Service User Suicide on Healthcare Staff: an exploration of the literature

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Literature Review

Abstract

Background: Healthcare professionals working primarily in mental health services may well encounter a service user who completes suicide at some point during their career. The impact of this experience on the member of staff may be significant and potentially compromise their ability to function effectively.

Aims and Objectives: To identify the incidence of professional carer experience of service user suicide, the impact of service user suicide on professional carers, and the training undertaken or recommended.

Methods: A range of databases were accessed and utilised, together with literature recommended by colleagues and contacts.

Results: Studies were limited in their number and focused mainly on medical practitioners. Some articles took the form of a case study. Professionals tended to reflect similar reactions to those seen in family and friends of a service user who completed suicide. In addition a number of 'professional' reactions were identified and explored.

Conclusions: The literature reflected an expectation that this group of people would be expected to support others but little evidence emerged of specific training aimed at preparing them for the impact that a service user suicide may have on them.

Introduction

The World Health Organisation estimated that the suicide rates have increased worldwide by 60% in the last 45 years and about one million people completed suicide in 2000, with 150,000 of these occurring in the countries that made up Europe. Within different countries the number of people completing suicide varies dependent on a variety of factors. An indication of the impact on specific countries can be seen in the selected examples for the year 2004, as shown in Table 1.

Table 1: Sample of countries and numbers of completed suicides in 2004

Country	Population	Nos. of Suicides	Rate per 100,000 of population
United States	302,000,000	32,439	10.74
Japan	128,000,000	32,325	25.25
United Kingdom	60,000,000	5,554	9.25
Australia	20,100,000	2,098	10.43
New Zealand	4,100,000	486	11.85

The countries outlined in Table 1, together with many others, have strived to address suicide as an area for the investment of resources to reduce the number of people who die by this means. The impact of suicide on survivors (see Table 4) is well documented in the literature and in many strategic documents there is also acknowledgement of the potential impact on many professional groups, notably police and paramedical services (Bennett et al 2004, Richards 2002). In his research into police involvement with both those who attempt or complete suicide, together with the role of frequently being required to inform survivors, Richards (2002) recommends training for all police cadets in an effort to prepare them for this possibility. The National Institute for Mental Health in England (NIMHE) in 2007 indicated that 25% of people who had completed suicide 'had had a registered contact with a police officer within three months of death', which is the same percentage as those who had been in contact with mental health services in the year before their death. Against this recognition it is surprising to note little acknowledgement within strategic plans of the need to prepare healthcare professionals for these experiences. Documents, such as those identified in Table 2, appear to identify the need for highly trained staff to deal with the impact of suicide on survivors (family, friends, significant others) but not the impact on professional colleagues.

The potential for service user suicide exists in a diverse range of healthcare situations but perhaps is most frequently associated with the area of mental health services. This statement recognises that some 70-75% of people do not present to any services, therefore it is the 25% of those who do that will encounter professional services. It has been reported that whilst the number of people who completed suicide whilst in a mental health unit has decreased to 154, as recorded in 2004, the number who have been in contact with mental health services prior to completed

suicide has increased (NIMHE 2007). The impact of suicide on survivors has been acknowledged in a wide range of reports and articles published worldwide for some considerable time. The American Association of Suicidology (2007) estimated that for every person who completed suicide there were six survivors, consisting primarily of family and friends. Although Hawton and Simkin (2006) indicated that one of these groups of survivors deeply affected are healthcare professionals, what is less apparent is how many of these survivors are healthcare professionals.

Table 2: Sample of countries and strategic documentation related to suicide

Department of Health - National Suicide Prevention Strategy for England	2002
Scottish Executive – Choose Life	2002
Health Service Executive (Ireland) – Reach Out	2005
Australian Government – National Suicide Prevention Strategy	1999
Department of Health & Human Services (US) – The Surgeon General’s Call to Action to Prevent Suicide	1999
Akita Prefectural Government (Japan) – Health Akita 21	2001
New Zealand Suicide Prevention Strategy	2006

Method

Literature was identified and accessed utilising a variety of databases, primarily electronic. In addition, material was suggested after contact was made with colleagues and individuals who had direct experience related to the topic area.

Key search terms including ‘suicide’, ‘professionals’, ‘healthcare’, ‘support’, ‘impact’ and ‘staff’ were utilised together with related terms in an effort to gather a cross section of relevant work. In an effort to both identify pertinent literature and ensure response within a reasonable time frame, a number of parameters were set, including:

1. Published in English or available in an English version.
2. Subject explored related to impact of suicide completion and involvement of healthcare professionals (doctors, nurses, therapists). In addition, related literature that informed some of the themes emerging (e.g. impact, training) was identified and included.
3. Documents and articles readily available without any significant delay or financial payment. This was identified as important to ensure that material utilised should be that which most practitioners could acquire reasonably easily if interested.

4. Use of keywords was utilised to identify material for appropriateness and consideration. These consisted of combinations involving the terms: suicide, staff, completion, committing, doctors, nurses, professionals.
5. Systems accessed and searched included CINHALL, MEDLINE, PsycINFO, ASSIA, NLH – Mental Health, Google, Google Scholar. A number of other sources were accessed utilising an ATHENS account. Additional material was suggested following contact with a number of people and colleagues.
6. In addition to this, strategic documents that identified key policy and practice developments were accessed and included as appropriate within the discussion.

Incidence of suicide in mental health services

The variation in incidence rates within the literature is marked. Ruskin (2004) indicates that 14-33% of psychiatric residents had experienced a service user on their caseload who completed suicide, whilst Foley and Kelly (2007) state that this applied to 50-70% of consultant psychiatrists. Wozny and Zinck (2007) indicate that approximately 25% of mental health professionals will experience a service user who completes suicide. Sakinofsky (2007) predicts that 50% of psychiatrists will experience such an event at least once during their career, closely mirroring the 51% revealed in a survey of 259 psychiatrists by Chemtob et al (1988). Alexander et al (2000), in their study of consultant psychiatrists, indicated that 68% of the respondents (n=247) had had a service user complete suicide. Shooter (2004) states that suicide is an 'occupational hazard' for psychiatrists. Studies that have included medical students within their research have identified an equally diverse range of figures. Pieters et al (2003) in their study (n=114) indicated that 30% of first year trainees had experience of a service user who completed suicide, similar to Ellis (1998) who indicated 33%. Yousaf (2002) cited 43%, Dewar et al (2000) 47% and Foley and Kelly 40-50%. Pilkinton and Etkin (2003) in their study introduce an additional element indicating that 61.4% of psychiatric residents have direct experience of suicide; 61% involving service users and 16.5% by a colleague, friend or relative. In addition to the above, a survey carried out by Hendin et al (2000) suggested that 'the loss of a patient to suicide is a common and traumatic experience for the treating psychiatrist... during a clinician's training, a particularly traumatic experience'.

Much of the literature identifying incidences has a focus orientated towards medical staff and in particular psychiatrists, both qualified and in training. Considerably less material is available on other healthcare

professional groups such as nurses and psychologists. Bromley (2000) in his paper indicated that 11% of psychology trainees had encountered a service user who completed suicide.

Hendin et al (2000), in their study of 26 therapists (21 of whom were psychiatrists) representing a range of healthcare professionals, indicated that 81% of them had treated someone who completed suicide. Linke et al (2002) in their study indicated a figure of 86% for staff who were primarily nurses and social workers. Walmsley (2003) indicates in his article that a ‘typical’ crisis team may be involved in up to a dozen attempted or completed suicides by service users each year. Akechi et al (2003) indicated that nurses encountering suicide on a ward was ‘practically inevitable’, being further supported in an article by Bohan and Doyle (2008) who stated that a staff nurse working in an acute mental health setting had a high chance of encountering a service user who attempted or completed suicide.

Table 3: Risk of health and social care professionals encountering a service-user who subsequently completes suicide

Professional Groups	Incidence of suicide encountered
Consultant psychiatrists	50-70%
Psychiatrists	33-80%
Medical students	14-61%
*Mental health nurses	*50-86%
*Clinical psychologists	*81-86%
*Psychologist ‘trainees’	* 11%
* figures related to limited literature	

Impact

The literature identified a range of reactions generally similar to those found in family and friends of someone who has completed suicide. Plakun and Tillman (2005) state that ‘there is reason to believe that the impact of suicide on a psychiatrist or other mental health clinician is considerably greater than the impact of the death of a patient treated by other medical specialists’. Gordon (2002) in his exploration of secure mental health facilities acknowledged that the completed suicide of a service user had a potentially traumatic effect on all those involved, including the healthcare professionals caring for that person. Eagles et al (2001) suggested that the more predictable and potentially preventable suicide caused greatest distress to psychiatrists. McAdams III and Foster (2000) stated that the

completed suicide of a client resulted in significant emotional stress for counsellors. SIEC (2005) stated that the impact on many professionals is one of a 'significant sense of personal loss and considerable personal turmoil', and Ellis et al (1998) concluded that suicide is identified as the leading source of stress for mental health practitioners.

The impact on the healthcare practitioner is considered to consist of two groupings (see Table 4), one of which has been classified as 'personal' by a number of authors (Campbell & Fahy 2002, Linke et al 2002). These reactions include grief, sadness, shock and disbelief, sleep disturbance, anger and guilt. These reactions are seen to reflect those that would be expected in family members and friends of a person who had completed suicide.

Another group of reactions were classified as 'professional', as these were distinctly related to the professional and their role. These included an avoidance of service users perceived to be at risk (Linke et al 2002), shame, over-cautiousness with other service user's prescribing, self-doubt and increased use of mental health legislation. In addition, fear of litigation and reduction in referrals were noted.

Hodelet and Hughson (2001) indicated that although all staff are affected, those with the least professional training are vulnerable to poor outcome. They also raise the issue of potential disruption within the staff group with some valued members considering the option of leaving the profession. Heydt and Potschigmann (1989) in their survey of 40 nurses identified a wish for better training and to improve their own ability to handle feelings of inadequacy and guilt. Valente and Saunders (2002) in their exploration of literature related to the nurse's reactions to suicide identified the degree of grief and stress that occurred. Soreff (1975) added the additional variable of issues related to a nursing colleague completing suicide.

