

'Map and Talk'

– A Cognitive Analytic Therapy Informed Approach to Reflective Practice in a Forensic Setting

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Abstract: This paper describes the context, ethos and establishment of a Cognitive Analytic Therapy (CAT) informed approach to Reflective Practice in an Inpatient NHS Forensic setting in East London. It is a preliminary description of the project, setting the scene for further quantitative research in the future, and captures our experiences and initial thoughts at this early stage.

The 'Map and Talk' approach (Potter, 2010, 2016) is described, followed by a discussion about the achievements, challenges and reflections on the process of introducing the model to the service. The paper emphasises the importance of a robust supervision structure, and multidisciplinary input at all levels of the project in order to maintain the ethos of 'doing with not doing to'. The experience has highlighted the importance of reciprocal roles and multiple positions as 'active' ingredients of the approach. The development of the Reflective Practice Groups as they have formed from discussing patient staff interactions to reflecting on wider themes such as gender, hierarchy, race and culture, which are often unspoken, is described, as well as the resonating of relational patterns across the various levels of the service and the supervision structure. Reflections on the impact of the project on the project lead group are included and the project is described in relation to the wider social and political context. Finally future directions and research opportunities and directions are outlined.

Keywords: Reflective Practice, Forensic, Multidisciplinary, Staff Groups, Map and Talk, Cognitive Analytic Therapy

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IN 2013, Sir Robert Francis QC published his report of the public inquiry into Mid Staffordshire NHS Foundation Trust in England (Francis, 2013). The report is a summary of an investigation into the causes of serious failings in the provision of care in that Trust between 2005 and 2008. In his conclusions, Francis indicates that an organisational culture at Mid Staffordshire, which allowed poor and unsafe practice to be overlooked and which prioritised the meeting of targets above patient safety, played a critical role in those failings. The publication of the report gave rise to a period of reflection across the NHS in England about organisational culture and how the recommendations from Francis might be applied locally.

One year previously Adlam et al. (2012) published 'The therapeutic milieu under fire', a volume of chapters by experts in aspects of forensic mental health provision describing some of the challenges both psychodynamic and socio-political of working in secure care from a number of different perspectives. The 'fire' of the volume title is conceptualised as something both internal to the ward, as an 'emotional heat that is generated by an interaction of group dynamics and toxic attachments in both patient and professional groups' (Adshead, 2012) and also as coming from outside of the hospital setting from the socio-political context for example as cuts to funding and the deletion of services (Wrench, 2012) and attacks on professionals who work with people who present a risk of harm or who perpetrate actual harm to others (Cooper, 2012).

Both Francis (2013) and Adlam et al. (2012) came at a time of uncertainty and insecurity within the NHS in England as a result of financial austerity and restructuring. They helped to inform our thinking at a time when as a Forensic Service there was a renewed focus on how to maintain the health of our organisation in the face of these challenges. The creation of effective 'shared thinking time' was a consistent theme of discussions and seemed essential to critically evaluating culture and maintaining the psychological health of staff in order to continue to support them in delivering compassionate, patient-centred care.

Use of CAT in Reflective Practice

The use of Cognitive Analytic Therapy (CAT) in helping teams understand their experiences systemically and not as purely located inside the individual is not new. In the 1990s, there were several examples of the pioneering use of CAT in helping teams understand the complex interactions between the patient, staff and organisations, referred to in CAT as contextual reformulation (Ryle & Kerr, 2002). Walsh's (1996) qualitative research showed how CAT and the diagrammatic reformulation can help understand the relational patterns within a team with dysfunctional dynamics. Dunn & Parry (1997) discussed the value of incorporating CAT formulations into care-planning for patients with borderline personality disorder in a community mental health team. Kerr (1999) reflected on his experience of working with an individual with borderline personality disorder and how sharing the diagrammatic formulation with the team started the process of compassionately understanding the patient's presentation and how staff can play a role in maintaining difficulties.

Since then, there have been several innovative projects focusing on helping teams understand how the roles of the patient, professional and system interact to maintain or improve problematic patterns of relating. This includes the development of CAT skills training courses aimed at educating and equipping whole teams with a relational understanding, especially when working with the 'difficult' patient with complex and severe presentations (Kerr et al., 2007).

