

Mental Health Champions

Development Programme

Final Report – Initial Cohort 06-07

by

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Executive Summary

The Mental Health Champions Development Programme was a structured education programme created in response to recommendations from the Strategic Health Authority and findings from the national quality improvement programme Better Services for People who Self-Harm hosted by the Royal College of Psychiatry. The primary aims behind this programme were to improve standards of care for individuals using Portsmouth Hospitals Trust (PHT) services and support staff through a structured education programme. The programme has been devised and delivered by collaborative working between PHT and Portsmouth City teaching Primary Care Trust.

Programme content

Fourteen qualified nurses were recruited from clinical areas with PHT to undergo 11 taught days of mental health training and action learning over a 12 month period. Training was provided by various facilitators throughout the programme, including service users, and the areas covered were:

Attitudes	Communication skills
Understanding and interventions in self-harm	Overview of mental illness
Interventions for hazardous drinkers	Overview of local mental health services
Assessment of mental health	Root causes of challenging behaviour
Care of the confused and wandering patient	Mental Health Act within the acute hospital
Law, ethics and capacity	Learning disability issues
Looking after ourselves	Alcohol detox
De-escalation and breakaway techniques	Rapid tranquilisation

Each participant was expected to produce a written assignment and a change in practice project aimed at improving care for mental health patients within their clinical area. On the final day of the project key stakeholders were invited to attend a presentation day where the champions provided stands exhibiting their change in practice projects.

Outcomes

The aims of the programme were met and the following improvements have been noted and evidenced:

- Improved patient care
- Increase in staff confidence
- Decrease in staff anxiety
- Positive identification of risk
- Increased communication skills
- Clearer patient pathways
- Improvement in staff attitudes
- Recognition of all patients mental health needs hence improvement in patient care for all
- Collaborative working, fostering better working relationships between trusts
- Incorporation of mental health training as core for acute trust learning and development
- Excellent standard of practice improvement projects = improved patient care

Recommendation

It is recommended that this programme is run on an 18 month to 2 yearly basis with a multi-disciplinary focus. To enable staff to become confident and competent to care for patients mental health needs in addition to their physical needs. This will ensure that these patients receive the best quality of care within PHT, that they receive this care promptly and that risks to both trust and service users are minimised.

Abbreviations

CSIP	Care Services Improvement Partnership
DoH	Department of Health
GP	General Practice
MCA	Mental Capacity Act
MH	Mental Health
MHA	Mental Health Act
MHCDP	Mental Health Champions Development Programme
MHLT	Mental Health Liaison Team
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
PCtPCT	Portsmouth City teaching Primary Care Trust
PHT	Portsmouth Hospitals Trust
Q&A	Question and Answer
RCP	Royal College of Psychiatry
SHA	Strategic Health Authority
SUI	Serious Untoward Incident
TAG	Threshold Assessment Grid

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Introduction - national and local context

The Mental Health Champions Development Programme (MHCDP) was a structured education programme created in response to several serious untoward incidents (SUI) involving patients taking their lives within local trusts, subsequent recommendations from the Strategic Health Authority (SHA) and other national directives e.g. National Institute of Clinical Excellence (NICE) guidance. It had been identified that there were significant learning needs for staff in dealing with patients, relatives, carers and even other staff with mental health issues. Running concurrently, the Mental Health Liaison Team (MHLT), a team of Mental Health Practitioners based within PHT, were taking part in the Better Services for People Who Self Harm Project, a national quality improvement programme hosted by the Royal College of Psychiatrists (RCP). Recommendations from this project also indicated the urgent need to increase education for staff. The primary aims behind the MHCDP were to improve the provision of care for individuals using Portsmouth Hospitals Trust (PHT) services and support staff through a structured education programme.

The Kolb (1984) learning cycle is based on the premise that the more staff reflect on a task the more they will have the opportunity to modify and refine their efforts. Inspired by this Swenson (1997) asserts that the logic of this cycle is that small improvements made by many will constitute major improvements over time and this was part of the philosophy of the champions programme. Furthermore, Haines and Donald (1998) state that educational programmes are one of a range of specific interventions that can be used to promote change in practice. Quibble (2001) states that knowledge management should be applied by capturing and communicating information to those who seek it or who need it, provide information to the right person at the right time.

The project was conceived in early summer 2006 by the Mental Health Risk Management group, populated by members of both PHT and Portsmouth City tPCT (PCtPCT) who provide the MHLT service, both were leading on actions from the SHA recommendations. These same group members were part of the RCP working group. The group decided that a facilitator was required to lead on the project so a secondment was offered on a one day a fortnight basis. The Senior Practitioner for the MHLT was seconded to this post from her role. There was a provision of some administration support, although in practice this did not prove very practical due to the days of the secondment and part-time working hours not coinciding very often.

Recruitment Process

It became clear very quickly that the timescale put forward for the recruitment phase and the one day per fortnight secondment were not going to be compatible. Based on this evidence the secondment was extended to one day per week and the proposed start date of end of August was put back to end of September. To enable recruitment an application form was designed (see appendix 1) which would provide opportunity to assess the level of commitment potential from the individual. Jooste (2004) points out the importance of nurse leadership in acting as agents for change within the

healthcare environment thus there was an additional expectation that the champions would demonstrate some leadership qualities. Each form required a commitment signature from the clinical area manager to ensure that the possibility of the person being able to attend regularly and be enabled to take time to fulfil the requirements of the course were maximised. This was considered essential, as it is pointed out by Platzer et al (2000) the culture of the organisation the person works in can be a barrier in itself to learning and implementing change.

The management group decided that the content of the programme would follow a distinct structure with explicit expectations. These were:-

- that the course would be a year long taught programme with members attending on a one day per month basis
- that each champion would produce a change in practice project aimed at creating a small change that would have an impact in improving patient care.
- that each Champion would provide a reflective essay, outlining their personal development on the course, details of the practice development project and the rationale behind it.
- that the days on the programme would be provided on a taught morning sessions and afternoon action learning group basis
- that the last day of the programme would be dedicated to presentations from the champions of their change in practice projects and evaluation.