A number of articles explored the impact of suicide on healthcare professionals in the form of a case study or survey. Akechi et al (2003) explore the reaction of a nurse who discovered a service user who had completed suicide on a medical ward. Gitlin (1999) in a detailed case discussion of one doctor identified the marked impact the event had, particularly as it occurred early in the clinician's career. Biermann (2003) examined the reaction of a resident-in-training with a view to the

opportunity offered to learn and grow from the experience. Ellis et al (1998) indicate that suicide is identified as the leading source of stress for mental health practitioners.

Campbell and Fahy (2002), in their article, develop the theme to incorporate the psychiatrist's role after experiencing service user suicide, to other service users, staff and self.

Table 4: A summary of personal and professional reactions identified

Personal	Professional
Grief	Increase in use of legal restrictions
Shock and disbelief	Fear of litigation
Guilt and anger	Fear of loss of referrals
Crying	Changed relationships with colleagues
Sadness	Avoidance of clients considered to be at risk
Sleep disturbance	Professional self-doubt
Low mood, irritability	Consideration of early retirement
Withdrawal	Change in medication management
Isolation	Shame and embarrassment

Discussion

Much of the literature examined identifies the significant impact that completed suicide has on the healthcare practitioner. The identification of both personal and professional reactions to this event further signifies the need to consider how best to prepare practitioners for the possibility of this experience.

Glair-Gajewski (1993) identified that practitioners are sometimes reticent about talking about the experience and seeking help due to perceptions about their role and being in control, a view that is echoed by Hotelet and Hughson (2001) who indicated that this reticence might also be due to not wishing to burden a colleague. The organisational structure and the practitioner's view of the support available occurs as a common thread through the literature (Hodgkinson 1987, Valente and Saunders 2002).

Misch (2003) suggests that 'the failure of psychiatric trainees to undergo personal intensive psychotherapy is identified as a major obstacle' in terms of helping to prepare them to be able to learn from such a traumatic experience. Coverdale et al (2007) in their editorial indicate their support of other authors who have called for the continued development and

evaluation of suicide care programmes but with the added inclusion of medical students, an approach mirrored in the article by Fang et al (2007), though with an additional focus on exploring the impact of service user suicide on residents. Wozny and Zinck (2005) identified a significant lack of suicide intervention / training in some counselling programmes (98% and 94%).

Dexter-Mazza (2004) suggests that graduate programmes need to 'do a better job of providing formal training'. Coverdale et al (2007) discuss the lack of a coordinated approach to curriculum development and place an emphasis on early preparation of the practitioner together with the need to prepare a policy for debriefing the practitioner in the event of the suicide of a service user. Little (1992) cautioned on the ambiguous nature of meetings exploring feelings with the possibility that positively it might help to reassure but equally could negatively reinforce blame.

Tillett (2003) identified the increased morbidity related to health professionals but notes that staff tend to be ambivalent towards their own potential morbidity. He sees an important role for personal therapy or counselling in assisting staff to reflect and regain a balanced perspective with regard to work and personal life. Valente and Saunders (2002) offered a number of ideas including counselling (individual and group), workshops and the opportunity for the practitioner to write about grief as part of the healing process. This is set against the recognition that engagement by staff who have been directly affected by the event may be difficult and, occasionally, individuals may feel that they have been ignored and isolated by their colleagues, though have engaged in a process of distancing themselves for fear of receiving a negative reaction from them.

Conclusion

From the literature explored, evidence has emerged that suggests a number of points, which include:

- The staff involved with a service user who completes suicide are very likely to be markedly affected, both personally and professionally.
- The probability of staff encountering a service user who completes suicide is variable but considered highest for healthcare staff working in mental health services. These include doctors, nurses, psychologists and therapists.

- The majority of the literature explored is related to doctors and medical students, with limited material looking at other professional groups such as nurses.
- The strategic documentation explored tended to focus on the impact of completed suicide on a range of people (e.g. family, friends, police), but contained very little information related to either the impact on those healthcare staff involved or the support that was available specifically for them.

In addition to the above, a number of other aspects emerged but with less clarity and consensus, including:

- The specific nature of training that healthcare staff should receive by way of preparation for the completed suicide of a service user they had been directly involved with. The literature identified a rather patchy picture with some areas investing more time and effort than others in incorporating elements of the subject in the curriculum. There is clearer consensus on the need for a proactive rather than reactive approach.
- The need for postvention is identified but again the nature and structure that this should take is less clear. A degree of ambivalence exists over the value of encouraging healthcare staff to talk about the experience with concern expressed that, although this might permit opportunities for the extinction of self-blame and allow closure, it could exacerbate feelings of guilt and shame. Whether staff should be encouraged or required to engage in individual and/or group sessions is not explored and the approach taken to assist staff who withdraw from the team is not clearly identified.
- There is a need for more research around the potential and actual impact of service user suicide on healthcare staff, and particularly nurses. As indicated previously, much of the existing literature has a focus on doctors and medical students.

With the continuing changes in the focus of provision and support for users of mental health services, particularly in the UK, there is a need to recognise that healthcare staff will be faced more frequently with decisions related to risk with service users living in the community rather than in specific mental health units. Given the fact that of the 5,554 people who completed suicide in the UK in 2004, 154 were in a mental health unit (NIMHE 2007), the inevitable conclusion drawn is that most people who

will complete suicide will do so outside specialist mental health units. Recognising this point is important in considering what steps need to be introduced to ensure that healthcare staff have an opportunity to access services and support that already exist in a structured and explicitly recognised format, rather than a hastily convened event after the incident. The risk of some mental health service users completing suicide has been clearly demonstrated within this work. The recognition of these facts by healthcare services, together with a clear and workable framework to accommodate the impact of service user suicide on staff, has not been clearly evident within the available literature.

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Personalisation in Mental Health Care: some initial thoughts

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Discussion Paper

Social Care provision in the UK is in a state of rapid change, with an increasing emphasis on user-led outcomes and self-directed care. Mental health services, in particular, have experienced a range of change over the last decade, with the implementation of the National Service Framework (NSF) (DH 1999), the push towards integrated health and social care, and more recently the introduction of *'New Ways of Working'* (DH 2007). The local authority circular *'transforming social care'*, published in January 2008, followed on from the 2006 White Paper *'Our Health, Our Care, Our Say'*, and clarified the outcome framework for service delivery and embedded it within the vision of personalisation as the cornerstone of modern social care. This circular forms the first stage of the changes that public services are to develop with the stated aim of:

'...everyone who receives social care support, regardless of their level of need... will have choice and control over how that support is delivered.' (p4: para 14)

So how does this aim translate into current mental health services?

New ways of working places significant emphasis upon the skilling-up of professional groups, so that the full range of psychosocial interventions can be delivered within existing mental health services. Transforming social care on the other hand indicates that a wider choice of service providers, including service user led and voluntary sector organisations, should be developed and delivered to enable choice and control to become a reality. These two agendas are going to be difficult to reconcile within the current climate of service delivery, with an emphasis on risk aversion and best interest decision-making.

Historically, the statutory sector (e.g. NHS Trusts and Social Services Departments) have been the major players in the delivery of mental health services, and at the current time this is still very much the case.

Commissioning arrangements between health and social care are often bureaucratic processes which for small third sector or service user-led providers is a difficult and complex system to negotiate. The rules of engagement are often not clear, and while statutory organisations are used to operating in this manner, organisations outside of this system may have trouble when it comes to establishing a share of the market.

The impact of organisation culture on choice & control:

Working within a mental health service is to operate within a distinct culture. Organisations, professions, and individual teams all have a manner of operation based on custom and practice, as well as an evidence-base that contributes to the way in which workers perceive and react to concepts such as the social care outcomes. The challenge for senior managers within large integrated agencies, such as Partnership Trusts, is to manage and balance the competing understandings and agendas. The use of medication is a particular example of the differences that can occur in the views of professionals and service users. Whilst the medical practitioner considers the service user's wish to stop taking medication an unwise decision, and potentially a sign of deteriorating mental health, the service user's understanding could be that they no longer need the medication as they feel much better, or they are unwilling to continue to endure severe side effects – stances that are unrelated to a deterioration in their mental state. The choice and control exercised / not exercised by the service user in this situation could be a significant and positive step that they are taking within their overall recovery, though the professional will not view this as a positive outcome and as such it is likely that the choice and control is impaired as a result.

A Vision of the Future:

Whilst there are evident difficulties in the delivery of the personalisation agenda within mental health care this does not mean it is impossible. Organisational culture shifts will be required and support for the third sector will need to be embedded within the commissioning processes. By addressing some of the power dynamics which are currently apparent across all levels of services, and incorporating positive risk taking within risk management processes within services, it is possible to make changes to service provision. However, this is a long-term task and buy-in from all the various stakeholders will be needed to make personalisation less of a rhetoric and more of a reality.

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Refocusing CPA: a summary of the key changes

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Briefing Paper

Introduction

In March 2008, the Department of Health (DH 2008) published revised guidance on the use of the Care programme Approach by Mental Health Trusts across England. It had been reviewed to ensure that national policy could be consistently and clearly applied and to reduce the burden of bureaucracy.

The document identifies that all service users should have access to high quality evidence based mental health services, with underpinning values and principles for person centred care. However, they (DH) recognise that some service users have more complex needs and risks and for these individuals alone the Care Programme Approach should be applied, with effect from 1st October 2008. Those service users whose needs are straightforward, are stable within the care packages and services they are currently receiving, and have contact with only one agency will no longer be subject to CPA.

During this transition period, and prior to 1st October 2008, the term (new) CPA will be used to describe the refocus, however, following this date the term used will be CPA.

