

Mental health communication between service users and professionals: disseminating practice-congruent research

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Abstract

This paper considers the demand for evidence-based practice in mental health communication and describes how evidence from studies of health communication, as well as recommendations from educational models, professional bodies and policy directives have been incorporated into our 'Brief, Ordinary and Effective' model for communication in nursing. A key challenge in putting evidence to work in health care and bridging the theory-practice gap concerns the social and organisational context that may not always work to sustain new initiatives. Accordingly, we will describe an attempt to support and consolidate awareness of the role of evidence in health care communication via a Managed Innovation Network and the development of the Brief, Ordinary and Effective model of health care communication. This enables us to align the quest for new knowledge and insights that are practice-congruent with the kinds of applicability criteria that modern health care providers set out. This has yielded important insights about how research can be embedded in informed practice and how evidence-based communicative practice can be nurtured and made viable in communication in mental health care.

Key words

Mental health, language, evidence, managed innovation, theory, practice

There is currently no coherent program to promote evidence-based mental health communication worldwide. While there has been a growing literature in this field, it is demonstrably fragmented and is often profession specific (Hassan *et al*, 2007). In our day-to-day work as clinicians, health communication academics and educators, it is possible to detect multiple organisational barriers that prevent research evidence from informing mental health practices.

This paper is based on an attempt in the UK to bring together the demands of evidence-based practice, the organisational imperatives of health care institutions and insights from studies of health communication. We will describe the

development and evidence base of what we have called the Brief, Ordinary and Effective (BOE) model for health communication (Crawford *et al*, 2006). This initiative emerged from findings on the barriers and promoting factors for evidence-based practice in mental health (Crawford *et al*, 2002), work to advance 'evidence-based research' (Brown *et al*, 2003) and a drive to advance 'evidence-based health communication' (Brown *et al*, 2006).

The context: evidence-based practice in health care

Developing an initiative that responds to the demands of evidence-based health care and is

sensitive to the fine grain of successful health care interaction requires us to step back and consider the context. Sackett *et al* (1996: 71) characterised evidence-based practice as '*the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients*'. Much evidence-based health care is driven by how well patients perform in relation to treatments, whereas the language of health care encounters typically concerns two people and notions of average patient improvement may be less meaningful (Moore *et al*, 2008). Further difficulties with the implementation of evidence-based policies in health care may derive from the faith on the part of researchers and policy-makers in the *prima facie* or obvious benefits of research evidence. If one presents evidence, in other words, then clinicians will start using it. The fact that they often do not do so may reflect an important aspects of clients' and practitioners' values, as well as clinical circumstances that are often not accounted for in evidence-based practice initiatives (Tilburt, 2008).

In mental health in particular, many commentators complain of an enduring theory–practice gap (Reynolds, 2000). Some theoretically-informed attempts to shed light on why this is (eg. Traynor, 1999) see exhortations from policy-makers as a kind of social control exerted over practitioners such as nurses, who may lack a robust intellectual tradition of their own and have an unhappy history of subservient, non-academic status that may conspire to prevent the application of evidence in practice (Ousey & Gallagher, 2007). Some of the specific barriers to the implementation of evidence-based practice include: lack of organisational investment and managerial commitment; the overly structured nature of many recommended interventions; caseload and time management issues; staff apathy and burnout, as well as difficulties with accessing information; and the ambiguity of much primary research when it comes to deriving practice recommendations (Crawford *et al*, 2002; Williams, 2008).

In mental health care, there are indications that the kinds of psychotherapeutic and psychosocial interventions recommended by the UK's National Institute for Health and Clinical Excellence (NICE) (NICE, 2002; 2004; 2005) are implemented for only a minority of clients, for conditions such as schizophrenia (Berry &

Haddock, 2008), obsessive compulsive disorder (Lovell & Bee, 2008), and self-harm (Pitman & Tyrer, 2008), with many practitioners focusing instead on issues such as risk management and medication compliance. The challenge then is to not only inquire into 'what works', but into how this can be implemented within the human and organisational environment of health care.