Based on previous experience of learning and development members of the management group, it was decided that action learning would be the most useful approach to take in maximising learning potential for individuals (see fig.1).

Action learning sets bring people together in order to:

- Work on and through hitherto intractable, messy problems, issues or ideas of managing and organising. This must be a voluntary commitment.
- Work on problems which individually and personally engage the set members- situations in which "I am part of the problem and the problem is part of me"
- Check individual perceptions of the problem, to clarify and render it more manageable, and to create and explore alternatives for action.
- Take action in the light of new insight. This insight begins to change the situation. An account of the consequences of the action are brought back to the set for further shared reflection and exploration.
- Provide the balance of support and challenge which will enable each member to act and learn effectively.
- Be aware of group processes and develop effective teamwork. Usually sets have an advisor or facilitator whose role is to help members identify and acquire the skills of action and learning and group processes.
- Focus on learning at three levels:
 - ◆ About the problem which is being tackled
 - ◆ About what is being learned by oneself.
- About the process of learning itself, i.e. " learning to learn" (Neubauer ,1996)

Fig 1

Based on difficulties releasing staff and ideal numbers for group facilitation the project group decided that 24 would be an optimum number with which to run the group which would allow for three action learning groups and the facilitators for these groups would be provided by PCtPCT. The culture of the organisation at the time of recruitment was difficult in that staffing levels were in crisis and it was envisioned as extremely unlikely that there would be that many people released to attend. The facilitator and senior management members of the Risk group made contact with each clinical area's senior staff, modern matrons and managers, to emphasise the importance of releasing staff. This was done in person and by email using the briefing notes for managers (see appendix 2). It was agreed that the minimum number of staff required to run the programme would be six. Managers were asked to consider nominating staff with a prior interest in mental health and the programme was also advertised in the trust newsletter 'the Link' (see appendix 3) Each taught session was opened to the rest of the trust to attend and advertised in the Link prior to the day and eight of the taught sessions were also attended by other employees, ranging from nurses and healthcare support workers to discharge planners. The risk group agreed nine learning outcomes for the project (see fig.2).

Learning Outcomes

By the end of the programme participants will have:

1. Demonstrated improved confidence and ability in dealing with patients with mental health issues, this would include adults, older persons and people with Learning disabilities.
2. Demonstrated improved understanding about mental health issues including signs, symptoms and risk factors, including self-harm and substance misuse.
3. Reflected on, understood and be able to apply of TAG (Threshold Assessment Grid) and other MH assessment and observation tools to enhance the support and care of people at risk with mental health issues.
4. Reflected upon the therapeutic use of self, including communication, engagement and observation.
5. Developed in-depth awareness of their own and others attitudes towards people who have mental health issues.
6. Through the action learning set process, explored, developed and discussed understanding of the complex issues and dilemmas that surround mental health eg. Equal opportunities, societal discrimination, cultural influences.
7. Disseminated new learning within clinical area and supported others in dealing with issues around mental health.
8. Planned, implemented and reported an evidence based practice development project to improve the experience of MH service users in their care setting.
9. Undertaken effective communication with a variety of support and external agencies, ensuring patients with mental health issues receive the support they need.

Fig. 2

By the start of the programme there had been ten completed applications with many more expressions of interest so it was unclear exactly who would attend on the first day as interest had continued right up until the last minute. In the event fifteen champions attended and all but one, who secured another job elsewhere, remained with the programme until the end. The clinical areas that sent nurses on the champions programme were as follows:

Medicine	Gynaecology
Surgery	Maternity
Head & Neck	Orthopaedics
Out patients – rheumatology	Emergency Department

The proposed programme was drafted for consultation with the champions on the first day, to identify if there was anything they required that had not been included. The programme was offered to the champions who highlighted that a session on looking after their own mental health would be valuable. The programme outlined overleaf was provided. In the first six months of the course the afternoon sessions were divided into time for projects and action learning sets at which point champion feedback and negotiation led to the dropping of the project time and insertion of another taught session. This was in recognition of the fact that the area of mental health is vast and the champions felt that some of the topics demanded a more in depth session. It was recognised that, as asserted by Bhoopathi and Sheoran (2006) teaching techniques in health care are often didactic thus the facilitator encouraged those attending to provide training to use a range of techniques where possible.

Evaluation

In order to measure the effectiveness of the MHCDP Kirkpatrick's four-level model of evaluation (Kirkpatrick 1994) has been used to gather and structure the evaluation information. (See fig. 3 below)

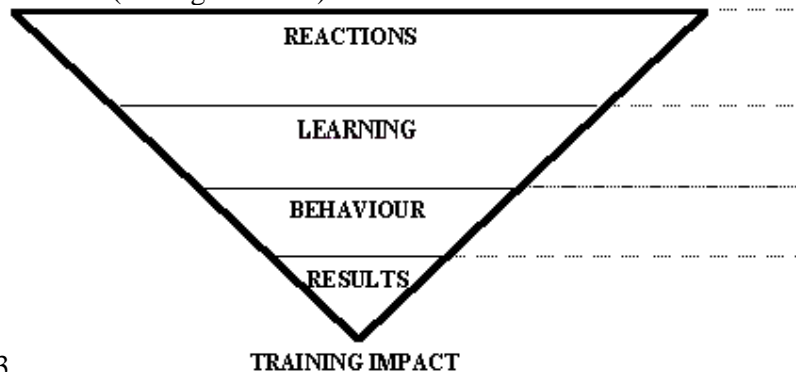


Fig 3

The project was critically evaluated. At the beginning of the course the champions were asked to rate their progress with regards to knowledge, attitude and confidence (see appendix 4). This was repeated at the six month stage and at the end of the programme. During the project each day's taught sessions were evaluated and the facilitator of each action learning group took notes of the discussions held. The course facilitator also kept a reflective log throughout the duration of the project. At

the six month point in the course each champion's manager was contacted by email to request feedback regarding the individual's practice and this was repeated at the end of the programme. The response to this was poor, however where there was a response it was positive and it was argued that the fact that each champion continued to be released on a regular basis (only one champion attended all eleven study days) could be seen as positive feedback in itself given the difficulties in releasing staff from clinical areas. Despite these problems the champions managed a rate of 85% attendance throughout the programme.

