Using formulations with older people

Mapping the process for your service

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Exercise

1. What are you trying to achieve?
2. What has gone well so far?
3. What do you want from today?
Exercise: Mapping your plan

- Your two main goals
- Your stakeholders and the primary concern of each?
- What is the culture of your organisation?
  - e.g. Risks, drivers, reputation, ambition, CQC reports, financial status, managerial culture, change management, impact of national issues
Potential stakeholders

- HR/ Ops managers
- IT
- IG
- Finance/ PBR
- Audit
- Communications
- Patients/ Carers
- Other professional groups
- Direct staff team
- Psychologists/ therapists
- R&D
- OD
Our culture in 2007

- Trust ambition to be recognised as the best
- Managers who were challenging, insisted on clarity, focused on what makes a difference to patients and willing to take a reasoned chance, evaluate it and then decide.
- Two wards were struggling and under a formal management plan
- Two trusts had just merged
- There weren’t many psychologists
That meant

- Well articulated innovation was encouraged
- We would be closely monitored
- Processes would have to be tight
- We had an invitation to lead change but no plan of how
- There were multiple changes of which we were just one
- We needed to do the one change that would make the most difference
Which model to choose is the easy part (and that can seem like a mountain)

What model are you going to / do you use?
Specifics for older people

- Cognitive factors
- Cultural discrepancies between client group and most staff
- Physical health problems
- Capacity issues
- Dominance of medical model/psychiatry and reinforcement through links with acute trusts
- Increasing focus on positive factors (wisdom – Ken Laidlaw, wellness enhancing beliefs etc)

- What are you formulating and why?
  - client, team, client’s family, wider team
The MDT

- Has to be useful for / incorporate information from whole MDT.

- Biological & behavioural aspects of ‘hot cross bun’ help with medical/ physiotherapy/ OT assessments

- Formulation model needs to fit enough to be accepted but push enough to challenge
Referrals for complex case consultation

- Difficulties engaging client in therapeutic work
- Problems with risk management
- Bring teams together to agree roles and responsibilities
- Splitting, resource demand, clients coercing care, isolating, overwhelming

Walton, 2011

? reflecting fear, frustration, helplessness, feeling inadequate?
? Needing advice, containment/consistency, inspiration, a way forward,

How does your formulation model take these into account?
Matching goals to model of formulation

- Help staff do a more holistic /‘human’ ax
  - Columbo model & 5Ps excellent. Easy to share.
  - 5Ps - helped staff think about the timeline of problem.
  - Columbo helped re-humanise challenging clients.
  - But difficult to use the diagram to generate ideas for interventions.

- Help staff understand theory and meaning
  - Achieved with more formal CBT model
  - Hard to implement in initial stages
  - Demanded a comprehensive training package cascaded to large numbers of staff.
  - But has led to wide scale cultural change
History (inc sig physical)

Core beliefs

Rules for Living

Trigger/s 1. For current admission, 2. Day to day

Cognitive Filters 1. ‘Organic’ Abilities 2. Biases

Automatic Thoughts

Biological

Emotional

Behavioural

Environment

Interpersonal Patterns

Referred to in service as ‘Roseberry Park’ model of formulation
Why this model?

- NICE evidence
- Most staff had heard about CBT
- Model of ‘normal’ thinking
- Can bring in all MDT
- Integrates cognitive problems for organic services
- Easy to integrate other psychological theories
  - E.g. CAT, attachment
- Provides very obvious links to interventions
- Link with challenging behaviour and ABCs
Moving on with Interventions:

Only 46% of recommendations made in consultation were recorded as attempted or completed. Walton (2011)

How are you going to ensure the formulation session isn’t an isolated incident and that interventions Happen & Happen how you envisaged?
Outcomes: Prove the team fn makes a difference....

- What did you and others want to achieve?
- Is that mirrored in the outcomes you use?
Outcomes

● Problematic because, if a system is supporting you to make widespread change, you’re unlikely to be the only thing happening.

● Outcomes can be related to e.g.
  ● patients (care, process, specific interventions),
  ● staff (knowledge, understanding),
  ● organisation (risk, culture, pathways).

● Need to balance the long term pre-planned outcome measures with watching for the day to day changes.
Possible Outcomes

- Risk perception
- Incidents
- Admissions (repeat)
- Length of stay
- Medication
- Empathy/ compassion
- Ability to formulate
- Knowledge/ theory use
- Quality of care plans/ notes/ language
Promoting your success

- Go back to the first exercise

- With what you know about your stakeholders and organisation:

  How are you going to make sure that people know about it?
Process: How are you going to achieve what you want?

- Technical competence does not lead to good leadership.
- Being a good technical psychologist is not enough.
You have to see and position yourself / and be positioned as a clinical leader

What are the existing processes you can hijack?
Formulation has to be one aspect of a range of interventions:

- Proving your own worth with difficult cases
- Supervision
- Teaching
- Mapping clinical models of care/ processes
- Helping manage risk
- Helping staff articulate the need for new resources etc with a clear theoretical rationale.
- Helping staff evaluate and write work up
Achieving Change in Complex Organisations

- A *simple* problem is one where there is a reliable known approach that delivers almost identical results every time.

- A *complicated* problem requires much higher levels of coordinated knowledge, skills and experience to achieve the required result.

- A *clear plan* is critical and necessary.

- The process requires high levels of expertise in many specialised fields that are rigorously coordinated.

  New ways of working for applied psychologists,
  Working psychologically in teams
Beverley Alimo-Metcalfe (2011)

- Jim Collins and Henry Mintberg

- humble quiet leadership ~courageous perseverance.
- Leadership doesn’t need to be heroic, it’s about qualities that psychologists should be easily capable of.
- Top American companies that sustained move from good to outstanding had leaders with fierce personal resolve, unassuming / humble (rather than charismatic and confident), and surrounded themselves by the right people.
Help the system

- Articulate how training fits with staff KSF bands
- Anticipate whether new roles may lead to job redesign
- Will the work they do with you fit their job plan and banding?
- Underlie and support the core assessment and intervention process rather than being a separate piece of work that sits outside these fundamental requirements
Concluding thoughts
Own thoughts

- Don’t be grateful for being allowed to do any formulation.

- If you believe it’s the right thing, refuse to take an individual referral before the team have joined you to formulate the case (we’ve found it excellent for triaging referrals / increasing psychological thinking to team interventions).

- Don’t set it up so that staff feel they’ve failed if they have to ask for a formulation

- Whatever you choose to use as the tool your role has to be about containment/ reflection/ theoretical rigour for the team not just the client.
● Articulate how what you’re doing fits with the service goals and aspirations.

● Help them see how it should make life easier in the long run

● This is a leap of faith because the extra time is put in at the start and once you know the information it’s hard to imagine how the intervention would have gone in its absence.
They’re not a panacea

- In using formulation there was a feeling that clients had to emphasise the impact of their experiences to reinforce that they’re not weak/ incapable
- Diagnosis can be easier/ less embarrassing to share with other people than the details of a formulation
- Diagnosis seemed to offer more justification and validation of difficulties. Life events alone don’t seem to be enough. Clients needed lower burden of proof for diagnosis than formulation.
- However, also a lot of negative characteristics associated with diagnosis.

Leeming, Boyle and Macdonald (2009)
References

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