Refocusing CPA: a summary of the key objectives

The term Care Programme Approach (CPA), from 1st October 2008, will describe the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics only (DH 2008:11).

Where a service user has straightforward needs and has contact with only one agency, then an appropriate professional in that agency will be the person responsible for facilitating their care. Formal designated paperwork

for care planning and the review process for these service users is not required. However, a ‘Statement of Care’ agreed with the service user should be recorded, which could be completed in any clinical or practice notes, or as a letter – this will constitute the care plan. Everyone referred to secondary mental health services should receive an assessment of their mental health needs.

Whilst the DH have published a list of characteristics of service users who may require (new) CPA, the list is not exhaustive, and there is not a minimum or critical number of items on the list that should indicate the need for (new) CPA – merely providing a reliable and useful tool (Table 1).

Table 1:
Characteristics to consider in decisions for requiring (new) CPA (DH 2008: 13)

Severe mental disorder (including personality disorder), with a high degree of clinical complexity
<p>Current or potential risk(s), including:</p> <ul style="list-style-type: none"> ○ Suicide, self harm, harm to others (including history of offending) ○ Relapse history requiring urgent response ○ Self neglect/non concordance with treatment plan ○ Vulnerable adult / child protection – for example: exploitation (financial / sexual); financial difficulties related to mental illness; disinhibition; physical / emotional abuse; cognitive impairment; child protection issues
Current or significant history of severe distress / instability or disengagement
Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse, learning disability
Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
Currently / recently detained under the Mental Health Act or referred to crisis / home treatment team
Significant reliance on carer(s) or has own significant caring responsibilities
<p>Experiencing disadvantage or difficulty as a result of:</p> <ul style="list-style-type: none"> ○ Parenting responsibilities ○ Physical health problems / disability ○ Unsettled accommodation / housing issues ○ Employment issues when mentally ill ○ Significant impairment of function due to mental illness ○ Ethnicity (e.g. immigration status, race/cultural issues, language difficulties, religious practices), sexuality or gender issues

Clinical and professional experience, training and judgment should be employed in using the list to evaluate which service users will need the support of CPA. The list should not be used as indicators of eligibility for secondary mental health services and CPA should not affect whether a service user is entitled to take advantage of eligibility for Fair Access to Care Services (FACS).

By making changes to CPA there were concerns that certain key groups of service users would fail to receive the support they need, therefore for certain service users the default position will be that they will automatically be included within CPA, unless a ‘...thorough assessment of need and risk show otherwise’ (DH 2008: 14). These key groups of service users are those who: have parenting responsibilities; have significant caring responsibilities; have a dual diagnosis (substance misuse); have a history of violence or self harm; and/or, are in unsettled accommodation.

In addition to these groups, all service users subject to Supervised Community Treatment (SCT) or subject to Guardianship under the Mental Health Act (Section 7) should be supported by (new) CPA, unless the reasons are clearly documented in the care records that this is not appropriate.

The Trust will still be required to maintain a record of essential information on all individuals receiving secondary mental health services, and must ensure that care reviews take place regularly (this can be at a usual appointment).

Active service user involvement and engagement will continue to be at the heart of the approach, as will a focus on reducing distress and promoting social inclusion and recovery.

(New) CPA will relate mainly to adults of working age, though the principles should be applied to any individual receiving Trust services, regardless of their age.

A Statement of Values and Principles has been published as part of this guidance for individuals and professionals, as shown in Box 1.

Box 1: Statement of Values and Principles (DH 2008: 7)

The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognizes the individual as a person first and patient / service user second.

Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well being.

Self care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued and appropriate equitable and coordinated care. The quality of the relationship between the service user and the care coordinator is one of the most important determinants of success.

Care planning is underpinned by long term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them. All care plans must include explicit crisis and contingency plans. The Trust has set up a working group to review the current documentation and all changes will be highlighted across the Trust to staff, service users and carers.

There should be renewed attention by all to the evidence, principles and good practice to ensure that activity takes place, assured through

governance systems, training and audit, ensuring service user and carer involvement. The focus will be on agreeing desired outcomes of care and treatment with the service user and carer at the beginning of the care process. Outcomes assessment using HoNOS (Health of the Nation Outcome Scales) will be completed at significant points of change through the care pathway, and at least once each year.

Local commissioners are expected to contract for advocacy services for certain patients (Section 30 of the Mental Health Act 2007).

Services should consider at every formal review whether the support provided by (new) CPA continues to be needed. Those who are ‘...concordant with treatment, well supported and have recovered from a complex episode’ may no longer need CPA and a move *towards self-directed support will be the natural progression, with the need for intensive care coordination support and (new) CPA ending*. This should not remove the entitlement of service users to continue to receive any services for which they continue to be eligible and need, whether from the NHS, local council or other services. The decision to move away from (new) CPA can only be made when a thorough risk assessment, with full service user and carer involvement, has been undertaken.

National Treatment Agency (NTA) guidance indicates that people receiving treatment within substance misuse services who have co-existing mild to moderate mental health problems should have their care coordinated by the allocated key worker in the substance misuse service.

To strengthen the role of the care coordinator and reduce local variation, work has been undertaken to identify care coordinator principles of practice, core functions and competencies (linked to associated National Occupational Standards and the Knowledge and Skills Framework). National training is now being commissioned. It is not the intention that the Care Coordinator necessarily is the person that delivers the majority of care.

Auditing and monitoring the quality of care will remain essential components of secondary mental health services for all service users and carers, whether needing the support of (new) CPA or not. The DH is thus

commissioning a review of local CPA audit tools and methods to judge if they meet the requirements of updated policy and good practice.

It is recommended that Trusts work to integrate the Single Assessment Process (SAP) with CPA for service users within older persons mental health services. Within services for people with a learning disability, CPA should form an integral part of the service user's health action plan.

Table 2: A Summary of Requirements & Expectations

Service Users needing (new) CPA	Other Service Users
an individual's characteristics	
<ul style="list-style-type: none"> ○ complex needs; ○ multi-agency input; ○ higher risk 	<ul style="list-style-type: none"> ○ more straightforward needs; ○ one agency or no problems with access to other agencies / support; ○ lower risk
what the service user should expect	
Support from CPA care coordinator (trained as part of job description, co-ordination support recognised as significant part of caseload).	Support from professional(s) as part of clinical practitioner role. Lead professional identified. Service user self-directed care, with support.
A comprehensive multi disciplinary, multi agency assessment covering the full range of needs and risks.	A full assessment of need for clinical care and treatment, including risk assessment.
An assessment of social care needs against FACS eligibility criteria (plus Direct Payments).	An assessment of social care needs against FACS eligibility criteria (plus Direct Payments).
Comprehensive formal written care plan: including risk and safety / contingency / crisis plan.	Clear understanding of how care and treatment will be carried out, by whom, and when (this can take the form of a clinician's letter).
On-going formal multi-disciplinary, multi-agency review at least once a year, but likely to be needed more regularly.	On-going review as required.
At review, consideration of ongoing need for (new) CPA support.	Ongoing consideration of need for move to (new) CPA if risk or circumstances change.
Increased need for advocacy support.	Self directed care, with some support if necessary.
Carers identified and informed of rights to own assessment.	Carers identified and informed of rights to own assessment.

Implementation across the Trust

Across the Trust there is a CPA Local Implementation Group (CPA LIG), chaired by the Chief Operating Officer, with representatives from each Directorate, the Consultant Practitioner in Social Care, Deputy Director of Nursing, service-user representatives (Impact), representatives from the Local Authorities and the CPA Manager for the Trust. The Directorate representatives chair their own working groups, which involve practitioners from the key disciplines and managers, who are considering the detail of the proposed changes affecting service users and carers within their service area. These Directorate groups take the form of a 'time limited' working group of practitioners, who are engaged in reviewing the current CPA documentation, with the aim of streamlining the CPA paperwork, promoting a service user and carer orientated approach, whilst fulfilling the legal and statutory requirements.

Information for Service Users and Carers

Information is available for service users and carers on the Department of Health Website and a DVD has been produced to support these written messages. In line with this, the Trust will be reviewing the local information materials for service users and carers. Service users and their carers may need to be assured that the CPA level will not be equated to FACS (Fair Access to Care Services) eligibility criteria, which must not be used as a gateway to Social Services or entitlement to services or benefits.

Conclusion

The aim and challenge of the considerable work that is now being undertaken in preparing for the implementation of Refocusing CPA is to minimise the perceived over-bureaucratic processes of CPA. We must assure our service users and their carers that care will be delivered using the Values and Principles for Mental Health Services regardless of whether or not they are supported within (new) CPA.

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Useful information: <http://www.eastern.nhs.uk/scripts/index.asp?pid=303&id=89973> ; www.cpa.org.uk ; www.csip.org.uk ; www.dh.gov.uk/publications

Implementing an Evidence-based Carer Support and Education Programme

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Service Development

Introduction

'Having the right answer is of no use if we are unable to get people to use it' (Taylor 2005: 160).

Quality is now a purpose rather than an inconsistent side effect of care provision (Cullen et al 2000). The art of evidence based practice not only ensures quality but increases confidence and ownership of decision making, thus increasing assertiveness and managing historically inequitable power systems (Hamer and Collinson 2005). However, with evidence continuously being updated and reconsidered, the only constant in current practice is change (Duffy and Griffin 2000, Daly et al 2004).

The aim of this article is to discuss the process and content of implementing change in the form of an evidence based carer support and education programme.

Practice Area: *the setting*

Meadow Lodge is a multi-disciplinary community mental health team based in rural mid Bedfordshire with a client group of working age adults (16-65 years) who have severe and/or enduring mental health problems (Department of Health 2002), with most clients living in stable accommodation and having contact with their immediate family. However, local resources are limited in terms of day time activities and vocational opportunities for clients, resulting in many clients relying on family support for transport and social support. RETHINK offer a monthly carers support group in Bedford (though 10 miles away) with the emphasis on mutual support.

