The role of psychology in a multi-disciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team.

Abstract

Objectives: Psychologists routinely work in psychiatric inpatient settings but it is acknowledged that they cannot work in isolation from the multi-disciplinary team. The aim of this study was to examine the multi-disciplinary team's perspective on the role of psychology within the acute psychiatric inpatient setting.

Design: A qualitative approach was taken utilising semi-structured interview for data collection.

Methods: Interviews were undertaken with twelve multi-disciplinary team members (occupational therapists, psychiatric nurses, psychiatrists, and clinical managers) examining their perspectives on the role of psychology within the acute psychiatric inpatient setting. Thematic analysis was used to analyse data.

Results: The analysis identified two key themes "psychological treatments", which describes the perceived function of psychology on the ward, and "integrated psychological working" outlining key issues that psychologists should consider when working in multi-disciplinary teams.

Conclusions: Psychology is seen by MDT members as an integral, but not first line, treatment option in the psychiatric inpatient setting. Both direct and indirect work was valued by multi-disciplinary staff participants. The multi-disciplinary team do not have a clear understanding of the role of psychology, and both education and dialogue about the role is required.

Practitioner points:

- The role of psychology in the psychiatric inpatient setting is valued by the multi-disciplinary team.
- Psychology was not viewed as a first-line treatment option on the psychiatric inpatient setting but an "add-on" to medical treatment.
- Psychology was a valued source of support for skilling-up and offering reflective space to the multi-disciplinary team.

- Psychologists need to better promote their role and their skills to the multi-disciplinary team.

Introduction

Psychiatric inpatient hospitals deliver care to those who are experiencing a distressing mental health crisis and who are at risk to themselves and others, such as self-harm, suicidality, violence and aggression (Bowers et al., 2009). The primary presenting difficulties in an inpatient setting are experiences of psychosis, and in smaller proportions, experiences associated with a personality disorder (Department of Health, 2017). This client group has an array of complex needs as they often additionally present with substance misuse, social issues, and cognitive difficulties (Wolfson, Holloway, & Killaspy, 2009). Given the complexity facing psychiatric inpatient care a multi-disciplinary approach to care is crucial, and is best-practice for inpatient care (Bowers et al., 2009). It is recommended that inpatient care should involve psychiatry, nursing, occupational therapy, and psychology (Bowers et al., 2009; British Psychological Society, 2001), and that these professions should work together to provide holistic care underpinned by a biopsychosocial model (Christofides, Johnstone, & Musa, 2012). Each multi-disciplinary member should operate from within their disciplinary approach but undertake collaborative joint work in order to provide effective care (British Psychological Society, 2001; Royal College of Psychiatrists, 2010).

Psychological therapies, such as Cognitive Behavioural Therapy (CBT), are recommended to begin in the acute phases of mental health and to be delivered in the psychiatric inpatient setting (NICE, 2014; Royal College of Psychiatry, 2015). There is evidence to demonstrate that such therapies are effective in the delivery to inpatients with multiple presentations, including depression, psychosis, and personality disorder (Paterson et al., 2018). However, the inpatient setting continues to present a number of barriers which make the delivery of psychological therapies difficult. These include the restrictive physical environment and treatment options, a service delivery system which is avoidant of emotions and feelings (Bentley, 2014), and working within a team which adopts a predominantly medical approach (Baguley et al., 2007). It has been acknowledged the psychological therapies within the acute inpatient environment cannot be delivered in isolation (Small et al., 2018), and the support or involvement of the multi-disciplinary team is crucial (Kerfoot, Bamford, & Jones, 2012).

A recent qualitative study, which interviewed inpatient clinical psychologists, demonstrated the importance of psychologists being integrated into the multi-disciplinary team in order to better deliver psychological therapies (Christofides et al., 2012). This involved developing collaborative relationships, attending multi-disciplinary meetings and offering a psychological perspective in patient care whenever possible. However, to the author's knowledge, there

has been no examination of the inpatient multi-disciplinary team's perspective on how psychology can be best integrated into the team and work alongside these diverse professions. It would seem imperative to understand their perspective on how psychologists can work effectively alongside them in order to improve the delivery of psychological therapies. As this is an exploratory study of staff perspectives a qualitative approach was deemed most suitable (Braun & Clark, 2013). Therefore, this study aims to conduct a qualitative examination of the multi-disciplinary team's perspective on delivering psychological provision within the psychiatric inpatient setting.