Thompson et al. (2008) evaluated a team training course that incorporated an intensive training week, a brief personal reformulation followed by six months of CAT case supervision in a small group setting. A qualitative thematic analysis showed that the course increased professional's therapeutic confidence and skill as well as fostering the development of a shared model within the team and bringing a sense of cohesion. Challenges were also discussed including increased work load, 'non-compliance' with aspects of the model and role confusion.

More recently, Caruso et al. (2013) evaluated a parallel initiative in Italy. They delivered a basic CAT training intervention to twelve team members from different professional backgrounds. The training consisted of five two-hour theoretical and practical sessions introducing the use of CAT and contextual reformulation. They administered several measures before and after training and at one-month follow-up. Results showed that the training facilitated team cohesion and patient engagement whilst reducing burnout levels.

The value of contextual reformulation has also been emphasised in forensic settings. Marshall et al. (2013) provide one example of how an overarching CAT framework based on the 'Map and Talk' approach (Potter, 2010) has been developed within a forensic unit. They describe a tiered approach including a two-day introductory training for all staff and a more intensive CAT skills training for several people referred to as 'champions' to help embed the model into the ward environment.

In summary, the literature reviewed highlights the value of using CAT with teams with the aim of promoting team cohesion, staff wellbeing and patient care. Key ingredients include developing understanding and a common language in a non-blaming way, using tools such as diagrammatic reformulation.

The Map and Talk Approach

'Map and Talk' (Potter, 2010) has continued to develop the application of CAT to reflective practice. This approach focuses on the collaborative construction of a map with teams to aid the process of reflection. This involves sketching out (on large paper) the relational dynamics of a particular moment, theme or interaction, such as when there has been a serious incident or when a strong feeling has been elicited, positive or negative. The facilitators are there to help develop the map *side-by-side*. The aim is to do reflective practice *with* and not *to* teams. The mapping enables a dialogic process, extending beyond talking as the name would suggest to becoming a 'listening' map as well.

The emphasis is on 'using' and not 'doing' CAT, as the approach does not try to teach/deliver CAT as a therapy but incorporates some key CAT concepts and techniques in reflective practice sessions to help teams understand the relational dynamics at play.

The Helper's Dance and One-Third Rule

The ethos of 'Map and Talk' is encapsulated by 'The Helper's Dance' and 'One-Third Rule' (Potter, 2014), emphasising how helping others is a joint activity. Professionals working in complex care settings are inevitably invited, or invite others, to join many different relational 'dances' with patients, colleagues and the wider organisational contexts. Some dances may be positive, such as joining in a caring and compassionate interaction.

Others may be problematic, perhaps even harmful, at times. It is not a case of if, but when, we will join the dance. Each one of the thirds (the professional, the patient and the organisation) are dancing together to create and maintain any given situation.

Potter emphasises the importance of not avoiding or hiding from the possibility that certain dances will happen but to become more confident in *noticing* and *naming* what is happening relationally to *negotiate* a better outcome for all involved. This involves the professional not only negotiating the dance with others but also negotiating its operation within themselves. Facilitating the 'three Ns' of Noticing, Naming and Negotiating is the aim of reflective practice meetings. To avoid any individual feeling blamed, it is important to name the dance and *not* the dancer when reflecting on the relationship dynamics in teams. The more or less 'One-Third Rule' encourages teams to notice and name the contribution of the different thirds, shifting the dance from blame to one of shared responsibility.

Reciprocal Roles and Multiple Positions

'Map and Talk' uses the core CAT concepts of reciprocal roles, multiple positions and the procedures that link them as the basis of the map. The reciprocal roles procedures (RRPs) that are drawn out may represent the dynamics between and within any of the thirds. The patients, professionals and organisation as a whole will each bring their own repertoire of RRP's stemming from earlier experiences, both personally and professionally. The interaction of these RRP's can result in a variety of dances being enacted at any one time, leading to team members sometimes having very different experiences in the same situation. Helping teams understand that such multiple positions exist and to notice and name them is a key focus of this approach.