Thinking about Change

Change is a dynamic and interactive process (Duffy and Griffin 2000) and many issues need to be considered and addressed when implementing change. Wye and McClenahan (2000) advise that four main needs should be met for change to be successful:

- the proposed change needs to offer benefits to frontline staff;
- resources need to be sufficient;
- the right people need to be on board;
- the approach needs to be interactive and evidence based.

Effecting Change

Any change should be built around a model to enable comprehensive and ongoing evaluation, not only of the outcomes but of the change process itself (Joyce 2005, Cullen et al 2000).

Project management of change, which is concerned with the process, is therefore crucial (Carson 2005) and involves (Iles and Sutherland 2001):

- identifying the purpose – why;
- defining the change – what and who;
- planning – when and how;
- monitoring and control processes – whether it is on target or needs modification;
- and, evaluation of the proposed change – whether it was useful and effective.

Preparing for Change

This involves identifying the purpose of the change and defining the change itself.

Rationale for a Carer Support and Education Programme

There appeared to be a number of key influences for developing a carer support and education programme, which included:

1. *Clinical Influences*

The persistence of negative symptoms in schizophrenia accounts for most reported sources of distress and burden in families (Pharaoh et al 2006). There appears to be a correlation between positive outcomes with regard to reductions in relapse rates and experienced

psychological distress, improved family relationships and social functioning when families are supported in their caring role (Barbato and D'Avanzo 2000, Pharoah et al 2006, Pilling et al 2002, Dogan et al 2004).

2. Social Influences

Grief and loss are common emotions that families experience with mental illnesses like psychosis (Gamble and Brennan 2006, McFarlane et al 2003) and families / carers need support to understand and cope with this. Mental illness is also one of the most stigmatized conditions, not necessarily linked to 'others' attitudes. Clients and their families may be responsible for labelling through misinformation or misunderstanding (Link et al 1991).

3. Political Influences

Many Government Acts and policies have been introduced to advocate and assist carers in their role, for example: *NHS & Community Care Act 1990*, *Mental Health (Patients / Community) Act 1995*, *Carers (recognition and services) Act 1995*, *National Service Framework 1999*, *Caring for Carers 1999*, *Mental Health Policy Implementation Guide 2001*, *Carer's Equal Opportunities Act 2004* and *the Mental Capacity Act 2007*. Carers now, quite rightly, have an abundance of rights – for example: to be recognised as a carer; to have their own needs assessed and addressed, including vocational assessment and support; and, to be involved (as permitted by the client) in the planning, monitoring and evaluation of the care plan.

Although these various acts may appear to be altruistic there are financial implications to supporting families. For example, savings of between 19 – 26% have been identified in both direct and indirect cost for families who received Family Interventions (Tarrier and Barrowclough 1990). Therefore supporting carers is an integral requirement of the care process today.

We realised that we needed not only to identify a strategy for incorporating the main evidence based constituents of effective family intervention – *psycho-education, communication skills training, problem solving, and behavioural strategies and techniques* (Pharoah et al 2006),

but to do so in such a way that addressed the limited resources of time, and manpower within the team.

Evidence base for Carer Support and Education Group Programme

Psycho-education is effective in enabling the family to conceptualise their models with various theories (Barrowclough & Tarrier 1992, Leff 1994), thus decreasing the feelings of guilt, blame and embarrassment. Enhanced knowledge has been found to enable relatives to access support more readily, consequently reducing the incidences and severity of crises (Budd and Hughes 1997, Link et al 1991, Campbell 2004). Psycho-education also has been found to increase the tolerance of *unusual* behaviours by decreasing a sense of unpredictability.

Although the most long-standing benefits are achieved through individual family interventions (Pharoah et al 2006), it is cost ineffective and resource heavy. It has been highlighted that eight families would need to be treated in this manner to prevent one relapse (Pharoah et al 2006) which has had implications for implementation in routine practice (Fadden 1997). McFarlane et al (2003) advocates the application of the key elements of success rather than not implementing any family support at all. In a review of the literature they found that some of the key elements of successful intervention were common, regardless of the mode of intervention (multi-family / single family):

- exploration of carers expectations;
- addressing feelings of loss;
- communication skills improvement;
- problem-solving training.

Group psycho-education has the additional benefit of increasing social support and decreasing burden (Pollio et al 2006, Lim et al 1996, Cuijpers 1999). In a study by Budd and Hughes (1997), 40% of participants in a group psycho-educational programme reported a reduction in perceived stigma and felt encouraged about the future. This is echoed by a recent study by Mohr (2004) who found a key outcome for group members was normalising of their experience and a felt bond.

Pollio et al (2006) and North et al (1998) described the format of their multi-family group as a mixture of didactic teaching sessions regarding theories of mental illness and using a stress vulnerability perspective to

teach understanding and coping strategies for behaviours. The programme was also flexible in that it addressed issues raised, at the first session, as concerns by carers. Interactive discussion, brainstorming and reflection were also a key feature. Additional literature was given to attendees to compliment the sessions. Both studies report positive outcomes in terms of vicarious learning, mutual support, increased coping and understanding. They also found that families were more interested in coping strategies for negative symptoms. One recommendation from the attendees was to have a programme specifically for the carers as they were less inclined to be completely open with the client / service user present.

Pollio et al (2006) also used the programme to identify families who needed further or more intensive intervention – for example, behavioural / systemic family therapy (Pickett et al 1998). In terms of professional versus carer run programmes there is evidence to support both modes (Pickett et al 1998), but professional led programmes can offer an opportunity to ask questions of professionals. Pollio et al (2006) suggests a collaborative approach to co-facilitation between carers and professionals.

McFarlane (North et al 1998) found a \$34 saving on in-patient costs for every \$1 spent on multi-family psycho-education per client.

Planning the Group Programme

Based on the current evidence and reviews by Pollio et al (2006) and McFarlane et al (2003), a group programme was planned as a 6 x 2 hour, weekly, carer education and support programme, aimed at:

- offering carers of clients with a diagnosis of psychotic illness an opportunity to share and access support;
- enhancing the carer's knowledge, skills and confidence with regard to living with a relative with a diagnosis of psychotic illness;
- connecting families with more intensive support services, as appropriate.

(Mino et al 2007, Pollio et al 2006, Glynn et al 2006, McFarlane et al 2003, Pickett et al 1998, Budd and Hughes 1997, North et al 1998).

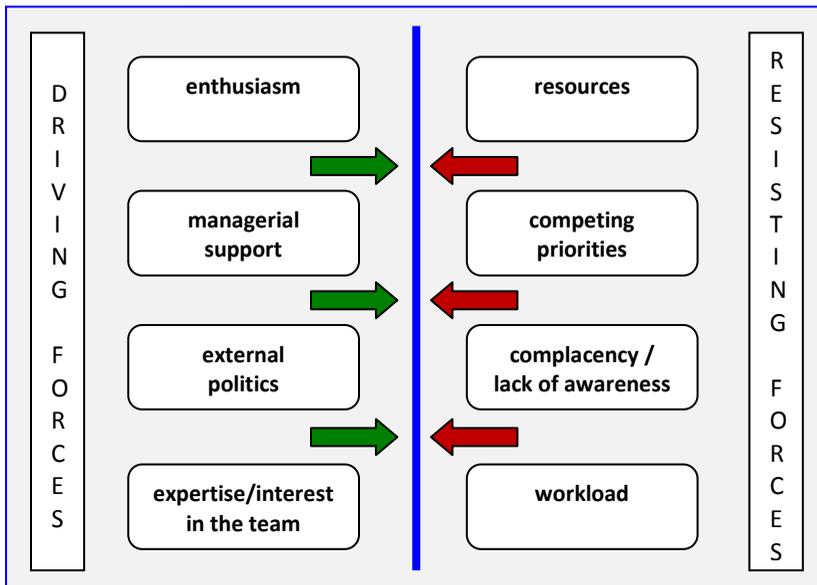
Based upon the reviewed evidence, the programme was designed as shown in Fig 1.

Fig 1: Carer Support and Education Group Programme

Session 1	What is Mental Illness? Expectations & Needs
Session 2	What is Psychosis?
Session 3	What helps Recovery?
Session 4	Coping with Symptoms of Psychosis
Session 5	Looking after your relative by looking after yourself
Session 6	* Carers Rights * Confidentiality Feedback & Evaluation
Session 7	Follow-Up Session: feedback & review
* identified as a need for programme content by carers within Session 1	

In successfully planning and implementing this service development, it was felt important to consider the drivers and resisting forces for change, in the form of a force field analysis, as shown in Fig. 2 (Iles & Sutherland 2001).

Fig 2: Forcefield Analysis of competing factors for implementing Carer Support and Education Programme



Cogin (2004) advises an acknowledgement of the culture of the system and sub-systems in which the change is to be implemented. As indicated in Fig

2, the driving forces are significant within the team, indicating a culture of openness where new ideas are welcomed and supported. People are generally enthusiastic and there has been a significant uptake in psychosocial intervention (PSI) training which has been consistently implemented in practice. Nevertheless, it has been suggested that addressing the resisting forces is more beneficial than enhancing the driving forces, as this may increase tension (Iles and Sutherland 2001). To get to the desired state, it is necessary to identify the strengths and weaknesses of the team and try to address these (Joyce 2005). A SWOT analysis was thus completed, as shown in Fig 3.