Reactions to the sessions were gathered via verbal feedback and session evaluation forms (see appendix 5). The primary theme emerging from these session evaluation forms was that the champions were more comfortable with and enjoyed most the more practical based sessions, the sessions that told them what to do in some way. In a very task orientated audience this is not surprising and sessions such as management of substance withdrawal where suggestions for medication dosages were offered and use of the Threshold Assessment Grid (TAG) a risk assessment tool to aid in the identification of risks and urgency of need to refer patients to mental health services were very well received.

'It is very useful to have TAG, risk assessment tool.' From Action learning group discussion 14/03/07.

One of the challenges for the champions was the difference in culture between the acute hospital environment and the mental health environment which is, as one champion pointed out in her assignment a:
'very grey area and it appears that sometimes nobody has the answer, which takes some getting used to.'

A desire for more concrete answers to problems associated with mental health patients was a consistent theme throughout the program and most of the criticism from the champions themselves revolved around this. Another theme emerging from the session feedback was the fact that the champions often had the belief that they should have the answers to give to patients and relatives and this added to their discomfort at having come on a mental health course for the answers to be told that there are no clear cut answers but that each individual situation may require a different outcome even where the patient has the same diagnosis! Even in medicine however, as Greenhalgh (1999) points out there are few rules that can be conditionally applied to every case or even every disease. On one sessions evaluation form the champion concerned wrote that the most important thing she had learned about herself that day was that she is not expected to know everything about everything and as a result she felt more confident. One message that appeared to have been fully absorbed by all the champions was the importance of communication, not only with patients with mental health problems but with all patients. Various supporting comments from forms would include. 'Communication is key' and 'Sometimes all someone needs is to be listened to.'

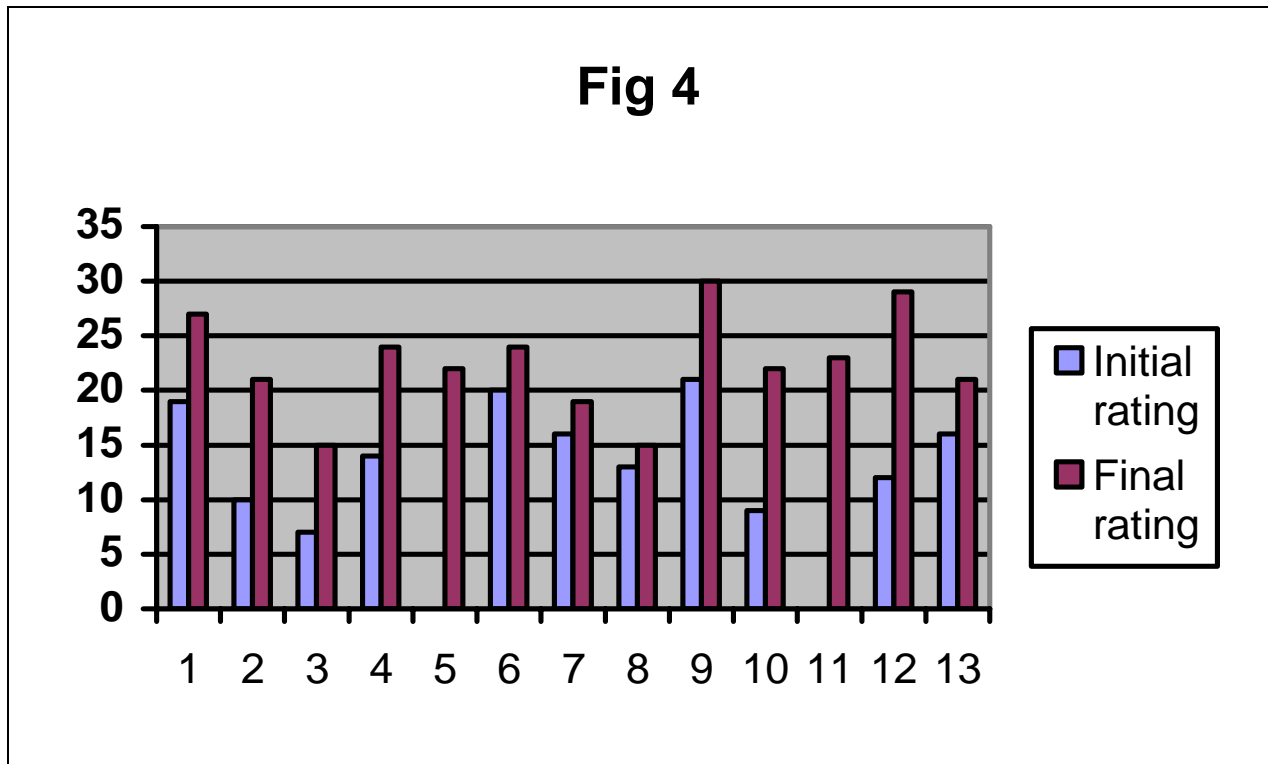
Course content

Time	Oct 31 st 2006	Nov 30 th	Dec 20 th	Jan 11 th 2007	Feb 12 th	March 14 th
Am	Intro to course Learning Outcomes Expectations Session outline Reflective Practice & Action Learning – What is it?	Attitudes and Communication skills introduction	Overview of Mental illness Overview of local mental health services	Communication skills	Interventions for hazardous drinkers.	Assessment of mental health Risk assessment
Pm	Project time Action Learning Sets	Project time Action Learning Sets	Project time Action Learning Sets	Project time Action Learning Sets	Project time Action Learning Sets	Project time Action Learning Sets
	April 5 th	May 22 nd	June 1 th	July 9 th	July 10 th	Aug 31 st
Am	Root Causes of challenging behaviour Care of the confused and wandering patient	Understanding Self-harm Interventions in self-harm	Mental Health Act within the acute hospital Law, ethics and capacity	Learning disability issues Looking after ourselves	De-escalation Breakaway techniques	Presentation of projects
Pm	Re-cap overview of mental illness Action learning sets	Communication and self-harm Action learning sets	Projects resources and presentations Action learning set	Alcohol detox, withdrawal Action learning sets	Rapid tranquilisation in the acute environment Project time	Final evaluation and wash up.

