Paul Scates
(Senior Peer Specialist, Education Trainer, Campaigner & Ambassador)

Service user experience in mental health services – Recovery orientated practice
Friday 12th May 2017
OBJECTIVES

• Define the role of a peer specialist within mental health care services, exploring their value and expertise.

• Identify a plethora of tools which are proven to reduce the acute symptoms of those living with SMI’s, to encourage positive well-being and safeguarding their welfare. Focusing on mental wellness not illness. Mental wealth.

• Recognise the key stages of recovery, the safe implementation of recovery model frameworks, and to identify key operational pathways for administering care.

• Explore the benefits of a person-centred partnership agenda. Putting ‘People’ at the centre of their care. Proactive V’s reactive care. Explore the benefits of delivering emotional resilience training and adopting a proactive approach Vs reactive care. Peer support, mentoring & well-being advocacy.
“The greater danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low, and achieving our mark”.

Michelangelo 1475-1564
Paul Scates
(Couture wedding designer and creative events director)
Beaux-Arts UK
(Creative events agency)

• A creative events/couture wedding designer will work with a vision, design and create a concept and produce and deliver the pre, live and post production.

• A Customer relationship is nourished and developed, building a collaborative partnership with mutual expectations. A multiple and diverse mix of communication tools which are presented through a variance of learning styles which achieves the agreed aims and objectives. All of which provides a meaningful and positive experience for both the designer and client.

• Thinking outside the box, working with a client on an individualised basis not only enriches their experience it also creates a memorable and desired outcome. Thus a client chooses to re-engage with our services.
Who am I?

• Senior Peer Specialist – Expert by lived experience - Dorset Mental Health Forum (DMHF).

• Role & responsibilities – REC, PMVA, Learning & Development, mentoring, CBT modules – Steps 2 wellbeing- 50/50 demographic, safe, non judgemental and validating environment.

• Role modelling & living recovery – unique to clinical expertise.

• Motivational coach and trainer- Corporate, education, private - 121, groups, consultation/supervision.

• Campaigner & Trustee- Mind, Rethink, Time To Change, Bipolar UK, Survivor’s UK, Enough Abuse UK, Acts Fast.

• Ambassador – Representing the voice of many service users’, survivors of abuse, CSA, CSE, rape victims and many others.

• Media representative, presenter and international speaker – BBC, ITV, CH4, CH5, SKY, National & international Radio & Print (Huffington Post).
Who am I?

'Suicide bid spurred me to help others'
Mental illness can be tackled

Someone you know has a mental health problem
Ready to start your conversation?
https://youtu.be/6R1lR2lSWbM
Background

• A bio-chemical imbalance - predisposition triggered by trauma.

• Family history- Paternal grandmother agoraphobic - physically hitting her head against the wall as the pain was so chronically intense. Died aged 49 of a severe brain Haemorrhage.

• Father suffered early psycho trauma –
• Both parents dead by the time he was aged 21
• Death of a child (my brother)
• Nursing my terminally ill mother.

• However, his significant trigger came aged 49 - contracted viral encephalitis, remained critical in a coma for 2 weeks. Post admission - periods of disappearance, psychiatric interventions, variance of high’s & lows.
Lived experience

• Aged 8 - My world changed and a part of me died. Experienced horrific sexual abuse pursued over a 9 year period

• Aged 9 - Experienced first encounter of psychosis, crippling paranoia of those around me wishing to kill me

• Aged 14 - First experience of drugs – cannabis, amphetamines, psychedelics – drug dealers became my friends – validation, identity & understanding

• Aged 16 - Kidnapped off the streets of London and subjected to a serious sexual assault where my life was very nearly taken.
https://www.youtube.com/user/findinghopeleicester
Lived experience

• **June 1997** – Visit to St Guy’s & St Thomas’s hospital to seeking clinical intervention. Extending the safeguarding process for anyone contacting services.

• **July 1997** - Aged 17 I attempted suicide. Jumping from a first floor window resulting in lower lumbar break, fused vertebrae and severe fracture of pelvis. House and bed bound for 6 months –followed by periods of extreme psychosis, out of body experiences, anhedonia. All very real!

• **February 1998** – Periods of admissions to hospital, crisis day centres– prescriptive measures, non engaging, science based, meaningless.
Lived experience (Training)

• My recovery journey - Guidance and collaborative partnership working with clinical psychologists’

• CAT therapy for 4 years, prescribed for 16 week programme. Seeing the person and meeting their individual needs

• ACT therapy for 16 weeks

• DBT for 2 years - group and 1to1

• These therapies were the main essential ingredients - provided hope & understanding - ergo reducing co-dependency of services and reducing incidents of self harm or violence. Engagement with third sector agencies - DMHF, Mind, Rethink, Bipolar UK

• Forward thinking clinicians - bridging the gap – Collaborative partners, clinical expertise & lived expertise
Lived experience (Training)

- Training - Engagement with psychiatric services 17 years of age to present day. Ranging from CPN’s, Consultants, OT’s, CC’s and Psychologists’

- Respite periods in acute crisis hospital for psychosis, violence & aggression, severe anxiety & depression.