Fig. 3: SWOT Analysis of the Team (strengths, weaknesses, opportunities, threats)

<p>Strengths</p> <ul style="list-style-type: none"> ○ most team members are psychologically minded & ‘get’ the reasons for psycho-education ○ line manger supportive and enthusiastic ○ cohesive team (open system) ○ expertise in team – many team members have completed PSI training and one other member is trained in Behavioural Family Intervention ○ clinical psychologist available for supervision is also trained in systemic family therapy 	<p>Weaknesses</p> <ul style="list-style-type: none"> ○ time to make referrals to group ○ short staffed ○ financial resources limited ○ caseload size ○ other roles of team members ○ no physical resources e.g. meeting room, OHP
<p>Opportunities</p> <ul style="list-style-type: none"> ○ cost effective / resource effective ○ Trust & Government Policy e.g. National Service Framework (DH 1999), Care Programme Approach (CPA), Policy Implementation Guide for Mental Health (DH 2001, 2002) 	<p>Threats</p> <ul style="list-style-type: none"> ○ no formal pathway to ensure training /evidence is put into practice ○ no formal pathway for carers to access support apart from carer assessment under current CPA documentation ○ competing priorities may dictate workload ○ programme will be conducted out of hours so staff may decline to interrupt their personal lives

Wye & McClenahan (2000) suggest that five necessary properties of the proposed change are needed in addressing resisting forces:

1. Relative advantage – will it make a difference to all those involved?
2. Compatibility – does it fit in with current agenda?
3. Complexity – is it easy to grasp?
4. Trial ability – can it be tried without major investment by any party?
5. Observability – will the results be obvious?

The carer programme appeared to have appeal on all levels and targeted resisting forces as well as weakness and threats, as shown in Fig. 3. The programme appeared to fit well with the current drive for service user / carer involvement (DH 2000). Furthermore, increased support for carers of team clients has the potential for decreasing staff workload by addressing the concerns of carers through a group programme (Kuipers et al 2006). In addition, the programme only required direct involvement by one other team member, and thus did not increase anyone's workload. However, the opportunity to co-facilitate the next group is available. Those who are involved will be able to demonstrate evidence-based practice, and achieve professional and personal development (Daly et al 2004).

Relatives and carers will eventually have a local resource for meeting, sharing and learning from each other (Glynn et al 2006, McFarlane 2003), and evidence-based outcomes could eventually lead to modifying the programme and developing a pathway for carers to access support and services (Joyce 2005).

Daly et al (2005) stress the importance of effective leadership skills at this (and every) stage to 'shape and share' the vision (McNichol 2006: 31). Leaders do not necessarily need to be in a position of power to create and share a vision. However they do need to be self aware and have 'emotional intelligence' regarding other's needs, values, attitudes and beliefs in relation to the change event and the context of that change (McNichol 2006), as people generally view change in terms of how it will affect them personally (Cogin 2004). An effective leader will have an understanding of the culture and sub-cultures and employ appropriate change strategies within the context of the change and culture (Joyce 2005).

The system of our organisation (the NHS) is task oriented with outcomes being defined – however, the sub-culture of our team has been identified

(Figs 2 & 3) as a learning culture with openness and support for new ideas (Cogin 2004). This type of culture requires a transformational leadership which is participative, collaborative and consultative (Koch et al 2004) and employs normative – re-educative strategies (Haffer 1986). This strategy relies on the values, attitudes and beliefs of followers to ensure acceptance of the change.

The Team Manager was very supportive during the whole process. Following the priming of team-members to identify those who were particularly interested (Wye & McClenehan 2000, Cullen et al 2000), a choice of three evidence-based projects were proposed at a Team Business Meeting, at which opinions, advice and volunteers were sought. Team-members were very enthusiastic and supportive and suggested progressing the carer support and education programme. Two team members were interested in co-facilitating, with one agreeing to defer until the second group.

Many authors have highlighted that change is more likely to be adopted if it is clear, collaborative and owned by the team (Daly et al 2004, Taylor 2005, Wye & McClenehan 2000, Cullen et al 2000). We again approached team members informally a few days later to remind them of the upcoming programme and rekindle interest (Wye & McClenehan 2000) and to generate referrals.

Planning and Implementing the Change

Duffy and Griffin (2000) suggest that implementing change needs pragmatism and flexibility but should also have a clear beginning, middle and end. Iles and Sutherland (2001) also advocate using tools to help structure the change.

We developed a work breakdown structure (Iles and Sutherland 2001) which assisted in breaking the project into the manageable steps that were necessary for completion (Wye & McClenehan 2000). We also developed a Gantt chart (Carson 2005) that enabled a visual timeline for achievement of specific goals in relation to the project. Borbasi et al (2004) suggest that an effective leader needs to monitor and evaluate the whole process at each stage, invite and disseminate feedback. Consequently other team members were involved in the informal preparation sessions, providing feedback and helpful suggestions to the facilitators.

The programme itself was constantly monitored and reviewed, enabling a re-definition, as appropriate, and clarification of goals (Daly et al 2004). Indeed during the first group session, the group were asked to identify their needs and expectations of the programme, as advocated by Pollio et al (2006), following which the programme was amended (Fig. 4).

Fig. 4: Summary of Carers Expectations (discussed in Group Session 1)

1. 'How to cope with my own emotions (fear, frustration, anger, sadness and guilt)'
2. 'To gain knowledge about origins and treatment'
3. 'To feel better about recognising what I can and can't do'
4. 'To be prepared'
5. 'To learn when and how to back off and not be over-protective'
6. 'To know when I should ask for help and how to do this'
7. 'To learn how to deal with situations'
8. 'To know my rights'
9. 'To have something for me'
10. 'To understand what I can know and not know' (confidentiality)
11. 'To meet other carers; to feel normal – less alone'

Feedback was invited from participants at the beginning and end of each session.

Evaluation

Daly et al (2004) advise that any evaluation of change should answer the following questions:

- Does the change reflect environmental goals?
- How efficiently did it achieve its goals?
- Are all stakeholders satisfied with the process and outcome?

Wye & McClehenan (2000) suggest that success can be defined as meeting the objectives, *or* not meeting the objectives but learning from the experience. Well-organised evaluation can lead to the development of clinical guidelines and commissioning of services (Joyce 2005, Carson 2005) which is crucial to the survival of newly implemented changes. Indeed, Fadden (1997) states that unless changes are labelled as special projects and implanted in policy they are unlikely to survive. Furthermore, feedback about the process and outcomes to all stakeholders ensures ownership and commitment to the consolidation of change (Daly et al 2004).

As afore-mentioned, there was continuous evaluation in the form of anecdotal feedback during the sessions. Care coordinators also received feedback from carers outside of the sessions, which was generally positive. Daly et al (2004) advocate personalised feedback as it is more meaningful and pertinent, and especially as one of our outcomes was to help carers feel more supported. We spent the second part of the last session doing this and asked participants to complete an evaluation form at the final session. It would appear that carers felt that the group programme was a positive experience, as they expressed changes in thinking, feelings and behaviours (Fig. 5).

Fig. 5: Verbal Evaluation of Group Programme (at final group session)

<p>Thoughts:</p> <ul style="list-style-type: none">'I understand more about how the illness affects everyone and how''I recognise myself as a carer and realise I do a lot''I think more clearly about things – I am more focused on solutions now rather than the problem' <p>Feelings:</p> <ul style="list-style-type: none">'Less inadequate''Less isolated''A bit safer – things are not so unpredictable''Good''Less tired''Optimistic' <p>Behaviours:</p> <ul style="list-style-type: none">'Calmer''Trying to communicate more clearly''Talk more about things''Sharing the load with other family members'

The most helpful topics identified were problem solving, understanding mental illness, coping strategies and the group programme handouts. This appears to mirror the evidence of Budd and Hughes (1997) who found that 70% of attendees reported a positive impact from the educational aspect of their programme, with 40% referring to the written material outside of the group.

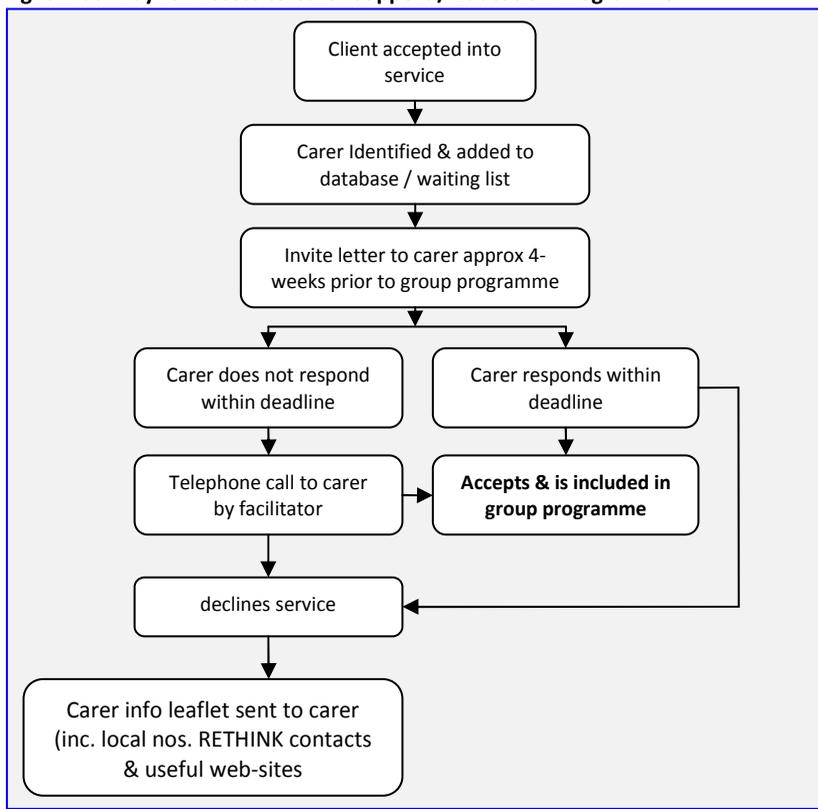
Consolidating Practice Change

Our Team Manager attended the final group session and has expressed her commitment to the continuation of the group in the future. We have also

planned a follow-up session for facilitating a two-way feedback session on how we intend to continue the programme and how the carers have found life since completing the programme. This will enable further modification (Iles and Sutherland 2001) prior to commencing the second programme in 2008. It is planned to extend this group programme to all carers of team clients.

We have requested a carer co-facilitator as advocated by Pickett et al (1998) and are awaiting willing volunteers. We have also developed a draft of a pathway for ensuring carer access to appropriate support upon contact with the service and to ensure an entrenchment of this support and education group, at least within our Team Operational Policy (Joyce 2005) (Fig. 6).