Making evidence count in practice

The need for practice to be informed by evidence about how to communicate effectively and in a way acceptable to clients is underscored by the prominence of this issue in clients' complaints. 'Poor communication' in clinical settings is the largest source of patient dissatisfaction (Kinnersley & Edwards, 2008). Inadequate professional communication has been consistently cited as a cause for concern by Ombudsman Reports on the NHS in the UK (www.ombudsman.co.uk). A number of initiatives have demanded improvements, including *Essence of Care* (Department of Health, 2003), *Tomorrow's Doctors* (General Medical Council, 2002), and *Good Medical Practice* (General Medical Council, 2001).

It is not always easy to ensure that practice follows evidence, even where this is available. From our own research and from other literature on 'implementation enhancement factors' that are likely to make it easier for evidence to inform practice, it is necessary to '*establish ambient conditions – that is, enabling factors – that foster innovation*' (Angle, 2000: 144). Implementation enhancement factors include ongoing resource availability including access to evidence itself (Crawford *et al*, 2002). Also valuable are access to technical assistance, staff knowledge of the innovation, implementation skills, education and skills development, the opportunity to network and share, as well as the freedom to express doubts. Massatti *et al* (2008) emphasise the need for an innovation to be underpinned by financial resources and for the organisation to be able to attract and retain motivated and qualified staff.

The importance of organisational and human relations factors in ensuring that evidence-based innovations are widely diffused in an organisation and that they are sustained, led us to consider how best to support improvements in communication. Fortunately, the opportunity arose for one of us (PC) to set up a Managed Innovation Network (MIN) in Mental Health

Communication at Nottinghamshire NHS Healthcare Trust, UK. These MINs are initiatives designed to bridge the gap between research and practice, promoted by the Institute of Mental Health at Nottingham University. One of the Mental Health Communication MIN's key projects has been to roll out a new framework for health care communication, namely our Brief, Ordinary and Effective (BOE) Model. This model derived from existing research from mental health care and related fields, and is described in Crawford *et al* (2006) and Brown *et al* (2006). It is derived from aspects of communication education in clinical settings that are suited to brief interactions, as well as drawing upon aspects of phatic communication or 'small talk' and politeness theory. We shall specify the model in more detail shortly, but as an indicator of its acceptability to policy-makers, it is worth noting that it was included as a key aspect of a recent *Chief Nursing Officer's Review of Mental Health Nursing* (Department of Health, 2006). In light of the foregoing discussion of the barriers to new initiatives in health care, this is significant as it signals support at a high level in the UK's health service. The BOE model has, therefore, provided a means of bringing an awareness of the importance of health communication research into policy.

The BOE Model sought to transform the focus on communication in mental health and steer it away from the dominant 'production line mentality' afflicting busy health care environments and the culture of professional expertise that has previously ascribed a relatively low status to communication skills.

The Brief Ordinary and Effective model in detail

First, let us try to specify the kind of 'model' that the Brief Ordinary and Effective approach claims to be. Like many models of nursing, it seeks to sensitise the reader to salient or prominent aspects of what they are doing, and functions as an *aide memoire* to assist desirable practice. In nursing, there are numerous models used to explore and shape nursing care from 'metaparadigms' (Fawcett, 2005) to middle range theories such as Hildegard Peplau's (1952) theory of interpersonal relations, Bonnie W Battey's theory of humanising nursing communication (Duldt & Griffin, 1985), and Phil Barker's 'Tidal Model' (Barker & Buchanan-Barker, 2005), where health and illness are seen as fluid and a person is

seen as undertaking a life journey on an ocean of experience. Taking its place within this tradition of nursing models, the BOE model seeks to be both sensitising and programmatic, in that it recommends attention to short communicative opportunities, and seeks to enhance practice in this area by promoting core, brief communication skills and the development of interactions with service users, which may appear ordinary but which we know enhance outcomes. As such, it calls for practitioners to adapt to task-dominated environments and utilise even momentary time slots to create emotionally supportive and communicative events. The finite resource of practitioner time has often to be parcelled out sparingly (Deacon & Fairhurst, 2008). Therefore, our approach encapsulates what we call the 'tardis effect' (Brown *et al*, 2006) – where any brief communication can be made to feel much bigger on the 'inside' than it appears from the outside. As we know from attempts to apply ideas about phatic communication or using 'small talk' in nursing (Burnard, 2003), even brief interactions such as a greeting, a smile or a few words may have important impacts on subjective well-being. The model thus attempts to bring together the implications of a large number of accounts – ranging from the anecdotal to the more formal and systematic – where client well-being has been effectively enhanced through relatively simple and commonplace communicative actions. Like many nursing models, its basis can be traced back to pragmatism, where

'the focus of human effort is to make the human lot as good as possible by creating advantages, and taking advantages of, emerging possibilities and opportunities in human potential' (Kim & Sjostrom, 2006).