Method

Design: A qualitative semi-structured interviews design was adopted. Interviews were conducted with multi-disciplinary team members exploring their perspectives on how to deliver psychological provision within the acute psychiatric inpatient setting. This study was approved by the Health Research Authority (IRAS 222917).

Participants: All participants were recruited from the psychiatric inpatient services of an outer London NHS trust. A purposive sampling approach was undertaken to ensure an appropriate spread of multi-disciplinary participants. The researcher presented the research in ward business meetings and also sent team emails detailing the project. Participants directly contacted the lead researcher if they were interested in taking part. Participants were included if they were (a) an accredited Occupational Therapist, Psychiatric Nurse, Psychiatrist, or Doctor (foundation years doctor, specialist registrar, trainee), and (b) currently work on an acute psychiatric inpatient setting with at least six months experience in that setting. No exclusion criteria was specified. Twelve multidisciplinary team members were recruited for the purposes of this study following guidance from Fugard and Potts (2015). No participants dropped out from the study.

Reflexivity: Reflexivity is reported following guidance from the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong, Sainsbury & Craig, 2007). The first and second authors are both clinical psychologists who have worked within the inpatient unit where the research was conducted for over five years. The latter two authors are a senior lecturer (and clinical psychologist) and professor of social and community psychiatry and independent from the inpatient unit where the research was conducted. All interviews were conducted by the first author who has previous experience of conducting qualitative interviews and attended relevant training. The first author worked clinically on one of the inpatient wards within the recruiting site. Attempts were made to recruit participants whom she had not worked directly alongside. As a result, she had worked directly with one participant but not with the remaining eleven.

Data collection: Two of the authors (LW & CW) developed the semi-structured interview schedule (see supplementary material). The interview schedule was taken to a Patient and Public Involvement Panel (PPI) for refinement. The schedule enquired about the important components of the delivery of psychology within the psychiatric inpatient setting. The interviews lasted on average 46.17 minutes (SD: 10.07; range 35 to 65 minutes). Interviews took place in a quiet room on the hospital site. Interview data was also used in another paper

which focused on understanding the care priorities of people experiencing psychosis in the psychiatric inpatient setting (Wood et al., under review).

Data analysis: Interviews were recorded and transcribed verbatim, coded and categorised using NVivo 11 (2017). Thematic analysis was used to analyse the data (Braun & Clarke, 2006). Thematic analysis is a flexible approach to qualitative data analysis and requires key decisions to be made before use. Thematic analysis was used from a critical realist positioning, latent themes were extracted and an inductive approach to data analysis was undertaken. Data analysis was primarily conducted by the first author. Interviews were listened to and transcripts read a number of times in order to be immersed within the data. Line by line coding of each interview was conducted and produced 297 initial codes. Codes were then collapsed and categorised across interviews. Analytical themes were then developed and discussed in supervision with CW and SJ. Once analysis was complete, it was presented to 25% of participants who gave their opinions on the analysis. Feedback was incorporated and a final theme structure was then established. Two final subordinate and twelve subordinate themes were developed.

Results

Participant demographics can be seen in table 1. Participants were a spread of professionals including occupational therapists, psychiatric nurses, psychiatrists and clinical managers. The group were ethnically diverse with participants from White (European and British), Black (British, African, and Caribbean), Asian (Indian) and Chinese backgrounds. The average length of mental health practice was 10.04 (SD: 7.90) years and average length of inpatient experience was 7.08 (7.39) years showing a relatively experienced population. All had experience of working alongside psychologists within an inpatient team.

[INSERT TABLE 1 HERE]

Analysis

The analysis resulted in two superordinate themes and eleven subordinate themes. The subordinate themes were "Psychological Treatments" and "Integrated Psychological Working". Themes are shown in table 2.

[INSERT TABLE 2 HERE]

Psychological treatments

This theme related to the perceived role of psychology and the psychology provision that the team found particularly beneficial. It was clear that participants viewed psychology as one of the prescriptive treatment options with a clearly defined remit of provision. Four related subthemes were identified.

Psychological formulation and hypothesising

Psychological ways of thinking were valued by participants. Psychologists were seen as being able to provide a different perspective and identify aspects of patient care that medical professionals may not notice. Psychologists were seen as being able to offer alternative hypotheses that would inform care planning.

"I've valued the input and often there's been formulation aspects of it, there's been a bit about picking up on nuances that non-one else has picked up on…" (participant 8; Consultant Psychiatrist)

Delivering group and individual interventions

The participants valued that psychologists could deliver evidenced based psychological intervention to patients in both individual and group form. Individual therapy was seen as a beneficial place where patients could talk in detail about their difficulties. Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) were mentioned as two dominant psychological approaches which they would like to be used more on the ward to target risk factors.