Fig. 6: Pathway for Access to Carer Support / Education Programme



Reflection / Conclusion

In conclusion we have shown that change is a complex and multi-faceted exercise with many issues needing to be considered, not least of all the qualities of effective leadership. Most of the work takes place in the planning or unfreezing stage: if people and policy are on board, change is much easier to effect. We found the implementation of this service development both mentally challenging and exhausting, but also the most rewarding work we have done for a long time. We feel that the next group may be improved in that we now have the advantage of hindsight with regard to planning, timing and dynamics.

This programme is now well on the way to being integrated within our Team Policy. Already care coordinators have asked about the next group and have put forward carers for referral. This is the best evidence that the change has been effective and is being valued by both the team and the client group, which is most likely to ensure continuation.

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The Interface between a Crisis Resolution and Home Treatment Team and Community Mental Health Teams: an exploration of experiences and expectations of the working relationship

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Abstract

Background: This research study focuses upon the relationship between a Crisis Resolution and Home Treatment Team (CRHT) and Community Mental Health Teams (CMHTs) in the local Trust. Analyses of the literature on inter-team/inter-agency collaboration indicate that problems do emerge when multidisciplinary teams attempt to work collaboratively. Others report that where protocols such as the use of integrated care pathways exist to guide the collaborating teams, the problems that emerge as a result of collaboration can be negotiated and sometimes avoided.

Aims & Objectives: A theoretical perspective was taken as a rationale for investigating whether or not problems do exist between the CRHT and the CMHTs in the Trust, because the care offered by these teams crosses team boundaries. This study aimed to elicit the types of problems, and the nature and impact of these problems (if any) on service-users, staff and the teams.

Method: To investigate this, two focus groups were conducted, each consisting of 8 participants who were purposively selected from the CRHT and Community Mental Health Teams respectively. The groups discussed semi-structured, open-ended questions to generate data. Audio-recorded tapes from the focus group discussions were transcribed verbatim, following which thematic content analysis was conducted.

Results: The major themes to emerge from the transcript analysis were problems with roles, responsibility (for teams and individual staff), information, communication and interdependence. The findings of this research study are consistent with some previous studies (Rummery 1998, Turnbull 1999) in which problems / conflicts were associated with inter-agency working, though not with others (Freeman & Peck 2006).

Conclusions: It is concluded that problems do exist between multidisciplinary teams which engage in collaborative working, especially where there are no protocols to guide the collaborative interaction. These findings have implications for practice and policy and program implementers. It is proposed that a comparative study of teams which have protocols to guide their collaborative relationships with others without such guidelines would confirm the findings in this and previous studies.

Introduction

In the Partnership Trust, a CRHT Crisis Resolution and Home Treatment Team (CRHT) works alongside well-established Community Mental Health Teams, providing a service to the same population. At a team building day in 2006 that involved members of both teams, a number of significant outcomes were highlighted:

- Things that were not going well and required action: lack of interface / joint working, joint planning and shared care; lack of respect of professional opinion between teams; a large number of referrals by CMHTs to the CRHT at the last hour on Fridays; and the members of different teams viewing their respective colleagues as unhelpful.
- Things to continue: working in partnership with the other teams; working to ensure that service users and their families are satisfied with the service.

The rationale for undertaking this research study was therefore two-fold: members of the two service teams recognised the need for and had requested an exploration of the interface between the two service teams, recognising the importance of collaboration and joint working; and, as the available evidence suggests that collaboration between teams can lead to conflicts and problems, this study would provide a direct test of collaboration and conflict between CMHTs and a CRHT within the Trust. *A review of the relevant literature was provided in a previous paper (Sesay 2008).*

Aims

The aims of this research study therefore were to:

- investigate whether problems do exist between the CMHTs and the CRHT;

- identify the main problems that both service teams experience in their working relationship;
- investigate how these problems impact on the teams' aspirations to succeed in the achievement of their goals; and,
- to clarify the reasons for these problems, and begin to generate potentially helpful solutions.

Methodology

A qualitative approach was adopted as the methodology, being most likely to elicit the subjective experiences of participants (Burns and Groves 2001). The significance of adopting this approach is that inter-agency / inter-team conflicts occur where inter-team collaboration is expected in the whole system of community care, and such conflicts are likely to affect service-users in their journeys to recovery between the CRHT and CMHTs (Rees et al 2004). It was hoped that this method would create a forum for participants to explore their teams' relationship with the other, with a view to highlighting any problems / issues which may impede collaborative working, which is suggested to benefit individual staff, teams, service users and their carers (Sim 1998).

Study Design

For the purpose of collecting data, it was decided to use focus groups as: the two service teams may have perspectives of each other that can best be explored through this method; group discussion is a familiar feature to both teams, wherein practice and management issues are often deliberated; this would allow participants' views and interactions to be observed, probed and clarified in a relaxed group atmosphere (Krueger 1994); and, the group process would help participants to explore their views and even generate questions in ways that may be difficult in individual interviews (Kitzinger 1995). Kitzinger (1994) defines the focus group approach as 'group discussions organised to explore a specific set of issues' (Kitzinger 1994), within 'a social setting, moderated by a facilitator, and sometimes co-moderator, so as to generate descriptive or explanatory information'. The use of focus group interviews to collect research has received considerable attention in the literature as a result of increased interest in qualitative research methods (Morgan 1988, Krueger 1994, Robinson 1999).

Research Participants and Sampling

Participants were recruited from four CMHTs and one CRHT in the Trust. For participation within the study, team-members needed to be qualified practitioners who had been working within the team between Jan 2005 & Jan 2007. Those eligible to take part were invited to do so via e-mail / letter. For the CMHTs, 24 of 28 team-members who were approached agreed to participate (response rate of 85%). For the CRHT, 16 of 22 team-members agreed (response rate of 73%).

Sample Generation

Purposive sampling was used to recruit participants to form two focus groups from those who had agreed to participate. Though not necessarily representative of the entire organisation which is being studied (Morgan 1998, Reed & Roskell-Payton 1997), the sample is naturally occurring as the selected groups work in the same teams and may therefore share similar experiences (Mansell et al 2004). Two focus groups were generated: a CMHT group with team-members from different CMHTs; a CRHT group. The CRHT group ranged in age from 25-45 years old, and was balanced for gender and ethnic background (Black, White and Asian). For the CMHT group, participants ranged in age from 25-55 years old, included mainly female staff, though was balanced for ethnic background.

Adopting the concept of smaller focus groups, 8 participants were recruited from each service team, yielding a total of 16 participants for the entire study. There are strong arguments favouring smaller focus groups (Krueger 1994, Fern 2001). Information on the study was provided to participants in the form of a 'participant information sheet' and written consent was obtained from each participant.

The Role & Recruitment of a Moderator

It is recommended for focus groups to be facilitated by a moderator, often assisted by a co-moderator or co-researcher (Sim 1998). The skills and role of the moderator are to facilitate and guide the discussion (Krueger 1998), while the co-moderator welcomes participants, sets up the room, records the discussions, observes and takes notes on the interactions among and between the participants (Mansell et al 2004). Trained group facilitators from a neutral department were therefore approached to fulfill the role of moderator, and especially as the researcher was a CRHT-member.

Data Collection Tools and Pilot Study

Semi-structured open-ended questions were prepared for use within the focus groups, to gain more specific information about selected topics (Bowling 2002: 378). The tool was prepared in consultation with staff from both service teams to determine the relevance and appropriateness of topics for discussion.

The semi-structured interview tool was piloted with a CMHT and another CRHT in June 2007, following which a number of refinements were made.

Data Collection

Two days prior to the planned focus groups, the semi-structured open-ended questions were distributed to participants to allow them the opportunity to consider their thoughts and the range of topics included for discussion (Bowling 2002). The two focus groups were conducted during July 2007, being facilitated by a moderator and a co-moderator. The moderator assured all participants of the confidential nature of the discussions and emphasised the need for honesty in their responses. Participants were reminded that their identities would remain anonymous, and that the findings would be presented to the service and team managers of both service teams which may have the potential to improve the quality of relationships. As recommended by Reiskin (1992) the moderator set the mood of the groups by creating a non-threatening, warm, accepting, enthusiastic, and objective environment, which encouraged all group participants to share their views honestly. Two methods of recording took place: audio-recording; and, detailed note-taking by the co-moderator.

Data Analysis

The audio-recorded focus group sessions were transcribed using a method suggested by Sandelowski (1991). Manual data analysis, using the 'Framework' method was conducted, being guided by an analytic approach (Ritchie and Spencer 1994). This method highlights key stages in the data analysis process, fulfills the principle of auditability in following a well-defined procedure, and has been cited as highly transparent (Barbour 2002, Lane et al 2001, Matthews et al 2006). This method involved five stages of qualitative data analysis: familiarization; identifying a thematic framework; indexing; charting; and, mapping and interpretation (Ritchie and Spencer 1994).

In order that the emergent themes were reliable and consistent, an independent second reader with expert knowledge and skills confirmed such by reading the transcripts against a summary of the findings presented (for inter-rater reliability). The data was validated by performing checks with focus groups members at two stages (Sandelowski 1993, Lane et al 2001): at the end of the interview either through a session summary using a flipchart or through a moderator facilitated summary of discussion; and, emergent themes were subsequently presented to members of each group, resulting in favourable comments about the interpretation of the sessions.

Findings

About the Participants

The CRHT focus group was comprised of six team-members, with an average age of 40 (range = 25-55), of whom three were female (two White and one Black) and three were male (all Asian). This group included one Social Worker, three Mental Health Nurses and two Psychiatric Doctors, all of whom were educated to university level.

The CMHT focus group was comprised of seven team-members, with an average age of 42 (range = 26- 58), of whom four were female (two White and one Afro-Caribbean) and three were male (one White, one Black and one of Asian origin). This group included two Social Workers, one Psychiatric Doctor and four Mental Health Nurses, all being educated to university level.