Thus, the BOE model has embedded values and this enables it to connect with the values espoused in nursing, to further connect these with evidence, and enjoy a resonance beyond the mental health field.

The Brief Ordinary and Effective model therefore suggests that we focus upon the following.

- *Brief forms of communication*, including eye contact, nodding, smiling, friendly or humorous small talk or phatic communication; touch, facial, hand or body gestures are valuable in establishing and sustaining rapport with other people.

- *Ordinary forms of communication* create, sustain and terminate therapeutic relationships with patients or clients, reduce misunderstandings caused by expert language or jargon and promote greater equality in interaction.
- *Effective forms of communication* bring about desirable outcomes in terms of client satisfaction, elicit or provide accurate information or advice, and promote constructive interactions.
(Crawford *et al*, 2006: 141)

The skills involved, which we will itemise below, were derived from research evidence concerning successful human and health communication, and are selected so as to privilege humanising, respectful and brief ways of improving communicative events. Let us review some of the key features the model includes and identify the research behind each of them.

Welcoming and initiating friendly and appropriate conversation

In this respect, the recommendations correspond to practices foregrounded in the Calgary Cambridge model of communication skills education (Kurtz & Silverman, 1996).

Conducting and sustaining polite, balanced, shared conversation with appropriate turn-taking and use of non-verbal and verbal prompts

This can include head nods and hand gestures that encourage interaction; phrases such as 'go on', 'I see', 'okay'; and expressions such as 'uh-huh'. Continuers such as these signal collaboration with the speaker's talk (Hutchby, 2006). There are acknowledgement tokens ('yeah', 'mm'), newsmakers ('oh', or the idea connector 'right') and change of activity tokens ('okay', 'alright') (Gardner, 2001). These kinds of features of ordinary interaction can be used to signal listening, interest and facilitate the smooth flow of talk in health care settings.

Ending or closing conversation in a mutually satisfying and respectful manner

Since Schegloff and Sacks' (1973) classic study, there have been many investigations of how conversations are closed by the speakers in a way that is intelligible and legitimate, such as a coda or summary – 'I'm sure things will turn out for the best'. Button (1987) suggested that

closing could be postponed by the use of new topic elicitors, and Knapp and colleagues (1973) identified 'appreciators' such as 'thank you for your time' and 'external legitimators' such as 'I have someone else waiting for me' as signaling impending termination.

Frequently acknowledging others by using brief, positive greetings, ordinary, everyday conversation

As Schegloff (2004: 83) reminds us, an everyday greeting like 'hello' signals the availability of parties for interaction. Equally, the absence of greetings can be taken to signal lack of recognition, rudeness or bad temper on the part of the interactant not doing them.

Using empowering language that encourages self-determination and decision-making of others

As Garrick and Ewashen (2001: 169) argue, it is possible to use language in a way that liberates and empowers clients, and which seeks to connect, validate and integrate. Moreover, some commentators have described how knowledge empowers (Stone *et al*, 2005). As Fisher and Owen (2008) remind us, empowerment occurs in and through social and familial networks rather than being the result of individuals pulling themselves up by their bootstraps. Thus, empowerment is best achieved by attention to intersubjective social factors as well as individual ones.

Using non-stigmatising language – avoiding the use of labels or descriptions that isolate, belittle or are abusive to others

Our concern is that the use of pejorative terms by practitioners – eg. 'manipulative', 'typical PD', 'miserable bugger' could disadvantage service users and make it difficult for them to recover from episodes of illness. Jones and Crossley (2008) go further and associate feelings of shame with the lack of control experienced during periods of hospitalisation, and draw attention to the role of language in occasioning self-abasement and feelings of alienation in patients.

Using dignified or self-respecting language

An example of this can be seen in the recent guidance from the UK's Nursing and Midwifery Council (2008) concerning the use of language with elderly clients, where members are warned

away from using potentially belittling terms such as 'love' or 'dearie'. While these may represent terms of endearment there is concern that such 'secondary baby talk' conveys low expectations of the clients' functioning and represents a means of structuring the power relations in a care setting in favour of the professional.