Map and Talk Template

Potter (2010) proposes a mapping template to capture the multiple positions often experienced by teams (Figure 1). This template comprises a 'stuck' or 'battling' place, a 'hiding' place, a 'hoped for' place and a 'feared' place. Within each position, a particular reciprocal role or set of roles is enacted and there are often procedures both within and between positions.

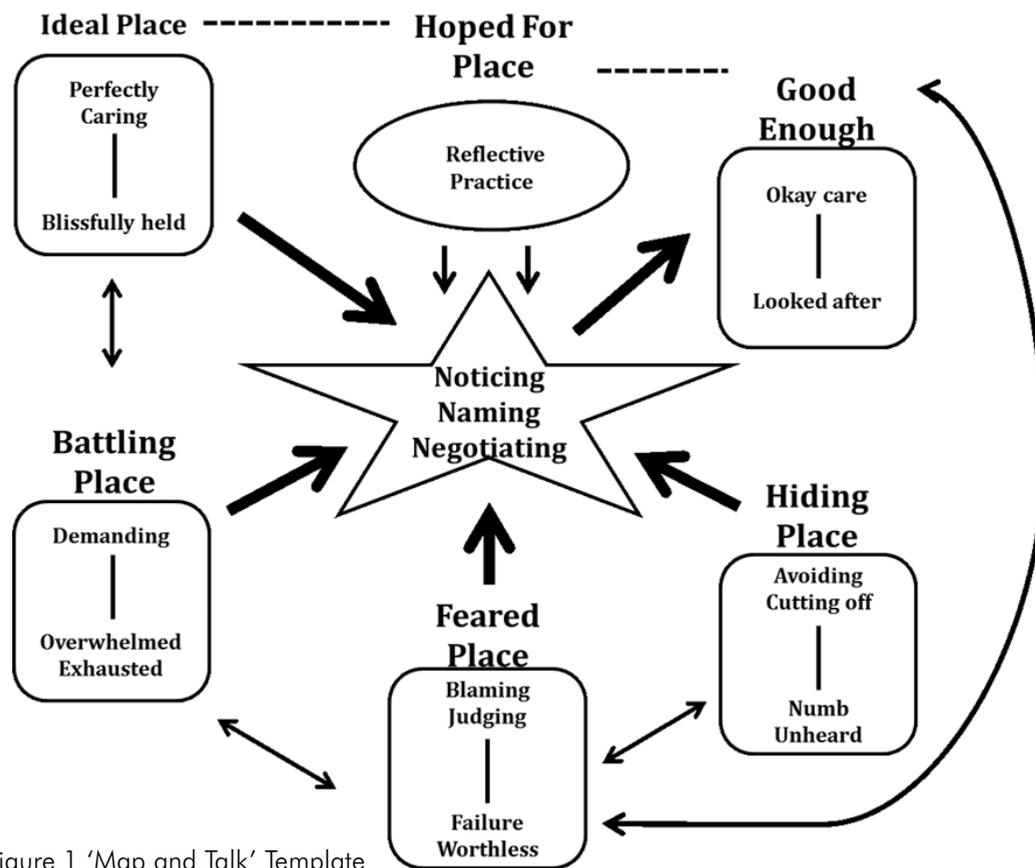


Figure 1 'Map and Talk' Template

In a forensic setting, the 'battling' place often relates to the violence and aggression that is perpetrated. This may be experienced as an *abusive/threatening/dominating to scared/vulnerable* reciprocal role for example. However, the 'battling' place is not limited to violence and aggression but can be understood in broader terms when someone feels like they are stuck 'battling' against something or someone. For example, the professional who responds to a patient's relentless demands by always trying harder.

The professional may sometimes feel like they have achieved the 'hoped for' place of being caring. However, the 'hoped for' place is on a continuum from the 'good enough' to the 'ideal' place. The professional who relentlessly tries to meet *all* the patient's needs at *all* times may temporarily find themselves in the 'ideal' place of 'perfectly caring' but this is impossible to sustain and the professional may be left feeling overwhelmed, burdened and exhausted.