- Mixture of medications Fluoxetine, Mirtazapine, Citalopram, Diazepam, Clonazepam, Quetiapine, Clozapine, Divalproex, Lithium & Olanzapine
Evidence in Practice

• The Royal College of Psychiatrists suggested mental health services were approaching a "tipping point" and that the situation was "simply unacceptable". How can current nursing levels sustain such demands on services.

• The survey also suggests that critically unwell patients are being sent home because no beds can be found for them. Thus causing imbalance to CMHT’s case loads and in some cases suicide.

• Investigations by BBC News and the online journal Community Care have highlighted that more than 1,700 mental health beds have been cut and that patients are travelling huge distances to access care. Within many trusts we hear of patients being moved some 250 miles from their family and supportive networks.
NICE guidelines

- Person centred care

- Health and social care provider organisations should train staff who work in services in **psychosocial methods to understand the meaning and relationship of those with SMI’s and substance misuse**. This training should enable staff to develop:
  - a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship - Therapeutic alliance - (CCG ACP review findings)
  - an understanding of the relationship between mental health problems and the risk of **substance misuse**
  - **skills to assess driven behaviour likely to lead to relapse or lapses**, including personal, constitutional, mental, physical, environmental (housing), social, financial, communicational, functional and behavioural factors
NICE guidelines

- Treatment and care should take into account **individual needs and preferences**. Service users **should** have the opportunity to make informed decisions about their care and treatment, in **partnership** with their healthcare professionals.

- **Adopt an individualised approach** to healthcare services that is **tailored to the patient's needs** and circumstances, taking into account their ability to access services, personal preferences and coexisting conditions. Review the patient's needs and circumstances regularly.

- **Inform the patient** about healthcare services and social services that are available locally and nationally. **Encourage and support** them to access services according to their individual needs and preferences.

- **Give the patient, carers, supporters information** about relevant treatment options and services that they are entitled to, even if these are not provided locally.
Person centre culture

• Integrated MDT’S who fully engage and communicate on multi faceted levels

• Pro-active V’s reactive services- At risk adults monitored before any crisis or acute symptoms present– Bio social model

• Data sharing V’s Data protection – fully integrated systems of data recording inclusive of all key partners -schools

• Collaborative partnership working with clients/customers- CSR

  • Person led safety plans- what does and doesn’t work

  • Flashpoints – proactive approach

  • Communication & consistency

• Safewards – common sense- CQC outstanding – Extra costs £0.00
Person centre culture

- Non judgemental – Avoid typecasting, limit setting approach, safety behaviours v’s self harm

- Congruency - Human to human not clinical to pathological- Getting to know your patients

- Transitions focus – Mental wellness V’s mental illness – Remove the ‘I’ to ‘We’

- Role Modelling recovery

- Compassion & empathy – CCG Acute pathway review- public document available online

- Hope, motivation, passion

- Psycho-education – Recognised as most effective treatment – Courageous conversations

- My recovery workbook- My Crisis Plan- inform CPA’s

- Services to embrace new technology- Business to fit customer’s needs and desires – Apps, online treatments
Good practice

- **Clinical Intervention at the right time** - My triggers were born from a collection of psychological trauma’s. Exposed too many years of sexual abuse, kidnapping and rape aged 16, and self harming with non prescribed drugs. At first point of contact as reasonably possible treatment to be offered.

- **Educate the service user – Psycho-Ed** - Many of those I now counsel and work with explain turbulent childhoods, disturbed psychological developments and experiences of trauma. Compassion focussed therapy. Many of those living with SMI will have had their conditions triggered through psychological interference. Treat the causation not just the behaviours.

- **Treat the individual holistically** - Generic treatments V’s person centred approach. No one size fits all re medication as there is no real evidence of when person A presents with difficulties (depletion in chemicals) V’s patient B (father & son) – recommended sensitive prescriptive measures (pharmacological & psychological) of treatment, considering person A and person B lifestyles. Treating all health not just mental health.
**BRAIN BASICS**

**Frontal Lobes**

Located behind the forehead, the frontal lobes are the largest lobes of the brain. They are prone to injury because they sit just inside the front of the skull and near rough bony ridges. These two lobes are involved in:

- planning
- organizing
- problem solving
- memory
- impulse control
- decision making
- selective attention
- controlling our behavior and emotions

The left frontal lobe plays a large role in speech and language.