"They can be some form of group therapy where psychologists are able to arrange activities in a group form for patients which I found really to be very helpful so far on the ward" (Participant 1; Consultant Psychiatrist).

"We do some CBT – but I would like to see, especially for self-harmers and stuff if we can develop more interventions, whereas they don't have to wait until discharge" (Participant 10; Clinical Manager)

Development of insight, understanding and coping strategies.

Participants believed the primary purpose of psychological therapy was to support the development of patient's insight and understanding in relation to their symptoms and reasons for admission in order to prevent relapse. The development of coping strategies was seen as an integral part of this process.

"I think when it comes to risk what I believe psychology can do in terms of that, which is very significant is actually helping patients to understand the kind of possibly risk behaviours they tend to carry out when they are unwell. Getting them to actually think about how best to probably behave when they are relapsing and helping them look at the pros and cons of doing certain things…" (Participant 1; Consultant Psychiatrist)

Treating interpersonal and intrapersonal difficulties

Participants viewed the role of psychology to primarily manage the interpersonal and intrapersonal components of a person's presentation which was not treatable by pharmacological methods. This included a focus on abuse, trauma, grief, interpersonal conflict, and self-esteem issues. Very few participants cited psychological therapy as a means to reduce psychiatric symptoms.

"But I think it's [reason for referral] usually if the person had had say abuse in the past. One of our patients was recently referred due to that. But I don't think there's really a very clear referral criteria. I think that would be useful for maybe the team as a whole to have, just in

terms of what the psychologist would be looking at, and the type of patients they would see…" (Participant 11; Occupational Therapist).

Suitability and referring to psychology

Participants believed that not every patient was suitable for psychological therapy and this impacted upon who they referred. They believed that patients had to be stable and psychologically minded to engage in psychological therapy. Patients with a non-psychosis presentation were more likely to be referred.

"The psychological stable, its different for the psychological minded. You do not want someone who is actively psychotic, its going to be difficult for the person to understand what psychology is all about" (Participant 1; Consultant Psychiatrist)

"someone suffering from depression, is likely to benefit more from psychological intervention than someone who suffers from schizophrenia" (Participant 2; Psychiatric Nurse)

Integrated Psychological Working

Psychology is an adjunct to pharmacological treatments

Psychology was seen as an important part of treatment planning but very much an adjunct to dominant pharmacological treatment. Participants identified that psychology could be a conflicting approach to the medical model which made it hard to integrate the two approaches. However, participants spoke about the ongoing need of trying to develop more of a balance.

"It's very medical, predominantly medical. Very ying and yang in fact, obviously this is my view but I can only view it as linear. Sometimes there's less like given to the triggers and identifying why someone keeps relapsing or what is their social situation. And it's more along the avenue of well they weren't taking their meds or they didn't have meds previous. So we give them meds, stabilise them, we sort out any accommodation issues and discharge them…if in-between psychologists can interject or there is some family issues or something like that then there will be more weight…" (Participant 6; Clinical Manager).

"a lot of them do mention they'd like psychology so we need to try and get that balance between medication and other interventions" (Participant 5; Psychiatric Nurse)

Visibility and accessibility

Participants appreciated having a psychology presence on the ward through increased visibility and accessibility. This allowed for the team to access both informal and formal psychological input to support the care planning of patients.

"the psychologist we had on the ward was pretty experienced and was, I guess had the enthusiasm to take on stuff… so just to have that presence on the ward makes a difference" (Participant 8; Consultant Psychiatrist)

Psychology integral to creating cultural shifts

Psychology played an important role in causing a necessary shift in the ward culture and general environment. Having psychology in the team meant that there was more time for reflection within the team and an important slowing down of a rapid treatment process.

"I find overall that they have a very settling effect overall and it's almost like, when I say it makes a more complete team it's because of the skills sets that people bring… they are able to take a step back and view the whole picture and provide really useful input… I think that's really important because sometimes there is a certain momentum…" (Participant 12; Occupational Therapist).

Consultation and feedback

Indirect work through regular consultation and feedback with a psychologist was particularly valued. Informal consultations were often used in formal settings to inform patient care planning. Moreover, participants also valued the regular feedback and communication from psychologists regarding information gathered through their direct patient input.