In contrast, a professional may go to the 'hiding' place by avoiding interactions with the patient, especially if they think that other colleagues

are always meeting the patient's needs. This may result in the staff member, as well as other with whom they interact, feeling cut-off or detached.

Being in the 'battling' or 'hiding' places often stems from attempts to avoid a 'feared place', characterised by unbearably painful feelings, which have often been experienced before. For example, being scared of failing or judged as not good enough. However, going to the 'battling', 'hiding' and 'ideal' places can be a defeating procedure that leads back to the 'feared' place.

Helping teams notice and name the multiple roles and positions experienced by the different thirds can lead to negotiations that help all involved reach the 'good enough' place. This may include reciprocal roles such as reflecting/understanding/communicating to understood/heard/safe. In the process of such map and talk interactions a key reciprocal role of compassionately and curiously negotiating to more fully understood is being encouraged as the basis of building reflective capacity for individuals and teams.

Putting it into Practice: The 'Who' and the 'How'

In setting up the 'Map and Talk' project, it became clear quite early on that decisions about 'who' would facilitate and attend reflective practice would be significant. Different opinions were (and are still) expressed about whether nursing teams need a space just for themselves which provides more of a staff support function, in that it gives them a place to air difficulties which it would be challenging to think about with other members of the team present. Another perspective is that it is more beneficial to aim to create sufficient safety so that we can have these discussions together and that not to do this creates a sense of reflective practice being something that is 'done to' rather than 'done with' nursing teams.

As a service we chose to have as our aim, the creation of reflective practice spaces that are attended by all members of the multi-disciplinary team for a ward, even though this would mean doing something different for most ward teams. We also chose to emphasise the multi-disciplinary aspect of the approach by inviting people from across disciplines to train as 'Map and Talk' facilitators. Our aim was to train a pair of facilitators from different disciplines for each ward in order to help to set up and facilitate conversations that cut across boundaries of professional identity

(and sometimes culture and gender by association). Careful thought was given to the inclusion criteria for recruitment, such as level of seniority required to run the groups effectively. An attempt was made to train facilitators from a range of ethnic backgrounds, as issues of diversity are very relevant in our service, where there is a multicultural staff and service user group.

Between April and October 2014, 34 facilitators from across nursing, psychology, social work, medicine, occupational therapy and arts therapies received five days of training in 'Map and Talk' provided by Steve Potter. We allocated Reflective Practice Facilitator (RPF) pairs to each of our 14 wards. We decided to allocate pairs of facilitators rather than individuals because the ward-based multidisciplinary teams can be quite large (up to around 30 people) but most importantly to aid the process of dialogic reflection. We asked the pairs to engage in a 'scoping phase' with their ward, working with the team on that ward to think about how 'Map and Talk' might best be introduced to their context.

This phase of the project was characterised by emerging anxiety about getting started and uncertainty about how to introduce 'Map and Talk' to the wards in a way which would give it the best chance of being helpful. There were tensions between those of us who preferred to 'jump in' and those of us who preferred to 'go slow' and hold off starting until an official launch date. There were differences of opinion about how much direction should come from senior management about attendance and frequency of sessions and how much the project should evolve around the varied team dynamics and spaces available for reflection on different wards. In reality, sessions started at different times in different ways on wards and there was some 'top down' support in determining that sessions would happen in team away days which occurred every 4-6 weeks. Our official launch date was in December 2014 and by March 2015 every ward team had had a teaching session on 'Map and Talk' and an identified reflective practice space.

An important aspect of the project was to develop a Supervision Structure (see Figure 2). As the Project Lead Group we (the authors) have led on the organisational and strategic leadership of the project. Alongside three other multidisciplinary colleagues we formed three multidisciplinary supervisory pairs (the Supervisors' Team) who each facilitate a closed monthly Supervision Group comprising of the Reflective Practice Facilitator pairs. We have maintained input from Steve Potter in the form of monthly supervision of the Supervisors' Team and the Project Lead team.