**Injury to the frontal lobes may affect:**

- emotions
- impulse control
- language
- memory
“There is no symptom which could be described as psychologically groundless and meaningless”
Still we see……..

• Those living with SMI’s, on average die 20-25 years younger than the general population. We know this is due to a number of factors – discrimination, medication, lifestyle and lack of safeguarding.
Challenging Traditional Approaches

“Symptoms considered indicative of psychosis...particularly hallucinations, are at least as strongly related to childhood abuse and neglect as many other mental health problems”
Read et al (2005)

Harmful Aspect of Traditional Treatment:
• Equating hearing voices with schizophrenia
• The “no hope” and “lifelong illness” image
  • Inability to accept people’s experience
• No interest in voices or what underlies them
• No alternatives to medication offered when it fails
  • Promoting “madness” belief in society
Romme, Escher et al, 2009)
Rebalancing the biopsychosocial
The Sociopsychobio model

Socio

Psycho

Bio
Safeguarding staff and service users’

• **Safe staffing levels** – Minimum nurse staffing levels – Spreading the workload (Peer Specialists’) Vs Frances report

• **Austerity measures** – Putting figures before safety of staff and service user. (Merging of services, access to services disparity of numbers, IAPT agency staffing to reduce waiting times, inconsistency of care)

• **Parity of esteem** – Expected to save a further 20 billion yet increase the quality of care and productivity. Accountability MUST sit at the top.

• **Increasing staff capacity** and decreasing staff resources (Crisis teams Vs CMHT’s budgets)
Evidence in Practice

• The Mental Health Foundation released a report into the future of mental health services. 'Starting today' warns that mental health services may be unable to cope with the demand in 20-30 years' time. At the current prevalence rates, 2 million more adults and 100,000 more children will need treatment in 2030. WARP leading the way for future services.

• The costs of mental health problems are estimated at over £100 billion a year.

• The Care Quality Commission (CQC) has published the 2013 annual survey of community mental health services. A survey of 13,000 people using community services outside of inpatient care across 58 trusts in England.

The survey picked out areas for improvement, including most prominently the continuing need for personalisation of care, involving patients in the plan for their care. The CQC has said that mental health services will be one of its main focuses with its inspectors work being informed by the survey results.
Evidence in Practice

• Also in the report it was noted one-in-four said a bed manager had told them that unless their patient had been sectioned they would not get a bed.

• Almost 30% have sent a critically-ill patient home because no bed could be found.

• A third had seen a patient admitted to a ward without a bed.

• And 22% had been forced to send a child more than 200 miles from their families for treatment.

• Norman Lamb was quoted as saying "Inpatient beds must always be available for those who need them. We are scrutinising local NHS plans to make sure they put mental health on a par with physical health." Who decides which patient is in more need, the individual, clinician ..........
Building Resilient Communities Report

• The 2013 report from Mind and Mental Health Foundation focuses on resilience; setting out the types of services, resources and infrastructure that need to be in place locally to support resilient communities, helping people to ‘feel good and function well’.

• The report brings together the evidence base and people’s experiences about what makes resilient people and communities, and calls on every council to prioritise mental health within their public health strategy.

• Increasing capacity of nursing staff by empowering those affected by mental health problems. Working with third sector partners.
Be the change you want to see in the world

-Mahatma Gandhi
Recovery Is

“A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness...”
Recovery is…

“Recovery is about taking back control over your own life and your own problems, about not seeing your problems as being uncontrollable, or that their control is just the province of experts.

“It is about understanding yourself - what is possible and what you can do to help yourself.”

Dr Repper from An independent investigation into the care and treatment of Daniel Gonzales (January 2009).
Personal perspective

“Creating a service which provides a transitional process from mental illness to mental wellness. To coach, develop and strengthen individuals, in a comfortable, validating and conducive environment, allowing the individuals the same opportunities for personal development. See the person not the diagnosis or behaviours.”
What’s the picture

• Services appear to be very effective in dealing with ligatures, escalation of violence and aggression but NOT effective in dealing with a patient who knocks on the office door? (Proactive care).

• Services, care models, pathways MUST be tailored to an individual’s needs, person-centred care (NICE), not services which cajole a service user into fitting the theoretical frameworks and ‘models’.

• We still see the main focus of training for new staff and existing staff being PI (Physical intervention) and not enough on the importance of therapeutic engagement.
A new approach

• Safety behaviours V’s self harm, allowing people to manage their behaviours (risks). Upskilling individuals – replacement behaviours – empowering individuals- personal responsibility.

• An approach which addresses the burden and impact upon current services and infrastructures by addressing a pro-active education and resilience based framework. GP’s – multi lead agencies.

• Services for people/customers not just commissioner’s & board members.

• Interview panels inclusive of service users- NHS England.