Summary of Key Findings

The main findings which emerged related to the following themes: roles, responsibilities, information, communication and, joint working / interdependence / collaboration.

1. Roles

The role or purpose of each team could be differentiated from the functions performed by individual professionals. Participants from one team seemed to know the main purpose of the other team. The following statements were used to describe the role of the CRHT as presented by the CMHT focus group: *“The purpose of the crisis team is to assist service users to remain in their own homes and be treated in times of crisis”*; *“to*

facilitate early discharge of service users from acute wards”; “to work in conjunction with other community mental health teams”; “to act at a point of crisis”; “to gate keep acute psychiatric beds”. Conversely participants from CRHT focus group discussed the following as the purpose of CMHTs: “Their role is looking after clients that have reached a point where they are quite settled, the clients that have chronic mental health problems”; “to treat and maintain patients to a level of functioning”; “I disagree with the maintenance role alone, as CMHTs can carry extremes of complex and a lot of crisis work”.

Whilst participants from one team seem to acknowledge the purpose / role of the other team, it also emerged that there was an overlap of roles between the CMHTs and CRHT in some of the functions they perform. For example, a description of what constitutes a crisis became a focal point in both groups: *“There are disagreements about the definition of ‘crisis’ and we tend to care for patients who are in crisis as well as those who are well settled”* (CMHT); as a CRHT participant put it, *“this is where there is the overlap and the CMHTs are not too clear when to refer patients who are in crisis to the CRHT, and likewise the CRHT are not too sure when to discharge patients back to CMHT’s”* (CRHT). From the above dialogue, there seems to be lack of role clarity for each team.

With regard to the role of individuals within the teams, other sub-themes emerged which in their totality may be constructed as problematic in the teams’ working relationship. For example: role confusion, where individuals from CMHTs and CRHT do not seem to understand each other’s roles. As a result there is confusion over who does what. For example: *“If we take somebody who is on depot and with the CMHT, sometimes we are not sure who should administer it – that’s where we have the conflict”* (CRHT); *“When my patient was discharged into the care of the crisis team and needed medication management, that was not done. The crisis worker said that was not his job – it required long- term work by the CMHT care coordinator”* (CMHT); *“Someone... from crisis team said... oh no! Health promotion is not for crisis workers, its long-term work that could be done by CMHT Care Coordination”* (CMHT).

Participants in both groups agreed that there needs to be some form of clarification to ensure that roles and functions are not duplicated or left undone.

2. Responsibility

Accountability and the capability of the teams and employees within them emerged as another theme which proved to be particularly salient to participants. From a team standpoint it emerged that whilst the CRHT adopts a team approach to patient care (where any team member can provide care to the same patients), CMHTs adopt an individual case management approach wherein a number of service-users are assigned to a team-member who is responsible for meeting the care needs of those service-users on his/ her caseload. In the midst of these differing approaches to patient care it emerged that conflicts do arise because the teams are not sure about their responsibilities, as illustrated: *“When it comes to taking some responsibility, as a team they will say... well it’s not our responsibility: I think that’s because they are not sure of how we work, and they say it’s not their responsibility”* (CRHT); *“In my experience with the CRHT, they never give us an up-to-date risk assessment as we would do when referring patients to that team”* (CMHT). It thus emerged that each team believes that the other is neglecting their responsibilities to their service-users and to the sister community team.

Participants, in their description of staff responsibilities in the CRHT and CMHTs used words or phrases such as: *“passing the buck”*; *“neglect of responsibilities”*. Care Coordinator responsibilities stood out prominently in both focus groups. It emerged that Care Coordinators are designated staff, usually a nurse or social worker, who organises care arrangements for a number of service-users on his/ her caseload. This is equivalent to a crisis worker in the crisis team. This arrangement makes the care coordinator / crisis worker accountable for the care processes for his/ her assigned patients. The following sub-theme was identified: inconsistent approaches to Care Coordinator / crisis worker responsibility.

A theme of the perceived neglect of responsibility and passing it on to others emerged strongly in the data: *“How can you possibly refer a patient to another team simply because the patient has missed his depot injection and is beginning to relapse?”*; *“Most of such referrals come in on Fridays or a Bank Holiday... and they may be saying, it’s up to them... it’s their responsibility now”* (CRHT); *“You sometimes go on a joint visit with a view to discharging a patient and the crisis worker is not the one who attends, and the one who attends does not know the patient. I’m sure if the crisis worker who made the care plan, did the risk assessment, you know, was*

there it will help a lot. Now the patient is discharged and I have no clue what I am doing with her” (CMHT).

It emerged from the data that the timing and circumstances in which responsibility is shifted to others is predictable. For instance: *“We spend a great amount of time on the phone talking to members of the other team in order to discharge their patient, but the response we get is that patient’s care coordinator is off sick or on leave, and I can’t accept that responsibility” (CRHT).* On the other hand the CMHT focus group commented: *“Of course staff in the crisis team are trained and can deliver special interventions such as medication management, but they would choose to refer patients to us” (CMHT).*

Being proactive and accountable in taking personal responsibility as a care coordinator/ crisis worker also emerged from the data: *“If only the care coordinators are a bit proactive to refer their patients to the crisis team before the patients become very unwell it will solve the conflict between us” (CRHT).* In a similar manner, CMHT data revealed that CRHT crisis workers hardly ever knew the patients they are assigned to: *“I once contacted the crisis worker about one of my patients in their care for update... and she could not tell me, saying ‘I do not know this patient’; ‘I asked for an up-to-date risk assessment and it took nearly two days before I got one” (CMHT).*

3. Communication

The need for better channels, consistent means and appropriate methods of communication featured prominently in the data for both groups. A number of sub-themes emerged which included the need for a central point / person to direct communication: *“You may have something urgent to discuss... say with someone who has assessed your patient, or made a referral to our team, but you are never lucky to get past the receptionist...” (CMHT); “That’s why I go straight to their manager... you know I have her number. That way I ask the question or request for the information and she directs me to the right person” (CMHT); “And I think they need to give us their mobile numbers like you were saying. They are not precious... you can liaise with them on their mobile because sometimes you have to wait for them to get back to you which they hardly do” (CRHT).*

A further sub-theme concerned a lack of feedback between the two teams, which seems to lead to frustration between teams and individuals: *"My experience is we never hear about the outcomes"* (CRHT); *"I think sometimes you do emails as a prompt to the CMHT and there is no response"* (CRHT); *"The main difficulty is with feedback after they have assessed the patient"* (CMHT); *"Getting feedback as soon as possible will reduce our anxiety... knowing that a suicidal patient is receiving care... is safe, but you need to call before anyone says anything"* (CMHT).

Another sub-theme relates to the nature of the communication style, suggesting that those communicating do not negotiate, do not take 'no' for an answer, nor explore alternative solutions: *"The ones that I've experienced... are the ones following an assessment and the patient did not meet the criteria for admission to hospital. The referrer was unhappy and said, 'that person has got to be in hospital, or with your team; I'm not taking anything else' "* (CRHT); *"Sometimes, and very recently I sent a referral by fax and one hour later I was asked to justify why this patient was referred. The caller's reason for the query was that this patient was discharged from their team not too long ago"* (CMHT).

4. Information

The use of and sharing information within and between teams emerged strongly as being helpful to patient care and allaying staff anxiety. However, the data revealed that information is either used inappropriately or not used to good effect. A sub-theme about inadequate or a lack of information emerged, with participants reporting that service-users are often discharged without the relevant risk information and this places those who then take responsibility for their care at potential risk or places the discharged service-user at risk: *"There is a need for the crisis team to fax a short discharge summary at the point of discharge to care coordinators and responsible medical officer. We have had incidents when patients are discharged without any background information relating to medication"* (CMHT); *"There was a referral we received a few weeks ago and two of us, females, went to assess this patient. We could not do it, because when we saw this patient, Oh!, he was so verbally abusive. It turned out later that even the care coordinator who referred this patient does not visit him at home, but this was not indicated on the referral form"* (CRHT).

A further sub-theme that emerged concerned misleading or delayed information, particularly at the time of referral between teams: *“Often you get a referral and when you go out to assess the patients it turns out the information given on the form is a bunch of lies and that’s not very good but you can’t complain”* (CRHT); *“What is even more traumatic is when they (CRHT) assess a patient and they tell them... ‘Oh we will not give you the outcome till we return to the office and discuss with the rest of the team. And minutes later a call comes to the patient to say sorry we did not find you appropriate for crisis intervention. Surely in that circumstance we will have no option but to ask the patient to go to the Accident and Emergency Department to be reassessed”* (CMHT).

In view of past unfortunate experiences in how information has been withheld, distorted or delayed, the data revealed suggestions about how to move forward to combat such anomalies, even though these suggestions are practices which participants expected to have already been in operation: for team-members from both service teams making available photocopies of relevant documents; having face-to-face meetings; giving advice on the health status of service-users; having an active link-worker between the teams; arranging opportunities for cross team shadowing to raise awareness of team practices.

5. Inter-dependence / Joint-working / Collaboration

Used as interchangeable terms by participants, there was recognition that the absence of inter-dependence between the two teams could have an impact on service users, team task performance and individual staff. Participants’ evidence from previous experience indicates that variable responses have been encountered when staff from one team had attempted to initiate collaborative working, which has had a lasting and potentially unfavourable effect upon team-members: *“Initially some CMHT managers attended our meetings, and that was useful. Relationship with those is fine”* (CRHT); *“My own experience is different – it’s about going to their meeting and not feeling welcome. Some of us have had bad experiences. I was told not to attend their (CMHT) meeting”* (CRHT).