Champions were asked to assess their **learning** via a rating scale evaluation form (see appendix xx) this form asked them to rate themselves on a scale of 0 – 8, where 0 is the lowest level and 8 the highest, with regards to:

- ✓ Knowledge and skills in relation to mental health issues
- ✓ Approach and understanding toward mental health issues
- ✓ Ability to influence colleagues regarding mental health issues
- ✓ Confidence about working with people with mental health issues.

Without exception all the champions who completed the forms showed a marked increase in ratings for each of the areas considered. A maximum of 32 points could be allocated within the rating scale and the numbers given by each member to themselves is recorded in fig. 4. One champion did not submit forms for this purpose and two members only did the final rating however they indicated verbally that they felt they had improved significantly in every area. The greatest improvement was judged to have been made in those who had rated themselves quite low on all areas at the beginning of the programme, they clearly felt they had improved significantly, those who were more confident at the start of the programme showed a less marked improvement however they still felt they had improved in all areas by the end of the programme.



To illustrate this point, the following three extracts are reflections taken from the same champion’s rating sheets at the three points of evaluation, beginning, midway and end. This also illustrates a change in **behaviour** for this individual

A gentleman was admitted to my unit with severe neck injuries that were self-inflicted. Although I felt confident in talking to the man and treating his physical injuries I did not feel at all confident in approaching him in conversation regarding the cause of his physical injuries and how he had arrived at that point.

Through the taught sessions of this course I have learnt that there are not always black and white answers to many of the problems but there are people who can be contacted who can be used as a resource and in the long term help to improve my clinical practice. I have made a conscious effort to try and allow more time for listening to patients concerns and fears and trying to address anxieties and any mental health issues at an earlier opportunity.

A 23 year old male came into the ward with a facial injury and had a history of drug induced psychosis with extreme paranoid episodes at times. He appeared quiet with a slightly agitated tapping of fingers and feet. I felt confident to talk with him openly about triggers that would increase his agitation and coping strategies that usually helped to calm him down. We agreed a safe space on the ward that he could go to if he felt he was becoming agitated and he could have access to a phone whenever he decided to call his keyworker if he thought this would help. This approach seemed to work well and he appeared calm throughout his stay.

The managers were contacted at the six month stage of the programme and again at the end and asked for feedback (see appendix 6) with regards to improvements in practice and changes in knowledge, skills and attitudes towards patients with mental health problems. One manager related that they had noticed 'Identifying skills of patients at risk have increased.' Another noted that the champion had stated during supervision that they felt they had learned a lot. Another stated that the champion 'definitely has more awareness' and 'Knowledge and attitude have definitely been more prominent since starting the development programme.' To illustrate a change in behaviour in another champion when dealing with a mental health patient the following two extracts are taken from the reflective writing on their first and last rating scales, this also shows reduction of risk for the organisation.

Whilst I felt comfortable talking to the patient, I also felt frustrated at my lack of knowledge and contacts and if fact legal stance....I am acutely aware of my lack of knowledge and how to access the best care for vulnerable patients.

We recently had a patient admitted who was under section. The patient absconded. I felt confident in dealing with this situation.

Berlim et al (2007) outline a brief training program on suicide prevention for general hospital staff and evaluate the effect this had on attitudes, the results show that the training had a beneficial effect and this reinforces the belief that this sort of training program is needed in the acute hospital setting. Bolton (2003) points out there is an historical divide between physical and mental health services which results in difficulty in meeting the psychological needs of patients within the acute hospital setting. He states that an up-to-date knowledge of mental illness is key in reducing stigma and therefore improving patient care. Care Services Improvement Partnership (CSIP 2007) report on attitudes to mental illness state that there has been a reduction in tolerance towards mental illness since 2000.

In order to examine the **results** of the programme, on the final day key stakeholders were invited to attend a formal presentation event (see appendix 7) at which the champions were to present their change in practice projects. There had been a lot of anxiety throughout the course as to the format of the essay and the presentation they were all expected to complete. Guidance was provided (see appendix 8) to assist but many of the champions felt that this was too academic and those who had had no recent report writing experience stated that they found this expectation overwhelming. In the event only half of the cohort produced written reports but all the clinical areas had change in practice projects implemented within them, in some cases with champions working together where they came from the same clinical area. In order to reduce some of the anxiety around the presentation of projects it was negotiated that they would provide talking poster presentations in the form of stands that the invited audience could view and ask questions individually of the champions present. The facilitator presented a short power-point presentation at the beginning of the event to the audience then invited all to peruse the stands and discuss with the champions. The audience were made up of a combination of representatives from training and development, clinical governance, clinical managers, modern matrons, service users and other professionals from both PHT and PCT.

The provision of this programme supports standard 4 of the National Service Framework (NSF) (DoH, 1999), Effective services for people with severe mental illness, in that increased knowledge and understanding from the acute hospital staff will promote patients receiving timely care with regards to their mental health needs; also an increased awareness of and use of a risk assessment tool will help to anticipate and prevent crises, reducing risk for both the patient and the service. It also supports standard 7 of the NSF, preventing suicide, in the same way. The DoH (1991) states that one way to ensure a healthier nation is by increasing education and training around mental illness

The reports produced were a combination of reflections on the course and the changes the individuals had noticed in themselves and their practice and their change in practice projects. Craft (2005) states that reflective writing is very useful in aiding the development of critical thinking skills and fostering understanding in dealing with difficulties encountered in professional practice. There was ample evidence within these submissions to support the learning outcomes of the project:

‘I had limited knowledge regarding issues surrounding patients with mental health problems.....and many staff were unaware of the mental health team situated within the hospital.’