• Services and models to fit individual needs not cajole a person to fit a service or model. Personalised care – Client A – Ice, Client B – Coded language- Client C – 48hr sleep deprivation- Client D - medication non compliant but engaging – Client E - alcohol dependent excluded from mental health services- Client F- drug dependency excluded from services “they’ll never amount too much it’s in their DNA”.

• The approach towards mental health for those experiencing mental ill health and their families would be based on valuing the interrelationship between mental health and physical health.

• We need to nurture and endorse a whole societal approach towards positive mental well-being, recognising the need for a continuum of mental health promotion and the prevention of disorders by early intervention and treatment.

• This approach involves educational policies, skills for social and emotional learning, a healthy psycho-social environment and better access to services.
What’s the ideal

• Understanding and validation i.e. - anxiety.

• Services to adopt a proactive approach – tools proven to reduce distress, emotion management (Psycho education).

• Therapeutic engagement - where monies and focus **MUST** remain to help and enable recovery/discovery.

• Provide robust and comprehensive training for all new and existing staff on the importance of therapeutic engagement and procedures which are proven to enhance someone’s experiences of services. Inclusive of support workers.

• Holistic approach treating the person as a whole not a pathology. One size never fits all. There is never an A typical patient.
# Clinical V’s Personal Recovery

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Personal</th>
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<tbody>
<tr>
<td>It is observable/ objective</td>
<td>Subjective to the individual</td>
</tr>
<tr>
<td>Rated by the clinician</td>
<td>Rated by the individual</td>
</tr>
<tr>
<td>Invariant across individuals</td>
<td>Varies across individuals</td>
</tr>
<tr>
<td>Symptom remission</td>
<td>Building life regardless of/ beyond symptoms</td>
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Stress Vulnerability Model

- **Vulnerability**
- **Stress**

- **No psychosis**
- **psychosis**
Cycle of Change

- Pre-contemplation
- Contemplation
- Planning
- Action
- Maintenance
- Relapse
What is Recovery?

• Probably the most useful way of understanding recovery is linking it to our own experience because it is something that is common to all of us; it is not specific to mental health problems.

• Any of us, who have been through a divorce, being made unemployed, a major illness or bereavement, know that that changes us; there is no way to going back to how we were before that event.

• We have to incorporate that into our way of living and we learn from that and move on with that - which is exactly what we are talking about in terms of recovery from mental health problems.
Types of Recovery

• Clinical recovery
• Personal recovery

Ultimately recovery is about building a life beyond illness without necessarily achieving the elimination of the symptoms of illness.
Recovery Focused Safeguarding

• Clinical Vs Personal crisis – Validation, A person’s wellbeing, listening to family and friends, advanced directives.

• CQUINS & PHQ’s – Standardised frameworks- statistical disparity

• Physical health checks – Compulsory MOT’s

• Purposeful Recovery – prevention of relapse – safeguarding in it’s entirety, contributing to society

• Education and empowerment (Taking back control) Care bill highlights a need for the person to control their day to day life including how their care is delivered.

• Person centred care approach – Safeguarding panels involving Peer Specialists’, CQC & NICE creating space for Peer Specialists’. Qualitative evidence.

• Personal responsibility - moving forward
Recovery Care Plan Reviews

• Support for the person in and outside of services—Defining and managing expectations both staff and service users. Safe wards—boundaries/safe space.

• Involvement of the person and practitioner—Valuable feedback and learning influencing future practice throughout their entire contact with services.

• Language and active listening: who’s doing the talking? Peer Specialists can engage on a different level to clinicians.

• Who are you involving, family & friends?

• Using a review as part of continual assessment—continued development and monitoring those measurable outcomes.

• Reviewing everything—not just mental health.
Recovery approach

• Changing the culture of nursing staff through partnership working with lived experience.

• Peer Specialists to be embedded into clinical practice as a MUST - MDT’s - interview panel processes, hand overs, Safe Wards, de-escalation & debrief, psycho-education. **An equal valued member of staff.**

• STOPP – Stepping back, take notice, observe, proceed, practise what works.

• Appropriate and safe staffing levels.

• Allowing a patient/service user/client/ PERSON to lead their care pathway.

• Removing fear – Historically in patient services were guilty to a custodian culture.

• A whole organisational change from top to bottom, making sure each employee is ready for change – The Change Acceptance Cycle, Cycle of Change- If it’s not uncomfortable then you’re not changing.

• Communication is VITAL and consistency is a MUST.
The WaRP- In Practice

- **Partnership working -Reducing risk and increasing nursing to patient ratio**: We have increased the scope and levels of sophistication of our partnership working between people with lived experience and professional staff. There is an increasing understanding of the importance of expertise by experience.

- **Hidden Talents**: This is for statutory staff within DCHS who have lived experience and are involved in challenging stigma and looking at how people can use their experiences within their work.