"Naturally would just go and talk to them. And I know they've given me insights which I've taken to handover and said this isn't my insight but I got this from psychology" (Participant 6; Clinical Manager)

"[psychologist] always writes and gives feedback… [psychologist] has made a huge difference with some of the clients..." (Participant 10; Clinical Manager)

Supporting the staff team

Participants saw an important role of the psychologist as supporting the staff team. This was achieved through multiple formal and informal formats including both training and reflective practice.

"I think on the ward we were discussing ways for CPD [Continued Professional Development] and you know more teaching in that would be a really useful one [for the psychologist to facilitate]." (Participant 3; Occupational Therapist)

"we have a staff reflective practice group… its generally a monthly basis, or it's the opportunity for staff to discuss concerns or anything that's happened over the past month that they would like to discuss" (Participant 11; Occupational Therapist)

Psychology a distant team member

Although psychologists were valued by participants, they were viewed as a distant member of the team. This was identified as having both pro's and con's as patients often preferred talking to someone more independent, but conversely this distance impacted on the psychologist fully integrating into the team. Moreover, participants explained that many staff, nursing staff in particular, do not understand what psychologists actually do, which was an additional barrier to psychologists being integrated into the team.

"it's not as close as they would feel to the occupational therapist or to the nursing staff because its, you know, just someone that they're going to, not face-less but, you know someone they don't know…" (Participant 7: Psychiatrist)

"as long as the nurses understand what the role of psychology is, you'd think that it's something that they'd covered in their training, but I think for them to actually understand… that would be very useful…" (Participant 4; Psychiatric Nurse)

Therapy allies: Occupational Therapy and Psychology

All occupational therapy participants (four participants) described psychologists as important allies in the context of a more dominant medical staff structure of psychiatrists and nurses. Joint working between the two professions as well as professional support was valued.

"It's been useful, there have been good points. Again it's sort of for me, it feels like a therapy team amongst a very medical model. It's been useful to have a similar approach to myself" (Participant 3; Occupational Therapist)

Discussion

This study aimed to examine multi-disciplinary staff perspective's on delivering effective psychological care in the psychiatric inpatient setting. Two superordinate themes were identified "psychological treatments" and "integrated psychological working".

The first theme of "psychological treatments" encompassed key psychological intervention strategies that the participants valued. Psychologists were viewed as providing a treatment option with clear intervention remits. Psychological interventions were seen as valuable particularly when pharmacological treatments were not an option. Perceived key target areas included developing understanding and insight, and the resolution of intra and interpersonal difficulties. It was evident that targeting symptoms and reducing risk were not seen as an important role of psychology, despite this being the primary focus of inpatient care (Bowers et al., 2009). Formulation of complexity, a core skill of psychology, was particularly valued by the team to gather new insights into patients' presentations. This supports previous research where formulation has been identified as a key mechanism to support inpatient staff teams (Berry et al., 2015; Christofides et al., 2012). Participants had a strong sense of what they thought was appropriate suitability criteria when referring to psychology, favouring those who were more stable and not presenting with acute psychotic symptoms. It is noted that psychosis is more likely to be viewed as a medical problem, treatment resistant, with less likelihood for recovery (Crisp et al., 2000; Read & Harre, 2001; Wood et al., 2014), which may impact upon why people with psychosis are less likely to be referred to psychology. Collectively, this demonstrates the importance of psychology having clear guidelines for inpatient teams about the full remit of psychology and what can be delivered, particularly for those experiencing psychosis, and developing a better dialogue with their multi-disciplinary colleagues. This could include the promotion of adapted psychological therapies, which have been shown to be feasible and acceptable with this population (Wood et al., 2017; Sheaves et al., 2017).

The second theme "integrated psychological working" demonstrated that psychology was valued and that participants wanted psychology to be integrated to the multi-disciplinary team. Despite wanting psychology integrated, psychology was viewed as an adjunct to pharmacological treatments. This is an ongoing challenge and a potential barrier to the delivery of psychological interventions in this setting (Clarke & Wilson, 2008). Key ways of integrating psychology, which potentially serve as a means of establishing psychology, were identified. These included having an ongoing psychological presence, offering informal and formal staff support and consultation, and regularly feeding back to the team. This supports previous research which has outlined the importance of psychology being integrated into the

mutli-disciplinary team to increase efficacy (British Psychological Society, 2001). It has been identified that wider system changes are required to otherwise establish psychology in equal footing to the medical model, including increased psychological resources and an overarching psychologically-informed model of care (Wykes et al., 2018). Occupational therapists particularly valued psychology due to having similar psychosocial approaches to understanding patients' difficulties and delivering care. This demonstrates that psychologists could optimise this relationship by completing collaborative joint-work and improving dialogue with multi-disciplinary colleagues.