Following the course this same champions states:

‘I have been able to instruct and teach other member of staff and this has been used effectively.’ In the use of a risk assessment tool designed to enable prompt management of risk and referral for patients with mental health problems. She also states that following the taught sessions she:

‘Took a greater understanding and information back to my clinical areas’

Another champion reported:

‘Colleagues had reported that they had a fear of saying something that could make things worse, when in fact the opposite had been occurring, it was the lack of shared information and communication that had been isolating the service users.’

She goes on to state that:

‘Such was the programme variety, not a day on the course went by without a new contact that could be used as a resource being obtained.....From a personal perspective I feel that through the MH Champions course my own knowledge of different mental health issues is much improved and I feel

an increased confidence in approaching and working with patients who have a mental health diagnosis.'

The majority of the change in practice projects took the form of a resource folder created for each clinical area which the champions took responsibility for keeping up-to-date. These contain information about current services available to patients with mental health problems and educative materials for staff about common mental health problems, substance misuse and other related topics as felt necessary by the individual champion in collaboration with their clinical area. One champion produced a project in the form of a poster educating pregnant mothers about the importance of looking after their own mental health during pregnancy (see appendix 9) this provides education in a non-discriminatory and non-challenging way that many women can access via maternity, it would be equally appropriate within GP surgeries. Another champion employed the services of a mental health service user to create a logo which she then had transferred onto a badge and poster with the phrase 'a problem shared is a problem halved' written on the poster (see appendix 10). Various members of the ward staff who had received some training in communication skills, would wear the badge and patients could approach these members of staff to talk to them about whatever was bothering them. The rationale being that those who are anxious about an operation or procedure are as likely to need someone to talk to as those with mental health problems. This again provides a non-discriminatory way of providing mental health care to all patients and illustrates an environment where there is an acceptance that mental health is the province of all and not just a few patients. This is a stand-point that is likely to mean that risks and problems regarding mental health are likely to come to light more promptly and enable a better response for individuals and services alike. Other examples of champion's projects include a new referral system to refer patients to substance misuse services, an audit to discover whether nurses are recognising signs of depression in rheumatology patients and information boards on mental health (see appendices 11-13 for examples).

One champion from an out-patients environment reports that she was able to phone the GP and arrange a mental health assessment for a patient and that in order to do this, 'new communication skills learnt were used.' This illustrates improved care for the patient and decreased risk for the organisation as the patient will receive the appropriate care at the right time thanks to training provided by the organisation. All the champions stated that their communication skills had improved and as Taylor et al (2002) point out many complaints largely result from communication problems between patients and staff, therefore one could logically conclude that if staff communication skills are improved then there should be a resultant reduction in patient complaints relating to communication problems.

Conclusions and Recommendations

At the start of the programme the perceived benefits were:

- Improved patient care
- Increase in staff confidence
- Decrease in staff anxiety
- Positive identification of risk
- Increased communication skills
- Clearer patient pathways
- Reduction in likelihood of staff assault
- Reduction in challenging behaviour
- Minimise likelihood of other Serious Untoward Incidents

This report shows there is evidence at this stage that would suggest that all of the above have been met, although research would need to be done looking at patient's experiences to evidence this further. In addition to this the following benefits have been noted and have also been evidenced:

- Improvement in staff attitudes
- Recognition of all patients mental health needs hence improvement in patient care for all
- Collaborative working, fostering better working relationships between trusts
- Incorporation of mental health training as core for acute trust learning and development
- Excellent standard of practice improvement projects = improved patient care

PHT learning and development department have accepted the positive outcomes of this programme and are planning to run another cohort during the next year. As it was hoped from the beginning of the programme that this would be the case the champions were tasked with creating a role descriptor to aid future cohorts, see fig 5

MH Champion Role Descriptor

- Advocate on behalf of Patients in issues relating to mental health
- Be a role model for other staff in dealing with patients who have issues with mental health
- Act as a resource for the clinical area in issues relating to mental health
- Promote good practice between agencies
- Facilitate interest in colleagues about mental health
- Keep Mental Health resource packs up to date
- Mentor and support future MH Champions
- Take part in MH study days, keeping up to date
- Meet with a facilitator, periodically, to share experiences, new information and for mutual support

Fig 5

Recommendations from Year 1- MH Champions programme **Champion's recommendations**

1. Look at 'burning issues' earlier in the course; Alcohol detox, challenging behaviour, looking after ourselves.
2. Add something about adolescent issues – these often present real challenges
3. Invite lecturers back for drop in Q&A sessions
4. Have a whole day on the MHA & MCA
5. Champions should get together for a ½ day sessions every 3/12 for support and motivation – this would need facilitation

Facilitator's recommendations

1. Run the course on an 18 month/ 2 year rolling programme – this will account for staff turnover
2. Offer this as a multi-disciplinary course
3. Consider active involvement of Work Based Learning team from the university to allow accreditation of the programme
4. Build into the next cohort a facility for gathering service user views of champions practice to monitor more effectively the impact on patient care

The mental health champion development programme, based on the evidence outlined above, could be deemed to be a successful venture for the trusts involved. The main stated aim of the programme was to improve the provision of care for individuals using PHT services and support staff through a structured education programme both of which have been met. This does not mean that the job is done, it merely reinforces the belief that mental health education continues to be something that is desperately needed within the acute hospital environment (RCP, 2003). This programme model does appear to be a successful way of providing education through creating local experts that can cascade knowledge to the clinical area, improving staff confidence and patient care. As Angermeyer (2006) points out there is still a long way to go in reducing misconceptions about mental illness and improving attitudes. As one of the champions states in her closing paragraph of her assignment:

‘By implementing the simple changes suggested in this project it is hoped NHS users and staff will experience the holistic and inclusive approach that the modern day NHS should strive to accomplish.’