Figure 2 Supervision Structure

Achievements, Challenges and Reflections

The 'Map and Talk' project has now been running across the medium and low secure sites of the Forensic Directorate for almost two years. All 14 wards of the Forensic Directorate now receive monthly or six weekly multidisciplinary Reflective Practice groups. Development has been an organic process, and while we were guided by the 'Map and Talk' approach, as outlined in the preceding pages, there were many aspects of the shape, process and experience of the project that we had to 'discover'. The following pages describe some of the achievements and challenges of the project, as well as reflections over the course of the project by the Project Lead and Supervisors' Team.

Achievements

As described in the preceding pages, a central principle of the 'Map and Talk' approach is that of 'doing with, not doing to', and the development of a 'common language' (Ryle & Kerr, 2002) to discuss the relational dynamics of patient, staff and institution (the three parts of the 'One Third Rule'). Multidisciplinary recruitment at all tiers of the project (Reflective Practice groups, Reflective Practice Facilitator pairs, and Supervisors) was central to this aim. To date we have trained 50 multidisciplinary Reflective Practice Facilitators. We have retained almost all

those trained in the project and the main drain on retention has been related to staff turnover, in that nine members of staff have left the service. Although the three Project Leads (the current authors) are clinical psychologists, the main criteria for these positions are that two are CAT practitioners and one is the Head of the Medium Secure Psychology Service thereby occupying an important 'political' role with links to the Directorate Management Team. The Supervisors' Team consists of three psychologists, two nurses (modern matrons) and a social worker. As such the multidisciplinary establishment of the project has been sustained.

Anecdotally, alongside the creation of more multidisciplinary relationships, there are more multidisciplinary 'conversations' across the various levels of the project. These are observably (and as evidenced in accompanying maps) different kinds of conversations – 'relational' rather than 'task focused'. For example, discussions about service users are focussed on the felt experience of the service user, and the impact of this on staff, rather than solely descriptions of events. The use of two hands held up in conversations to represent the poles of the reciprocal role, known affectionately as 'Potter hands' can be observed in conversations across the service, as well as gestures accompanying conversations which make explicit the 'mental map'. The use of mapping at all levels of the project (and the accompanying focus on reciprocal roles and multiple positions, as described in the preceding pages) helps to sustain a reflective process.

Challenges

Group Processes, the 'feared place' and the Zone of Proximal Development (ZPD): 'The fear that it won't work, the fear that it will'

At the 'launch' of the 'Map and Talk' project one of the members of our Supervisors' Team expressed the above 'fear that it (the project) won't work, and a fear that it will!' This was reflective of both the time, thought and emotion dedicated to the project, and the pressure this put on us to 'succeed', but also the impact of 'succeeding' – the daunting prospect of the experience of 'reflection' in a Forensic Service in which trauma, violence and danger are commonplace, and where often a depended upon 'dance' is to retreat to the 'hiding place' of avoiding/cut-off, or the battling place of powerful/powerless, controlling/controlled. The 'successful' implementation of Reflective Practice groups involved opening the door to difficult conversations the service, staff and patients

often protected themselves from for their very survival. Reflective Practice and Supervision Groups alike could at times feel extremely daunting, like 'opening a can of worms', mirroring the processes encountered in relation to patients in that risky or potentially traumatic aspects are either avoided or 'over controlled'. How to begin these conversations in a safe way for staff, facilitators and supervisors, negotiating the balance between 'exposing' and 'hiding' positions, was a crucial first challenge to the groups and the project.

In such situations facilitators often described feeling they were balancing between challenging and avoiding, this 'knife edge' itself describing the feeling of being 'in' the process of *noticing*, *naming* (by mapping) and *negotiating* these procedures. The facilitators' skill in engaging the group in this process through mapping provides a form of 'scaffolding' (as developed by Wood, Bruner and Ross, 1976) to allow the group to reflect on rather than simply re-enact the dance.