A strength of the study is the aim itself. To the author's knowledge, this is the first qualitative study exploring multi-disciplinary perspectives on the delivery on the role of psychology in psychiatric inpatient settings. As noted, psychology cannot be delivered in isolation from the multi-disciplinary team and therefore their perspectives on how to deliver psychological interventions is essential. This study followed guidelines in maximising the reliability and validity of the research methodology and analysis (Tracy, 2010). In particular, patient and public involvement was included making sure the questions were relevant to the patient population. A limitation to the study was that the sample was recruited only from site meaning the generalisability of these findings may be limited. However, given the qualitative design of the study and preferable homogeneity of the sample, only one recruiting site seemed appropriate. A further limitation was that the participants were interviewed by a psychologist, which may have positively skewed the discussions and limited the identification of challenges or barriers. Participants may have felt less able to talk openly about the limitations of psychology, and response bias may have been present. However, the researcher had not directly worked with eleven of twelve participants. The research being led by a psychologist also meant that the research question has led to important clinical implications for the delivery of inpatient psychology.

This study has important clinical implications. Firstly, it is evident that inpatient psychologists need to clearly promote their role and improve dialogue with the multi-disciplinary team. In particular, they need to demonstrate that they can offer evidenced-based psychological interventions which can target psychiatric symptoms, as recommended by NICE guidelines. This is particularly important for patients experiencing psychosis to ensure this population is offered the equal opportunity to engage in psychology. Further research should be conducted to qualitatively examine how psychologists could promote themselves better in the MDT and what information would be most valued. Psychologists may also need to be proactive in engaging people with psychosis in psychological therapy and not wait for referrals for the multi-disciplinary teams. It also evident that to maximise efficacy psychologists need to be integrated as much as possible into the multi-disciplinary team. It

would be important to further examine through research how these relationships can be best developed. Psychologists need to maximise their presence by being readily available and visible to offer formal and informal support, which was particularly valued by participants.

In conclusion, psychologists are valued member of the multi-disciplinary team but psychologists need to ensure that they are fully integrated into their teams, are visible and accessible, regularly promote their skills, educate team members on the role of psychology, and improve dialogue with the team.

Table 1 – Sample Demographics

Inpatient Staff Demographics		
Age (years)	38.18 (10.40)	
Length of mental health practice (years)	10.04 (7.90)	
Length of inpatient experience (years)	7.08 (7.39)	
		N(%)
Gender	Male	8 (66.66)
	Female	4 (33.33)
Ethnicity	White (British and European)	4 (25)
	Black (British, African and Caribbean)	6 (50)
	Asian (Indian)	1 (8.33)
	Chinese	1 (8.33)
Professional Role	Occupational Therapist	4 (33.33)
	Psychiatric Nurse	3 (25)
	Psychiatrists (2 consultants; 1 junior doctor)	3 (25)
	Clinical Manager (Nurse)	2 (16.67)
Ward Type	Acute Psychiatric Inpatient Unit	7 (58.33)
	Psychiatric Intensive Care Unit (PICU)	5 (41.67)
Worked alongside inpatient psychologists	Yes	12 (100)
	No	0 (0)

Table 2 – Superordinate and subordinate themes

Psychological Treatments	Integrated Psychological Working
Psychological formulation and hypothesising Delivering group and individual interventions Development of insight, understanding and coping strategies. Treating interpersonal and intrapersonal difficulties. Suitability and referring to psychology	Psychology is an adjunct to the pharmacological treatments Visibility and accessibility Psychology integral to creating cultural shifts Consultation and feedback Supporting the staff team Psychology a distant team member Therapy allies: Occupational Therapy and Psychology

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Appendix 1

Interview questions

1. *Can you tell me about your experiences of working as a nurse/occupational therapist/doctor in the psychiatric inpatient setting? Prompt: What does your role look like? Day to day tasks?*

2. *Can you tell me about the work you have done with people in the inpatient setting? What treatments have you used? What presentations have you worked with? What models of care do you draw upon?*

3. *From your experience, what do you think the therapeutic needs or priorities of people during a psychiatric inpatient admission?*

   Prompt: what have been the goals of your patients? What presenting issues have patients discussed with you? What is the focus of their care?

   Prompt. Suicidality, symptoms, social factors, other psychological factors

4. *What needs or priorities of inpatients go unmet during a psychiatric inpatient admission? How do you think we can address these?*

5. *What do you consider when making a referral to psychology?*

6. *Are there any barriers that you can identify to referring people to psychology?*