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Appendices

Mental Health Champions Development Programme

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Team Leader – Project facilitator

Appendix 1
Mental Health Champion Development Program

Please state in a min of 150 words why you feel you are suitable for this training, why you are interested in undertaking it and how you would see the role developing within your clinical area.

Please complete this section detailing your expected outcomes from the programme in relation to:

Your personal development
Your practice
For your clinical area
How will you measure the benefits of attending this course?
Please detail how you will ensure the role develops within your clinical area

You require the support of your manager to release you from practice to attend this programme. Please ensure that this section is completed before it is returned.

I confirm that has discussed this programme with me and that he/she has been given the time to undertake the programme. The intention is that on completion he/she will fulfill the role of Mental Health Champion and provide support and education for the staff in the ward/department in relation to patients with mental health issues

Managers Signature :

Date :

NAME IN CAPITALS :

Contact details:

Appendix 2

Mental Health Champions Development Program

BRIEFING NOTES FOR MANAGERS

Rationale

In response to several serious untoward incidents (SUI), subsequent recommendations from the SHA and other national directives e.g. NICE, the Trust has identified significant learning needs for staff in dealing with patients, relatives carers and even other staff with mental health issues. The aim behind the MH Champions program is to improve the provision of care for individuals using our services and support staff through a structured education programme.

Programme Elements

- Morning taught sessions on a wide range of Mental health topics
- Afternoon action learning sets to initiate change in the workplace and enable deeper personal and group learning through facilitation and reflection. Colleagues from MH Services in Portsmouth City Teaching PCT will facilitate all action learning sets.

Managerial Commitment Required

- Attendance at 12 study days at a rate of one day per month. It is essential that managerial commitment to staff release be provided on application. Dates for the whole programme are available from Sandra Cameron.
- Support for staff to complete a work based project to improve an aspect of MH care in your area.
- Support to develop the MH champion role within your clinical area and enable the dissemination of learning about MH issues to other staff.
- Course commences **27th September 2006**.

Benefits

Improved patient care

Decrease in staff anxiety when dealing with patients or others who have mental health issues.

Increased likelihood of identifying risk earlier and minimising possibility of further incidents/SUI's

Development opportunity for staff – increase motivation and productivity

Might this program apply to your area?

The Mental Health Risk group have identified priority areas who have the highest numbers of incidents and issues. These are:

- Surgery/Urology/Gynae
- General and Post Acute Medicine
- MAU/SAU and Emergency Department
- Orthopaedics
- Maternity
- Out Patients
- Oncology and Haematology
- Older Peoples Mental Health

Who is programme for?

Places are available for one member of staff from each priority area to a maximum of 24. Ideally, MH champions will have at least 2 years experience post qualification. A MH Champion role descriptor will be developed by course participants as part of course work.

DID YOU KNOW.....

- 1 in 3 people at any one time suffer with mental health problems.
- Self-harm is the most common cause of acute admission for women and second most common for men.
- A HUGE proportion of the people you deal with on a day to day basis have mental health issues.

Appendix 3

Mental Health Champions Development Programme

Did you know...?

Self-harm is the most common cause of acute admission for women and second most common for men.

Patients with serious physical illness have at least twice the rate of psychiatric disorder found in the general population.

In response to many requests for training and support around issues relating to mental health and to incidents that have happened within our Trust and others, a new programme has been developed to meet the needs of those caring for patients with mental health issues.

- Do you have a special interest in mental health?
- Would you be interested in developing your knowledge and skills in mental health?
- Would you be willing to commit one day per month for twelve months to participate in a mental health development programme?
- Would you be willing to share your learning with others and act as a Mental Health Champion in your area?
- Are you a registered nurse with more than 2 years experience?

Interested? For more info. Contact:

Appendix 4

Mental Health Champions programme – October 06 – October 07.

Evaluation and development question.

My progress as a ‘Mental Health Champion’

Name:-

Date:-

How do I rate myself as a mental health champion in relation to the following?-

[using a 0 – 8 scale with 0 as the lowest level and 8 as the highest, please assign a number to each of the following statements]

My knowledge and skills in relation to
mental health issues =

My approach and understanding
toward mental health issues.
[0 = not particularly positive or
optimistic, 8= extremely positive and optimistic] =

My ability to influence colleagues regarding
mental health issues =

My confidence about working with people with mental
health issues =

Please write a brief reflection [this may be a situation from clinical practice] that demonstrates where you feel you are at the present time in terms of your development.

Appendix 5
Mental Health Champion Programme

Session Evaluation

Name:

Date:

1. I enjoyed the session because:

2. The session could have been improved if:

3. Three things I have learnt today are:

4. The most important thing I have learnt about myself today is:

5. The thing I will take back to my clinical area from today is:

6. The one thing that stands out about today is:

7. The style of facilitation?

Thank you for completing this evaluation. A copy will be returned to you.

Appendix 6

-----Original Message-----

From: Cameron Sandra - Team Leader
Sent: 12 April 2007 14:56
To: Matron Trauma Orthopaedics and Rheumatology & Rheumatology Clinical Nurse Specialist
Subject: MH champions feedback

Dear Colin,

I am writing to ask you to consider the following two questions with regards to the practice of your team member xxxxxxxxxx, who you kindly released to allow her to attend the MH Champion development programme. I would be grateful if you could provide feedback at this point where the champions have been on the programme for more than six months.

- Have you noticed or heard reported any improvements in practice when xxxxx is dealing with mental health patients?
- Have you noticed or heard reported a change in knowledge, skills and attitude from xxxxx, towards patients with mental health problems?

Thanks for your time
best wishes

Sandra Cameron

Team Leader

Mental Health Liaison Team

A&E, Queen Alexandra Hospital

Southwick Hill Road, Cosham,

Portsmouth, PO6 3LY

Tel: 023 92286000 x5930

Fax: 023 92286588

Mob: 07884001358

Appendix 7

Portsmouth City 
Teaching Primary Care Trust



Portsmouth Hospitals 
NHS Trust

INVITATION

You are cordially invited to attend the final presentation day of the

Mental Health Champions

The Mental Health Champion Development Programme, a fine example of collaborative working between two trusts, is coming to the end of the first year. The champions invite you to come and see how it has been for them, what they have learned and developments in practice that have and are improving things for patients.