- **Lived experience mentors for psychiatrists**: We have a pilot project where people who have accessed the service are coaching psychiatrists on how to work in more recovery orientated ways.

- **Peer Specialists/Interview panels**: We are continuing to develop our peer specialist posts (people with lived experience working in NHS teams modelling recovery) and the initial pilot project gave positive results. Interview panel processes, hand over, Safe Wards, de-escalation and debrief.
The WaRP- In Practice

• **Reducing the pressure in mental health services** - The wellbeing And Recovery Partnership – *Getting the skill mix right.*

• A partnership between the Dorset Mental Health Forum (DMHF), and NHS Dorset: Dorset Healthcare University NHS Foundation Trust.

• **Finding the right people** - The aim of the WaRP is to change the culture of mental health services and people's attitudes to mental health in Dorset through promoting the principles of wellbeing and the philosophy of recovery. Central to this is the partnership between people with lived experience, their supporters and mental health professionals.

• **REC** – Recovery Education Centre. Community and inpatient services

• Recognised nationally by: the Centre for Mental Health, the NHS Federation and the National Mental Health Development Unit's 'Implementing Recovery for Organisational Change' (ImROC) programme.
Turning Points and the Road to Recovery/Discovery

It’s a journey, not a destination
The Road to Recovery
(Andresen et al 2006)

Distress
Time of withdrawal
With profound Sense of loss & hopelessness

Awareness
Realisation that all is not lost & that a fulfilling life is possible

Preparation
Taking stock of strengths & weaknesses + Starting to develop recovery skills

Rebuilding
Actively working towards positive identity, setting Goals & taking control

Growth
Living a meaningful life
Illness is self-managed
Resilience and positive Sense of self
Recovery Advisory Group
Recovery model

Wellbeing, empowerment, recovery

Determined commitment TO BE WELL

Action plan

Insight

Awakening

Anguish

(Ralph and Corrigan 2005)
Having anxiety and depression is like being scared and tired at the same time. It's the fear of failure but no urge to be productive. It's wanting friends but hate socialising. It's wanting to be alone but not wanting to be lonely. It's caring about everything then caring about nothing. It's feeling everything at once then feeling paralysingly numb.
Behind the mask of indifference is bottomless misery and behind apparent callousness, despair.

— John Bowlby
The Job of Mental Health Professionals

- Supporting hope
- Supporting identity
- Supporting meaning
- Supporting personal responsibility

Mike Slade
2009
Building resilience & emotional intelligence

• Everyone needs to have the opportunity to learn about emotions, the function of emotions and to know the positive behavioural pathways in how to channel those difficult emotions. An understanding of the process. Working with Football Association, Rugby League.

• People need to have a place of safety and comfort to be able to have their voices heard -15 second challenge with PT’s & Gym.

• We know supportive education, in a safe environment is conducive to developing essential skills and knowledge around mental health. Individuals need to be able to access the knowledge through practical experiences in a familiar environment in order to recognise positive mental well-being.

• An education of awareness and recovery can harness personal development and we must allow people the opportunity to express themselves in a way which is helpful to them. Working with boxing academy & Frank Bruno.
How could this look

- Peer Specialists’ presence within services and community settings.
- Training for teachers, parents and any other interested parties. Mental health nurses in schools, surgeries for students to attend.
- Emotion management education. DBT frameworks, CFT – recovering from trauma.
- Development of healthy minds programme which supports individuals taking hold of their mind through evidence based approaches of mindfulness.
- Intermediary services for people with mild to moderate difficulties.
- Reshaping of current services through co-production partnerships with peer specialists’.
- Recovery focused education. Understanding the function of self harm.
- Benefits for those who self harm- replace as we take - safety behaviours.
Recommended overview

• Taking hold of your mind – an understanding of the different states of mind.

• Mindfulness sessions combined with fitness – relaxation techniques to enable focus. AFCB – walking football, Fitness sessions, rugby training etc.

• Distress tolerance skills- coping strategies, grounding exercises.

• Interpersonal effectiveness – managing emotions with others.

• Emotion management – managing difficult emotions, naming emotions, understanding emotions, regulating emotions.

• Understanding the relationship between thoughts, feelings, emotions and behaviours.

• The mountain climb.

• The 3 A’s.
Recovery Focused Safeguarding

• Clinical Vs Personal crisis – Validation, A person’s wellbeing, listening to family and friends, advanced directives.

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• Purposeful Recovery – prevention of relapse – safeguarding in it’s entirety, contributing to society

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• Person centred care approach – Safeguarding panels involving Peer Specialists’, CQC & NICE creating space for Peer Specialists’. Qualitative evidence.