It was reported that due to the lack of close working relationships, with regard to care coordination, service-users are not easily discharged (because there is no one to continue care for them) leading to an increased caseload. This leads some individual staff to feel irritable and angry: *“My*

fury at times is that we plan a joint visit to see a patient with a view to discharging them and there is no one from the crisis team to handover the patient” (CMHT); “Sometimes you refer a patient for follow up and you are told ‘oh the care coordinator is on leave / off sick and I can’t take that responsibility” (CRHT). Participants, upon discussing the impact on service users of the lack of collaboration between the two service teams, revealed that service-users are the ones who suffer as a result: “We can’t work in isolation; otherwise it’s not going to be good for the service users” (CRHT); “Sometimes when the patients’ care coordinator is on leave / off sick... no one takes responsibility and we discharge the patient to no one, which is unfortunate for the patient” (CRHT); “They (CRHT) hardly share information on what has been done with the patients and when we take over, the patient is left confused about our own role” (CMHT).

In view of the difficulties posed by a lack of collaborative working, the data revealed participants making proposals about ways of achieving joint working: *“team building activities with the CMHT such as having joint away days....” (CRHT); “mentorship”; “more active link workers with the CRHT”; “induction of new members about work in other teams in both teams”; “cross-team shadowing, or developing care pathways” (CMHT).*

Limitations

There are a number of limitations which might have affected the findings of this study: the limitations of the focus group approach, in that some participants may feel inhibited in a group situation (Greenbaum 1998) or social pressures could cause over-claiming (Webb 2001); the presence of the researcher, as a CRHT team-member, at the focus group interviews may have inhibited some participants to actually air important issues, instead expressing what they thought was wanted; only two focus groups were conducted, limiting participation to 13 team-members from a total eligible group of 44; purposive sampling could be criticised in not being representative of the population being studied (Morgan 1998); in one of the focus groups, one of the participants attempted to dominate the proceedings and this may have inhibited others from making a generous contribution to the data. Nevertheless, the findings may be viewed as credible as the team had an opportunity to express views on the questions prior to the interviews. This could have given the individual teams time to pool their ideas which would have been presented by participants. In this

context the results could be generalized within the Trust, though not necessarily to other Trusts.

Conclusion

This study set out with the aims of exploring whether problems exist between the CRHT and the CMHTs and more specifically the form that these problems take and how they impact upon both team aspirations to achieve their goals and upon service users.

By using a qualitative methodology that involved using a semi-structured interview through two focus groups, which provided data that was transcribed in preparation for thematic content analysis, it has been shown that problems do indeed exist between the CRHT and the CMHTs in the Trust, which is not helped by the lack of a formal protocol to guide the two service teams in their collaborative relationship, as observed by Rees et al (2004). It emerged that there was role overlap between teams (CRHT and CMHT), with each team not being sure of where to start or finish their roles. Furthermore, the study identified individual role confusion, with participants demanding clarification. Instances were reported of some team-members failing to communicate care plans or information about service-users to members of the other team, which has led to the service-user either feeling confused, left to become very unwell to the point of hospitalisation or not being followed up after discharge, which is consistent with the findings of Higgins (1999), where a correlation was made between the lack of collaboration and poor patient outcomes. Team-members reported feeling angry, frustrated and irritable at times, and had no means of discussing their feelings, which is consistent with the study by Carmel (1999). It could therefore be inferred that some team-members have no forum to discuss their differences or the impact of poor relationships with the other team and the consequences of such.

As shown, the findings replicate those of some previous empirical studies and are consistent with a number of theoretical perspectives (DH 2000, 2001, 2002, Higgins 1999, Jehn et al 1999, Rummery 1998, Turnbull 1999, Rees et al 2004, Freeman and Peck 2006). The findings are also consistent with suggestions that problems / conflicts do exist in inter-agency collaboration (Rummery 1998, Turnbull 1999, Rees et al 2004), and that these problems are exacerbated where there are no protocols guiding how collaborating teams should interact.

This study contributes to understanding the relationship between inter-team collaboration and conflict, and individual staff and team performance, suggesting that protocols are needed to guide interacting teams. There is evidence to suggest that where guidelines are in place to map out the roles and responsibilities of collaborating teams, these problems / conflicts can be minimised. This evidence has implications for team-members, teams and for policy makers when commissioning new teams within a system where others are already in existence.

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Developing Skills in Psychosocial Intervention: reflecting on a practice session

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Reflection on Practice

Introduction

In this short paper I will give a reflective account of my experience in applying psychosocial intervention (PSI) in a practice session with one of my client's, for which her consent for audio-recording was obtained, with confidentiality being assured (UKCC 1992). My experience relates to an overall review of the sessions carried out with my client.

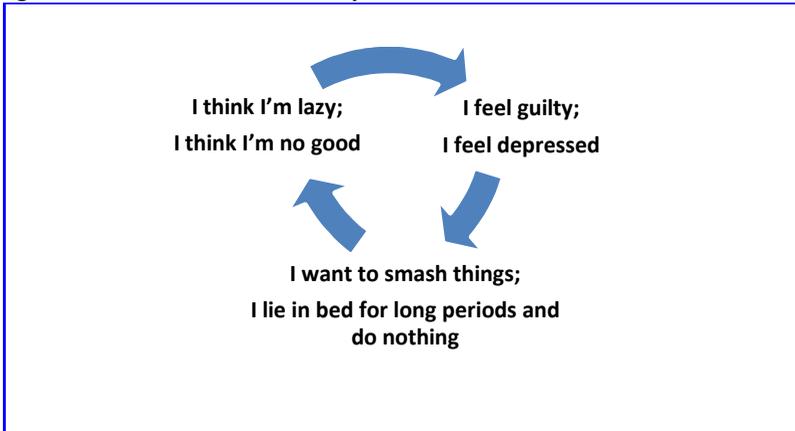
Reflection has often been encouraged as a way of analyzing nursing practice, which makes it possible to identify the need for change and how to implement this in practice (NMC 2002, UKCC 1992, Martin & Mitchell 2001). I will use Gibb's (1998) reflective cycle to reflect on aspects of my experience, as this cycle looks at both the bad and good feelings of each experience. Gibb's (1998) depicts reflection as a cycle and this model is very straightforward, practical and easy to use. It looks at what happened, the feelings identified at that point, the good and bad aspects of the experience, what sense can be made of the experience, as well as what could have been done at the time and how it could be improved if a similar situation arose.

Focus for Sessions

My client's identified goal was to increase her daily activities as she felt she spent most days in bed which resulted in her not completing any chores, and left her feeling "lazy". This left her feeling guilty, upset, depressed and made her feel that she wanted to smash things and hence, she spent even more time in bed. I drew up a basic formulation (see Fig. 1) to show the link between the ways she thought and how it affected the way she felt and behaved (Kinderman & Cooke 2002, Jones et al 1998). The purpose of this was to bring about some changes to her thinking that would impact positively on her behaviour (Hawton et al 1996). Our agreed intervention

was thus activity scheduling, with the use of a scale to rate her pleasure and achievement at accomplishing the tasks.

Fig. 1: a basic formulation of the key issue



Reflecting on a PSI Practice Session

We started by setting the agenda for the session and began with how the week had gone and a review of homework. In previous sessions, despite being given the opportunity to contribute to the agenda the client did not. At times, I felt under pressure to lead the session and although I felt more confident about my questioning style in facilitating guided discovery, I felt the need to keep things to a level that was understandable by the client. Apart from having some language barriers, I was conscious that this client due to the nature of her illness had some cognitive deficits, which resulted in her having difficulty concentrating or at times comprehending more complex or difficult questions. It has been suggested that where concentration, attention and memory are affected to an extent of difficulty in learning cognitive interventions, to focus more on making behavioural changes until deficits improve (Greenberger & Padesky 1995: 163).

It was quite clear during the review of the homework that the client had completed most of the agreed activities on the lists and even added more. She had rated more highly on pleasure and achievement for the activities than she had in the past. She attributed this positive outcome to a 'distraction of the mind', which she referred to as 'the best medicine'. However, there continued to be evidence of a pattern of not completing

tasks that she considered a chore (e.g. brushing teeth). Several attempts to explore whether the client's non-compliance related to more fundamental beliefs about herself proved futile and left me wondering whether this should be explored at a later stage (Hawton et al 1989, Nelson 1997).

The client described how she was able to talk herself out of staying in bed and going to one of her activities, which made her feel very good about herself. I was able to make reference to our initial formulation and pointed out how she was able to change her behaviour with a positive outcome (Williams & Garland 2002, Greenberger & Padesky 1995: 163). In hindsight, I could have asked how she thought she may have felt if she had stayed in bed as this could have highlighted how much progress she had made.

We were able to complete her problem severity and goal achievement chart, on which she rated the progress she had made since starting the sessions. The scores, which were rated on a scale of 0 (no progress) to 10 (goal completely achieved) had risen from a four, upon initially starting, to a seven, and she identified her overall progress as an 8. On reflection, I could have further explored with her what had helped her to reach an 8, what she considered her efforts to be and how she could acknowledge that she had done well. This would have been beneficial for the client in reinforcing her sense of self-efficacy (Wright et al 2002). She expressed that sessions helped her to learn that she could be happier with herself as positive feedback from our sessions served to cheer and motivate her into doing things. I feel that looking at the charted evidence of activities accomplished was beneficial for the client on the days when she felt she had done very little. Though she ended the session prematurely, I was able to attribute this to her inability to concentrate for lengthy periods of time.

Reflecting on the Outcome of Sessions

I am proud of both our achievements as I have spent almost four years trying to motivate her to incorporate more structure to her day. Having the knowledge to structure the PSI sessions and achieve such a positive outcome over a few months corroborates research evidence that specific interventions can improve outcome for clients in a number of areas (The Psychosocial Working Group 2003, Repper 1998). I feel clinical supervision was fundamental in assisting with developing effective clinical skills and allowed for reflection of practice, to learn and prepare for the next session with the client (Turkington et al 2006, Bradshaw et al 2007).

Overall, I felt we worked collaboratively to explore different options, to maximise the chances of success and to try in advance to predict and minimise any difficulties that may arise (Williams & Garland 2002, Hawton et al 1989).

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