Date: 31st August 2007

Time: 1230 – 1500

Venue: Room 12 QUAD

Lunch included

Action Learning Project

Project Guidelines

Aim of the Project:

The aim of the action-learning project is to enable you to undertake a **small-scale** change project in your own work area. The change is linked to the Mental Health Champion Role and **MUST** be associated with **improvements in the care of patients with mental health issues**. Your action learning set is there to assist you in developing your project. You may wish to discuss and comment on each other's ideas within the group meetings. You will also probably wish to discuss and agree your project ideas with your team and line manager. Try and focus on things that will directly improve the patient's experience. This could be indirectly via initiatives with staff e.g. implementation of a new assessment tool, or directly e.g. better information for patients with a substance misuse problem. You are required to produce a report of your change and give a short presentation, as you would be for any change project undertaken in the organisation. Both aspects of the project are **essential** to the successful completion of the programme. You will need to submit the project proposal slip to your Action Learning Set Facilitator by the end of January 2007.

Part 1:

Write a 1,500 word report detailing the change initiative. The report should include the following sections:

- **Introduction (150 words)**
- **Background to the Change (250 words)**
 - what was the current situation
 - why you selected this aspect of care to improve
- **Methods (250 words)**
 - What your anticipated aims and outcomes were from the project
 - Planning
 - What were the success criteria for the project?
 - What tools or theories did you intend to use (if any)?
- **Implementation (400 words)**
 - How you made the change – what actually happened?
 - How was the change communicated?
- **Evaluation (300 Words)**
 - What went well about the project?
 - Were any barriers encountered? How were these overcome?
 - What would you do differently next time?
- **Recommendations (150 words)**
 - What other actions are necessary as a result of your project
- **References (not in word limit)**
 - Detail any sources of literature you used alphabetically by surname

Part 2:

Prepare a **20-minute verbal/visual presentation** about your change project. This will be given on the last day of the champions programme in the presence of invited line/senior managers and key others. The presentation can take any format you think appropriate (e.g. PowerPoint or poster presentation) but must include details of why you chose to tackle the issue, how you went about it and how successful you feel your change project was, as well as recommendations for future practice.

If you wish to gain academic credit for this work via the University of Southampton's Work Based Learning module, please let Sandra Cameron know in order to arrange registration.

**Mental Health Champions Programme
Action Learning Project**

Proposal

Please submit this form to the Mental Health Champions Programme Course Facilitator (Sandra Cameron) by 31st January 2007.

Name of Participant:
Ward/Unit/Department:
Title of Project:.....
Rationale for Project Selection:.....
.....
.....
Aims of Project:
1.
2.
3.
Line Manager Signature:.....
Date.....
Programme Facilitator Signature:.....
Date:.....

Appendix 9

YOUR MENTAL HEALTH

PREGNANCY

1 IN 4 OF THE GENERAL POPULATION WILL HAVE SOME SORT OF MENTAL HEALTH PROBLEM AT SOME TIME WITHIN THEIR LIFE!

THE FACTS REGARDING MENTAL HEALTH ARE VERY DIFFERENT FROM THE VARIOUS MYTHS THAT SURROUND MENTAL HEALTH. MANY PEOPLE LIVE VERY NORMAL LIVES.

MOST MENTAL HEALTH PROBLEMS CAN BE TREATED - JUST LIKE PROBLEMS WITH YOUR PHYSICAL HEALTH!

THEIR MUM & LOT OF RESEARCH ON MY DEVELOPMENT IF YOU DON'T LOOK AFTER YOUR MENTAL HEALTH NOW! BUT SOMETIMES YOUR MENTAL HEALTH CAN ELEVATE YOUR BLOOD PRESSURE, IT CAN ALTER YOUR NUTRITIONAL INTAKE AND YOUR PERCEPTION OF LIFE EVENTS. THIS CAN THEN LEAD TO ME BEING BORN VERY SMALL OR YOU GOING INTO PREMATURE LABOUR. ... PLEASE LOOK AFTER BOTH OF US!

20-30% OF WOMEN HAVE A MENTAL HEALTH PROBLEM DURING THEIR PREGNANCY!

10-15% OF WOMEN WHO ATTEND ANTENATAL CLINICS SUFFER WITH DEPRESSION. THIS REDUCES TO 5% IN THE 3RD TRIMESTER!

NOT ALL PREGNANT WOMEN NEED TO BE TREATED WITH MEDICATION IF THEY HAVE A MENTAL HEALTH PROBLEM. HOWEVER IF THIS IS THE CASE THEN YOU ARE TREATED ON THE MOST EFFECTIVE AND SAFE DOSE FOR BOTH YOU AND BABY.


MANY OF THE SIGNS AND SYMPTOMS OF PREGNANCY CAN ALSO BE IDENTIFIED AS SIGNS AND SYMPTOMS OF DEPRESSION!

- ANXIETY
- ALTERATION IN SLEEP PATTERN
- ALTERATION IN APPETITE & DIET
- LIFE ADJUSTMENT
- LOW IN MOOD
- NAUSEA & VOMITING
- OBSESSIONS
- SELF PERCEPTION
- WEIGHT GAIN OR WEIGHT LOSS

THESE FOODS ARE A GUIDE AND INTENDED FOR EVERYONE'S MENTAL HEALTH. OBVIOUSLY THERE WILL BE SOME FOODS THAT ARE NOT APPROPRIATE WHEN PREGNANT OR BREASTFEEDING PLEASE USE WITH CAUTION AND SEEK ADVICE FROM YOUR GP OR MIDWIFE.