• Personal responsibility - moving forward.
Recovery Care Plan Reviews

- Support for the person – Defining and managing expectations both staff and service users. Safe wards – boundaries/safe space.

- Involvement of the person and practitioner – Valuable feedback and learning influencing future practice.

- Language and listening: who’s doing the talking?

- Who are you involving?

- Using a review as part of continual assessment – continued development and monitoring those measurable outcomes.

- Reviewing everything – not just mental health.
How can we better manage Behaviours that Challenge us?

- Look deep beyond actions
- Show humanity
- EMPATHY
- Self reflection - during group supervision & clinical supervision.
- Finally & arguably most importantly..............

Get to know & understand the patient, & their viewpoint, before any crisis occurs. **Establish a therapeutic relationship.**
Collaborative interaction

- Prof Len Bowers  SafeWards model- 10 core interventions- Clear Mutual Expectations, Soft Words, Talk Down, Positive Words, Bad News Mitigation, Know Each Other, Mutual Help Meeting, Calm Down Methods, Reassurance, Discharge Messages

- The aim of the interventions is to encourage staff to be mindful of how they communicate with patients to avoid flash points and potential for conflict and to ensure better therapeutic relationships. Reflective practice, regular clinical supervision v’s management supervision- knowing the difference.

- A review of incidents of physical restraint was conducted and it was found that the most common explanation offered by patient for violence was conflict with staff. Issues most often highlighted included enforcement of rules, denial of privileges, denial of requests and denial of discharge. The NO response without explanation

- Another study conducted found that a ‘limit setting style’ of nursing often led to confrontation. Blanket rules - control and containment prioritised over care , dignity and respect.

- Staff and patients need to feel a sense of safety – Boundaries and zone of helpfulness- Hamilton’s boundary see-saw model. Services which empower not rescue individuals
A safer ward for patients and staff

“To keep everyone on the ward as safe as possible by reducing the potential for flashpoints and improving our communication skills”
<table>
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<tr>
<th>Safe Wards Initiatives</th>
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<tr>
<td>- Clear and mutual expectations</td>
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<tr>
<td>- Soft words</td>
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<td>- Talk down</td>
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<td>- Positive words</td>
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<td>- Mutual help meeting</td>
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<td>- Know each other</td>
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Clear and mutual expectations

Some of the difficult and challenging behaviours exhibited by patients are due in part to lack of clarity about how they are expected to behave, or lack of consistency between the ward staff about what those expectations are. This lack of clarity is particularly problematic for patients who......
Clear and mutual expectations

These expectations work both ways, and just as the staff have expectations of patients, patients have expectations of the staff.

Clarifying these relationships allows the staff to be consistent, and the patients to understand their obligations and those of staff.

Communication between the two will be eased, and clarity in the social environment will assist patients to think more clearly, and experience less irritation and frustration. Lowered stress and anxiety help to reduce symptoms and aid patients’ recovery.
Talk Down

When patients become agitated, angry and upset and a crisis arises where it seems likely they might become more violent or harm themselves, it is often possible to talk them to help them calm down. That process is usually called de-escalation or diffusion.
Talk Down

**TALK DOWN TIPS**

**CONTROL YOURSELF**
- Act calmly and confidently. Show no fear, subjection, or servility.
- Have lowered, uncrossed arms and open hands.
- Relax face, don't frown, or purse lips.
- No hesitation or uncertainty of speech, use silent statements.
- Breathe deeply and concentrate on situation.
- Relax body, no hands on hips or in pockets, don't finger wag or prod.
- Use slow and gentle movements.
- Don't correct patients, threaten or make false promises.

**DELIMIT**
- Separate yourself from others/audience.
- Move to a quiet place, ask to come aside.
- Invite patient to sit down.
- Establish and support backup.
- Maintain distance.

**CLARIFY**
- Ask what's happening, use open questions.
- Sort out confusions.
- Use patient's name.
- Orient patient to time, place, and person.
- Speak clearly, say who you are, remind of existing relationship, and offer your help.
- Wait a second and gain turn.
- Paraphrase and check what they have said.

**RESOLVE**
- Request ask politely, don't command or be authoritarian.
- Give reasons, explain rules, reasoning behind them, be honest, express fallibility or even agree that it's unfair.
- Give patient opportunity to control him/herself.
- Make a personal appeal, remind them of previously agreed strategy.
- Deal with the complaint, apologize, make a change.
- Outline consequences of different courses of action.
- Offer choices and options, leaving power with patient.
- Be flexible, negotiate, avoid power struggle, compromise.
- Ask if there is anything else you can do or say that will gain their cooperation, ending positively.