Maintaining integrity to CAT

Grasping the concept of reciprocal roles in a short training event is not straightforward for many facilitators. This led to some debate early in the project about whether it is necessary to have reciprocal roles if other components of the map were present. However, we soon found that without understanding of RRP and multiple positions, the problems experienced by the whole team may be placed on one third only, recreating the blame dance. Take the example of a professional disclosing, in reflective practice, a difficult moment they have experienced. If only their feelings are named and the upper part of the reciprocal role is not acknowledged, then there is no realisation that something has happened to make the person feel that way. This may leave them feeling like it is their issue alone. Without multiple positions, there would be no acknowledgement that everyone is experiencing something in a shared moment, even if very different. It is not necessary to map every single position and reciprocal role procedure within a single session, but the overall template is helpful for the facilitators to hold in mind.

Reflections

Our experiences through the delivery of the Reflective Practice and Supervision Groups have therefore been of an emergent process for

groups, with mapping providing 'scaffolding' in relation to a Zone of Proximal Development (Vygotsky 1978), which leads to the development of reflection over the longer time frame of the group. In this respect over the longitudinal course of the project we noticed that groups increasingly moved from focusing on a discrete patient moment, to engaging in more difficult and potentially exposing discussions about relational group processes involving issues of discipline, hierarchy, gender, race, difference. Similarly our experience of the Supervision Groups has been that we have moved from 'how to' didactic supervision sessions, getting to grips with the practice of mapping as a skill, to becoming increasingly proficient at this to be able to concentrate on using the mapping tools and supervision spaces to reflect on the relational processes between pairs and groups, and how this might relate to the service-wide picture. We also discovered that at times varying the spaces occupied in the specific Reflective Practice and Supervision Groups was important, for example offering the group, when presented, the opportunity to reflect on positive moments sometimes seems to allow groups to feel safe enough to explore more difficult moments, involving emotions it seems more difficult to access in the Forensic setting such as sadness.

Iterative Processes ('Shimmering')

Described in preceding pages in relation to the 'One Third Rule', there was an observed 'shimmering', that is a resonating or iterative effect of the relational dynamics played out at all levels of the project. We often had the experience of dances 'cascading' through the system and as supervisors being just 'one step ahead' of the emerging dances subsequently described in groups. The use of mapping as a debriefing and supervision tool was essential in capturing the 'dances' we were each pulled into in relation to each other throughout these processes, and supervision provided the space to create and reflect on these processes. The importance of 'iterative' supervision at all levels of the project, although expensive in human resources proved to be particularly important to capture and reflect on this phenomenon.

A further reason that supervision has been such a cornerstone of the project is the disentangling of the 'thirds' and the need for a means to process the dances involved at every level. As described, we all have our own 'dances' impacted by both personal experiences but also sometimes the roles we find ourselves in relate to wider categories such as our

gender, race, culture, discipline. Being thoughtful about 'mixed' facilitator pairs along such dimensions, and the provision of a space to discuss processes between pairs involving these issues and groups in supervision was important to manage this. Noticing our own dances, through use of the 'Helpers Dance Checklist' (Potter, 2014) and feeling secure enough to risk exposure of discussing the processes between facilitator pairs and the groups in supervision was crucial in this respect to reflect on our own positions in the bigger 'dance' of the project. For this reason external supervision for the Supervisors and Project Leads groups has also been important.

Reflections as a Project Lead Group

The 'shimmering' effect was often acutely felt in the Project Lead team, and we (the authors) have reflected on the process of this as a group. As a group of three we noticed how we would often 'catch' the reciprocal roles described and enacted at other levels of the project and therefore perhaps it was very important to the project that we were a group of three, rather than one 'leader'. Through mapping our own experiences as a team we noticed how the impact of a position taken by one of us impacted on the availability of other positions taken by the other members of the three, at times leaving one of us at a time feeling alone and isolated, another feeling successful and empowered, another feeling pragmatic but cut off, and who occupied each position varied amongst us. By mapping the processes between us we were able to again bring the discussion back to the 'dance not the dancer', and recognise the impact of the 'One Third Rule'. For this reason the ongoing provision of external supervision for the Project Lead and Supervisors' Team was essential.

We have also reflected on the positions we have held in relation to the project as a whole. Whilst recognizing the importance of being 'side by side' there has also been a need for us to be 'leaders' at times, a position which has not always sat easily. We have reflected how, as considered with reference to the one third rule, the dilemma of 'doing to' / vs 'doing nothing' / as opposed to 'doing with' is a struggle encountered across the Forensic Directorate, and is also mirrored in our daily struggles to work with service users in a Forensic context. However we have also reflected that sometimes 'doing nothing' or 'doing to' is important.