SPEAK TO YOUR COMMUNITY MIDWIFE OR ONE OF THE HOSPITAL MIDWIVES IN CONFIDENCE FOR ADVICE. WE ARE HERE TO HELP!

BY SONIA BOWEN (MIDWIFE)



Food	Health Benefit
Wholegrain bread	Helps with constipation
Yoghurt	Helps with constipation
Prunes	Helps with constipation
Apples	Helps with constipation
Pears	Helps with constipation
Plums	Helps with constipation
Blackberries	Helps with constipation
Raspberries	Helps with constipation
Strawberries	Helps with constipation
Blueberries	Helps with constipation
Blackcurrants	Helps with constipation
Rhubarb	Helps with constipation
Watermelon	Helps with constipation
Cantaloupe	Helps with constipation
Cherries	Helps with constipation
Apricots	Helps with constipation
Oranges	Helps with constipation
Lemons	Helps with constipation
Limes	Helps with constipation
Peaches	Helps with constipation
Pineapples	Helps with constipation
Mangoes	Helps with constipation
Papayas	Helps with constipation
Guavas	Helps with constipation
Avocados	Helps with constipation
Olives	Helps with constipation
Almonds	Helps with constipation
Walnuts	Helps with constipation
Cashews	Helps with constipation
Peanuts	Helps with constipation
Soybeans	Helps with constipation
Lentils	Helps with constipation
Chickpeas	Helps with constipation
Black beans	Helps with constipation
Kidney beans	Helps with constipation
Pinto beans	Helps with constipation
Refried beans	Helps with constipation
Beanitos	Helps with constipation
Quesadillas	Helps with constipation
Tacos	Helps with constipation
Burritos	Helps with constipation
Enchiladas	Helps with constipation
Mole	Helps with constipation
Salsa	Helps with constipation
Hot sauce	Helps with constipation
Mustard	Helps with constipation
Ketchup	Helps with constipation
Mayonnaise	Helps with constipation
Salad dressing	Helps with constipation
Ice cream	Helps with constipation
Soft drinks	Helps with constipation
Alcohol	Helps with constipation
Tobacco	Helps with constipation
Drugs	Helps with constipation

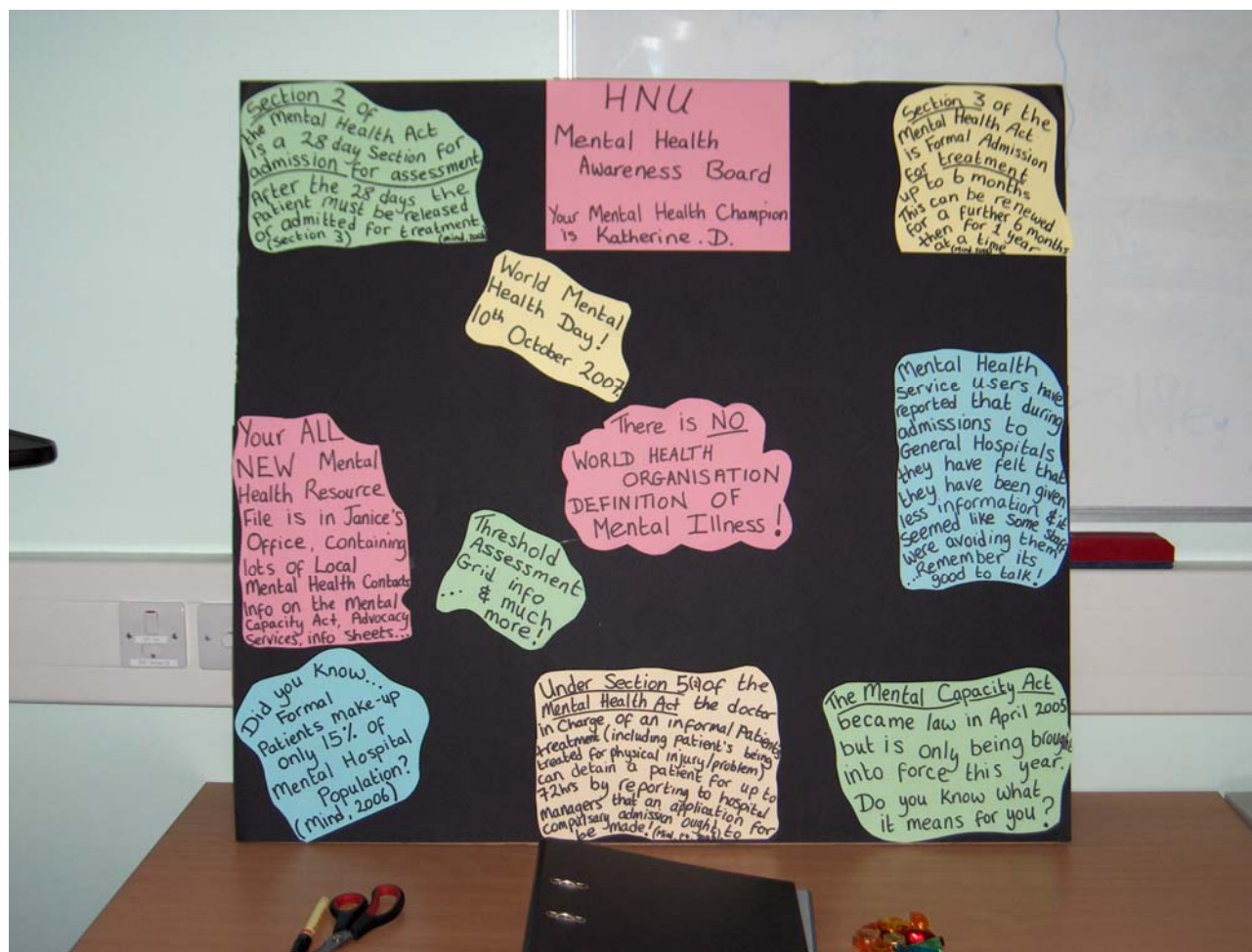
Appendix 10



Appendix 11



Appendix 12



Appendix 13