**RESPECT & EMPATHY**
- Show interest, concern and expression congruent with words.
- Have a concerned and interested tone of voice.
- Listen, hear, acknowledge feelings and needs, be sympathetic.
- Take time to hear the patient out, be patient and don't hurry them.
- Don't cut them off or shush - wait until they take a breath.
- Make eye contact (exercising care not to be confrontational).
- Extend self and thinking to understand patient viewpoint.
- Show sincerity, authenticity, and genuineness.
The idea is we put a little bit about our self on a poster for patients to see and read. This make us more human and not just a member of staff.
ADE ODUBANWO

Name: Ade Odubanwo

Job title: Teacher

Likes: Playing sports, watching TV, reading.

Dislikes: Loud music, crowded places.

Hobbies/Interests: Dancing, playing guitar, painting.

Previous/current occupation: Teacher in a primary school.

Previous/current occupation: Teacher in a secondary school.


Favourite Quote: "Life is what happens when you're busy making plans for something else." - John Lennon

Beliefs: "Faith, hope, and love are greater than the power of evil." - Saint Paul

Anything else you want to say about yourself??

I believe the best and most beautiful things in this world cannot be seen or touched but are felt in the heart. 
Mutual Help Meeting

A voluntary meeting of all patients and the staff on duty, to be held preferably first thing in the morning, and preferably every day (and certainly no less than three times a week).

The more frequently it is held, the shorter it can be.

The meeting is about how everyone can help everyone else during the rest of the day.
Sometimes we can tell when something is brewing for one of our patients. It might be their facial expression, tone of voice, snappish response to a normal reminder, restlessness, breathing pattern, body language, eye contact (or lack thereof) movement around the ward or other cues.

Calm Down Methods is a box of equipment that can be used by patients to help lower their levels or arousal and agitation.
Calm Down Methods
Reassurance

Following the occurrence of a potentially anxiety provoking incident on the ward every patient should be spoken to, either alone or in small groups, to ask them their understanding of what has happened, what effect it has had on them and to give them an explanation as to what has happened. If not all patients have witnessed the incident or heard of it in some way, then only those who have could be spoken to
Many patients are admitted in a state of depression and hopelessness about their state, even if that is masked sometimes with anger and resentment toward the staff and the hospital.

On the day of their discharge, each patient is to be asked if they would write a card for display on a special public notice board on the ward.

The card should say what they liked about the ward, the staff and what went on in the ward during their stay. It should also include what would be their most positive and helpful piece of advice for new patients. The card should be selected from those available and include a picture of the patients' preference.
Discharge Message Tree
Bad News Mitigation

Bad news from home can also precipitate conflict for patients.

Severe examples would be a death in the family, or the termination of a relationship with an intimate partner. However, things like the loss of tenancies, a burglary, and illness in the family, childcare issues, can all represent blows to patients.

The resulting stress and distress can then be acted out on the ward in increased irritability, aggression, violent incidents, and absconding.

This intervention is all about being mindful about how we deliver bad news to people.
Bad News Mitigation

Find a quiet place and give them time to express their feelings, acknowledge their frustration, express sympathy and empathy, perhaps make a friendly gesture like providing a cup of tea, or snack.

Answer any questions honestly, giving the patient time, attention, and respect. Showing that you are receptive to patients’ concerns can be achieved by some simple listening techniques such as making eye contact, asking about their worries, and using open ended questions, such as "Tell me more about it".
Handovers are virtually the only place where the nursing team alone gets together and discusses each patient who is on the ward.

They have a critical organisational function, making sure that the oncoming shift of nurses knows what has been happening, what the main risks are, what new patients have been admitted, and what has to happen in the following shift.
Positive Words

However in their report of what has happened during the shift, they will often focus on exceptional behaviour. That is the behaviour of patients which is difficult to manage or which presents risks to the patient or others.

As such, they may promote a negative perception of patients, so we look at how we discuss patients in handover.

Instead of just focusing on all the negatives try and find something positive to say that way it will have less chance on impacting on your perception and ultimately the shift
My Wellbeing Toolkit

Nutrition & Diet
Exercise
Mindfulness
Compliance with medication
Talking to family, friends, clinicians et al
Work & Career
Campaigning
Socialising
Rest & sleep
Data sharing between services- Joined up thinking

- A guide which allows me and those around me to monitor my warning signs, to inform on what I would or wouldn’t like to happen if I become unwell:

  Lack of interest in normal activities
  Analytical obsessions
  Sleeping too much
  Erratic/Self harming behaviours
  Over consumption of Alcohol
  Smoking cigarettes
  Vulnerability
  Illusive & secretive
  Agitation
Innovation

Mental Health Goes On Tour

The Journey begins...

The Methodology:

The methodology for delivery will follow a series of therapeutic practices all of which are scientifically proven to enable recovery. The informal style will encourage people to understand how a unified approach from both clinical practitioners and service users creates a higher future and breaks down the fears of a ‘them and us’ belief.