Clinical Governance and Responsibility

We have been fortunate in being supported to develop this project by our Directorate Management Team. To an extent our success in this project reflects the great willingness and enthusiasm of our staff group to think relationally and a desire to be compassionate, which it is important to protect and harness as described earlier in relation to the current climate of encouraging reflective practice in the NHS to maintain compassion. The 'collaborative' leadership, ethos and 'inclusiveness' of participants in the project has been an important part of our success. However we remain aware of the need to continue to nurture and support the project and all those involved in it. This is important to avoid the 'engine' for the venture being staff willingness to go 'above and beyond', risking burn out. It is important to recognise at all levels of the service and perhaps beyond in the wider context of the NHS that compassion needs to be supported from both above and below.

The Bigger Picture

We have noticed the resonance between micro and macro levels of analysis when 'zooming in and out' and mapping a micro moment can just as well represent the service as a patient. However we have also noticed resonances with issues 'beyond the walls' of the Forensic institution but which impact on our service users staff and service. For example, the stigma experienced by our patients in relation to society seems to be felt at many levels across the service – wards, disciplines, individuals feeling stigmatised or blamed or punished. The striving for control of fear has resonances with the experiences of patients in forensic settings, with staff in relation to the 'management' of patients, but also with a world in the grips of a 'war on terror'. We have noticed at times of threat in the groups, the tendency to resort to a 'them and us-ness', dance: groups and individuals finding security in the 'us' and projecting threat onto 'them', leading to a relentless 'battling' place, which is full of anger and fear. The impact of an NHS increasingly focused on performance and the need to be 'doing something', at the expense of 'thinking space' has also been played out in group processes. As such we are beginning to notice dances related to wider political, social and economic issues being played out in the Reflective Practice groups.

Limitations and Future Directions

'Map and Talk' is now embedded within the service and there are opportunities for further development. We have received requests beyond the ward-based teams within the service and there is curiosity about the project from other services within the Trust. While very exciting, this also feels somewhat daunting and makes us realise the importance of ensuring adequate support, resources and supervision before we venture into the next stage.

Although the project has now been running for two years, we feel that we are still in an early stage, perhaps reflecting the longer-term nature of working in an inpatient forensic setting. It is important to acknowledge the limitations of what we are able to offer. We have noticed in the service that the project can often be viewed as a somewhat 'magical' solution by all involved, which places additional pressure on the project to respond to new challenges as they are identified, and can be an impediment to acknowledging the limitations of the approach as well as the successes. The process has been labour intensive, raising some questions about sustainability and replicability. Kerr et al. (2007) reflected on how there needs to be clarity and realism in advance about the aims and limitations of such initiatives to avoid unrealistic expectations of what can be delivered, especially in settings that are confined by resource issues. This has been a work in progress and we have had to notice, name and negotiate aims and limitations as the project has evolved and will continue to do so.

We are now looking forward to the future. Whilst this paper focuses on our preliminary experiences and reflections it is clear in order to secure ongoing resources more quantitative and qualitative data are important. We are concurrently completing a more formal evaluation process, gathering data on ward atmosphere at six monthly points of the project. We are learning more about the key qualities required to be a Reflective Practice Facilitator/Supervisor and think it will be important to conceptualise what these core competencies are to contribute to professional development and adherence to the integrity of the approach. This may include incorporating strategies used by similar initiatives, such as more intensive CAT training for 'champions', both facilitators and participants of the reflective practice sessions. It will also be important to support some individuals to access CAT practitioner training to promote sustainability of the model. We are aware that this paper is mainly a reflection of the voices of the Reflective Practice facilitators and supervisors, not yet the voices of those in the groups themselves, and

how to discuss the themes of the groups whilst maintaining the confidentiality and safety of the Reflective Practice spaces is something we have wrestled with in this paper. This is something we intend to address in future evaluation and publication. □

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