Negotiating care with service users in the spirit of concordance with an emphasis on reaching agreement

For example, there are suggestions that being able to discuss the reason for a particular medication plan with doctors and pharmacists can enhance concordance (Du Pasquier & Aslani, 2008). Equally, concordance with treatment plans is enhanced where clients have appropriate skills and social support to follow through on recommendations (Price, 2008). Equally, as Pollock (2005) warns us, the appearance of concordance in health care consultations may be governed by the power imbalances and situational etiquette as much as by lasting agreement. Thus, the practitioner is best advised to be attentive to the situational factors that might induce short-term compliance at the expense of longer-term concordance.

Demonstrating appropriate use of silence

This can be used for example in facilitating reflection; expression of feelings; conveying empathy; to encourage response to open questions; as an opportunity to observe or convey interest. The role of silence in therapeutic contexts is coming to be increasingly appreciated (Blanton, 2007; Sardello, 2006). Ephratt (2008) notes that silence helps to maintain contact and alliance.

Demonstrating appropriate use of humour

Demonstrating appropriate humour can create an open, responsive social atmosphere; relax others and reduce stress; reach out to and engage others; increase interaction; and boost morale (Dean & Major, 2008; McCreddie & Wiggins, 2008).

Using appropriate open or closed questioning

There is also widespread agreement that patient-centred communication, using open questions, and trying to elicit the patients' full range of concerns and problems improves patients' health status and increases the efficiency of care by

reducing the need for supplementary diagnostic tests and referrals (Chan *et al*, 2003). At the same time the practitioner should be aware that asking questions may itself be stressful (Parslow *et al*, 2000; Van Dongen & Kutalek, 2007).

Responding to questions in an honest and clear manner

A number of commentators have suggested that patients often feel that they have not had the opportunity to ask questions (Brown *et al*, 2006; Zebrack, 2008). Being able to have one's informational needs fulfilled enhances the sense of autonomy and trust appears to increase as the sense of autonomy grows (Piippo & Aaltonen, 2008).

Clarifying or checking out the meaning of what people say by careful use of questioning, summarising and paraphrasing

This is especially important when dealing with complex issues. The value of reflecting and combining 'co-presencing' (the holistic amalgam of attitudes, qualities and interventions) has been underscored especially for suicide prevention (Cutcliffe & Stevenson, 2008), but has also been noted as valuable by those seeking to enhance empathy and therapeutic rapport between practitioners and clients (Norfolk *et al*, 2007).

Demonstrating sensitivity to ethnicity, cultural background, and the communication needs of people when English is their second language

Here, awareness of potential communication difficulties '*may in itself offset much of the trouble*' (Mauranen, 2006: 123). Indeed, in line with the 'ordinary' element of the BOE model, there are many aspects of natural language that are concerned with detecting and repairing misunderstanding. Moss and Roberts (2005) describe how GPs can use repair strategies to fill in and refine understandings and elicit patients' knowledge, experience and perspectives when the native language of practitioner and patient differ.

Identifying anger and frustration and using verbal de-escalation techniques

Many commentators note the importance of minimising 'physical contact situations' and

instead advocate reliance on verbal de-escalation techniques (Cowin *et al*, 2003). As Irwin (2006: 311) notes,

'ineffective staff–patient or patient–patient interactions appear to represent a major influencing factor on outcomes where this perception of a power imbalance exists, and are widely considered to be significant in the course of aggressive behaviour'.

Indeed, personal accounts from those who have been successful at de-escalation suggest it is a valuable experience:

'That was something I really enjoyed about being a staff nurse again, using those skills that you develop, and that is what I enjoy now [. . .] I do enjoy getting the opportunity to use skills to de-escalate a situation and the majority of times you do.' (Bigwood & Crowe, 2008: 219)

Providing accurate advice, instruction, information and professional opinion

There is some evidence from both self-report studies and studies of audio-recorded interaction that advice is often not tendered or is incomplete across a range of sites, including general practice (Smolders *et al*, 2008), pharmacy (Garner & Watson, 2007; Ylanne & John, 2008) and mental health support in rural areas (Sartore *et al*, 2008). Indeed, advice-giving sequences can be deflected and left incomplete when the client delivers an unexpected turn or says that the medication is intended for someone else rather than themselves. Thus, practitioners need to be mindful of the need to present complete advice sequences.