Moral and friendly environment will take away the fear of stigmatisation and offer people the unique opportunity to speak to those who have lived experience and who are indeed living successfully and positive lives.

The focus will shift towards wellbeing and recovery workshops. These sessions will be led by peer specialists, all of whom have different mental health diagnoses and will offer an insight into what a journey of recovery means and explain the positive ways that many follow. Above all, these sessions will encourage service users and their insights into the wellbeing and hope in those who accessed the bus.

Research shows a huge relationship between food and emotional states, we call them ‘mood foods’. Visitors will have the chance to engage with leading nutritionists to understand the relationship and share their own personal anecdotes or particular chemicals in the brain. Educating individuals on how to balance their diet while looking at foods that can actually provide nutrients and in some cases replace the need for medication. These talks aim to widen people’s knowledge of how they can better control their conditions with the right nutritional balances, knowledge is power and key to someone’s recovery.

An open cafe will accompany the bus so people can experience the many benefits that exercise provides for both mental and physical wellbeing. A healthy mind creates a healthy body. Many manage their mental health with a programme of diet, exercise and self-management. The benefits are obvious.

Explosive music and art therapists are known to release serotonin, increasing serotonin levels and will naturally be a part of the programme. Eventually, it is hoped that professional artists and musicians will form part of the bus providing further diversity for therapeutic recovery.

Peer specialists and clinicians will deliver a comprehensive programme of recovery courses. The courses help service users to understand their experiences and to manage their recovery. Top clinical professionals encourage them to sign up to workshops in their area, all of which are free of charge, to broaden their existing skills and interests.

Creative writing, dance and movement workshops/ performances will allow people to explore their talents and introduce them to local groups. Many report a sense of being able to distract their emotions in the mediums of music, dance or drama.

A social networking and online chat forum will be designed so people can continue to build relationships with other local residents.

The bus will be the beginning of people’s recovery journey to wellbeing and social continue as they are invited to reconnect with any of the specialists on our team. It will give you a focus, an understanding of recovery and empower them to make changes. A realisation that they no longer need to be a prisoner of their minds. Their recovery is unique to them and may follow many avenues but the key answers are within them. They can and will improve their lives.

Members of the public will be able to access services anonymously if they wish, without the fear of recorded information appearing on their medical records or employment files. Thus, by teasing away the apprehension for many to seek help and receive essential support and treatment.

Recovery is hugely positive and allows people to transform their lives for the better. Those with mental health diagnoses can and do achieve success.

The recovery and wellbeing bus is designed to meet change rather than waiting for change to happen.

The Partnership of open spaces and creative give essential when delving workshops, together they comprehensively explain mental health illnesses and provide invaluable education. Those workshops will look at specific sorts of illnesses, looking at key areas of warning signs, coping mechanisms, management skills, recovery plans and much more.

Keynote speakers will be present, throughout and will comprise of mental health experts, local council and governmental representatives, benefits advisors, voluntary sector employees, high profile individuals and inspirational guests.

Recruitment days will provide an opportunity for service users to further their recovery, through the potential of employment. A wide variety of opportunities and private companies will meet an exhibition which allows our clients to engage, find purpose and build lasting relationships. Key funding bodies will also be on board to assist and explore available investment opportunities.

The conclusion:

As a sufferer of Bipolar for 17 years experiencing various attempts, high anxiety, chronic depression, hypermania and many other manifestations I know only too well the dependence and terror people endure. I have been fortunate to overcome a number of challenges I have encountered over the years and that of many others I’ve spoken to. The difficulty in finding the appropriate care, support and help. Throughout the last 5 years I have been working on a journey of recovery and through this process I have experienced a number of unexplainable events. Recovery is achieved by taking small steps into the future and not on the timeline of others.

It is with this knowledge that I have now been able to move forward and find my own recovery, one in which I have not seen before. I have been fortunate to overcome a number of challenges and to enable a life of recovery and wellbeing.

It is with this passion that I have set the challenge to help people in an effective, efficient and sustainable manner; giving you the recovery and wellbeing tour.

A tour which will inspire and help thousands on a local and national level, in turn breaking down stigma and discrimination.

The tour will begin in Dorset and eventually travel the breadth of the country with the bus being stationed in towns, villages, cities, schools, work places and transport hubs. The duration is to create maximum impact and reach a wide and diverse audience. The aims to gain positive support from many businesses, encouraging CEOs to accept the uniqueness of potential and existing employees.

The bus will become a driving force which not only will drive on over stressed and reduced services but encourage support for recovery and helps those experiencing periods of crisis.

"Mental health, what’s the issue?

Healthy minds...
One final thing…

"Patients have a story, a life, priorities, fears & anxieties, not just pathologies. Learn about these"
Thank you!

Any final questions, comments or thoughts?
Any Questions...