Maintaining confidentiality in both spoken and written communication

While most practitioners would agree on the principle of confidentiality (Younggren & Harris, 2008), there can be difficult dilemmas to be resolved where clients are embedded within a network of friends and relatives who may all have a view of the issue and may be desperate for information (Chen, 2008; Gray *et al*, 2008). Accordingly, the practitioner must navigate the fine line between these competing interests and be proactive by eliciting the information sharing preferences of the service-user and discussing dilemmas with colleagues.

Answering telephone enquiries in an appropriate manner: identifying oneself, being polite, striving to reduce hostility or conflict, resolving queries or concerns

Much of the scholarship on telephone interaction comes from the conversation analytic tradition. More recently we have noted in telephone advice line interaction that skilled practitioners deploy a variety of techniques to establish relationships, minimise the potential intrusion of questions, as well as direct the client towards a particular course of action (Brown & Crawford, 2009).

Keeping brief, factual and accurate care records

This is particularly topical at present in the UK, as the entire record-keeping process is undergoing change. Initiatives to computerise records under the Connecting for Health initiative are accompanied by efforts to standardise and improve the quality of information and the availability of records (Carpenter *et al*, 2007). At the same time, the perceived accuracy and the suitability of the language used is particularly important, as patients may increasingly view or be able to contribute to records themselves (Staroselskya *et al*, 2008). The recommendation here for brevity and to stick to the salient issues in the situation comes from evidence that complex systems of classification for nursing or medical phenomena are unwieldy and impossible for practitioners to commit to memory (Hovenga *et al*, 2005). Moreover, the intelligibility of notes for transition between different care professionals, facilities and agencies has been noted to reduce error and costs (Westra *et al*, 2008).

Discussion: key themes in the BOE model

Having outlined core features of the BOE model that relate to communication, and indicated some of the rationale and evidence behind them, let us now consider some of the common themes that cut across the items in the model and how they relate both to traditions of enquiry in language study and to the policy and organisational context in which the model has been unfolded so far.

Notably, the BOE model gains strength of evidential support from its alignment with traditions in sociolinguistics, which emphasise

how language is used to build and facilitate relationships. Phatic communication or 'small talk' for example is valuable not because of the words used but because it opens up a shared cognitive space of mutual regard. As well as interaction between practitioners and clients, phatic communication has been noted to be valuable in creating shared spaces between practitioners, especially in cases of uncertainty (Schryer *et al*, 2007). The everyday aspects of communication, as we talk about ourselves and one another constitute 'small stories' (Bamberg & Georgakopoulou, 2008) through which we establish identities in the face of adverse conditions and constant change. So far, a great deal of the research on health care communication has been to do with how the business of the encounter is accomplished. On the other hand, many of the kinds of features we have identified are those which, while they might have instrumental functions in relation to the larger picture of health care, have often slipped through the net of scrutiny. By contrast, in our model we foreground the vital function of the 'tardis effect', of 'small talk' and other positive brief communication, in 'oiling the wheels' of interaction. Indeed, sometimes the phatic activity and 'small talk' may play a vital role in deflecting attention away from potentially onerous, painful or troublesome aspects of the health care encounter (Maynard & Hudak, 2008).

In conclusion: putting evidence to work

By way of conclusion we also wish to highlight the importance of considering and working with organisational factors if evidence is to be embraced and consistently applied. Hence our efforts to embed the BOE model in the working lives of practitioners. This is why the Managed Innovation Network is so valuable in its involvement of practitioners and researchers so as to encourage those features that have been identified as promoting the long-term viability of programmes of innovation in organisations (Massatti *et al*, 2008). It is here that we can advance both our understanding of how the relational work of health care is accomplished through communication and the implications of this for educating the next generation of practitioners. In this way we hope that the kinds of practice and awareness we are promoting with the BOE model will become part of what Watts (2003: 160) called 'professionally appropriate language performances'

and highlight the role of linguistic, and more broadly, communication capital in performing and transforming the professional and institutional tasks at hand. As we have argued elsewhere (Brown *et al*, 2006), the challenge is far more than merely to define communication skills, and it requires initiatives like the MIN to ensure that they are visible to health care professionals and inculcated in a way that is robust in the face of organisational and institutional pressures, which predispose rudeness and perfunctory treatment. For the application of research to be truly viable it needs to emerge from, and be congruent with, clinical practice and cultures of praxis.

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