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Advancing Practice
in Bedfordshire

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Editorial Group: *Advancing Practice in Bedfordshire*

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Editorial

by John Butler
Chair of Editorial Group

Welcome to Edition 3(2) of the Journal of Bedfordshire & Luton Partnership Trust – our eighth regular issue, in which we have an interesting variety of articles showing a strong theme of reflection. This is arguably our most balanced issue to date – so let me introduce a few of the articles to you.

Tarun Goel shares a very personal account of his initial experiences of fatherhood and the valuable impact of a medical placement with the local Child & Adolescent Mental Health Service, where a team of mental health professionals and therapists collectively contribute their views in forming an individualised case formulation as a basis for meaningful intervention. Tarun obviously found the experience enlightening to his own role as a father.

Terri Dorman and Ann-Marie Doody describe the development of induction processes at different levels within the Services for People with a Learning Disability (SPLD) Directorate. This includes an accredited Learning Disability Awards Framework (LDAF) Induction Programme and a LDAF Foundation Programme, which are soon to be combined into a new LDAF Initial Award. Complementing this, a core service induction pack has been developed to ensure a high standard of induction, which has now been shared with other directorates and stimulated similar developments – for example, the Acute Mental Health Service Induction Handbook (June 2006) – and thus exemplifying a real outcome to sharing development work.

C. Menna provides a reflective account of his involvement in planning and piloting a training initiative on the values-based Ten Essential Shared Capabilities, which all mental health practitioners are expected to achieve as best practice. He provides a clear outline of his approach to this initiative, reports an over-whelmingly positive evaluation of the training from a group of Adaptation Nurses and shares his own personal learning experiences.

Following a well-received presentation of their work at the Trust's Celebrating Success Seminar in December 2005, Cilla Kuzmanov and Seema Jassi describe a creative project initiative that focuses upon enhancing the meaningful occupation of older service-users. This involved the piloting of an activity level assessment tool within three older people service settings. A positive evaluation of this assessment tool is presented, following which a series of recommendations are proposed.

Further to Maggie Hodgson's carer perspective of the emerging local Crisis Resolution & Home Treatment Teams (CRHTs) which were established within Bedfordshire from December 2004, as published with Edition 2(2), we have included three personal accounts of the Luton CRHT, some 18-months on. We are delighted to be able to include such service-user and carer perspectives and would actively encourage similar such contributions for future editions of the journal.

Recovery and Social Inclusion are now fundamental principles for Trust services, as highlighted by Brenda Queeley in her summary of some of the highlights from the recent Trust Conference: *Overcoming Adversity – people can think for themselves.* Held over two days in April 2006 and attended by over 200 people, of whom over 50% were service-users, this event included local and nationally-renowned speakers. Especially for those of you who missed this event, take a look at Brenda's summary and find out all about WRAPs *and more.* Brenda is now looking for support in planning the 2007 conference: '*Make it Mainstream!*'. If you'd like to get involved, then you can find Brenda's contact details at the end of her article.

Dr Seshadri, with the help of several of his medical colleagues, reports on a brief audit of referral information to Community Mental Health Teams, in which he used a structured proforma to record information about alcohol and drug use upon referral. His work highlights the need to implement recommendations from the Royal College of Physicians.

Jill Gale provides a timely update on protecting children, her specialist area of practice, highlighting issues on the impact of parental mental illness, needs and risk, when to consider making a referral, and where to access guidelines to aid decision-making. As Jill says, look out for the laminated information sheet of the local referral process relating to safeguarding children.

This issue is completed with Dorothy Oakley's summary of findings from the recent local service-user satisfaction survey of acute mental health units / wards. As reported, there is evidence of increased satisfaction with local acute in-patient services, but more importantly this concurrent survey continues to draw attention to areas for further action and improvement.

With such variety, we hope that you will find something of interest to your own practice and development, and that sharing this work will encourage your own plans and, even, lead to your own journal submissions.

Finally, on behalf of the journal editorial group, I would like to thank Mandy Quarmby, as an outgoing editorial group member, for her support and assistance with our first issues of the journal, and wish her well in her career. I am also pleased to announce that Terri Dorman has joined the editorial group, as a representative for Services for People with a Learning Disability.

Child & Adolescent Mental Health – a most enlightening experience

Dr Tarun Goel

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PERSONAL REFLECTION

2:00am: I woke up in a sweat.

I had seen my daughter as a child with behaviour problems.

Fatherhood was supposed to be a pleasant experience till I became a father. She would cry, shout, not eat, not understand & not listen. I would argue with my wife at home and sleep in Community Mental Health Team meetings at work. The dream was real for me. Similar concerns had haunted me till I joined the child & adolescent mental health service (CAMHS).

CAMHS offers so much to learn that I was becoming smarter by the day. Children's issues are dealt with by paediatricians and psychiatrists with the involvement of an array of services and professionals, such as psychologists / psychotherapists who practice psychoanalysis, CBT and family therapy, and art / play therapists and counsellors. Then come the teachers, social services, education services, and the children within the 'looked after' team, and many others.

I wondered why so many services? Why so much uproar? Why so much head butting? After all, they are just children. Gradually it dawned on me that things are not as simple as they seem. Children can have obvious difficulties with learning, social skills and behaviour, but then there are the not so obvious causes of these difficulties, like autism, dyslexia, attention deficit hyper-activity disorders, family dynamics, social issues, and physical, emotional and sexual abuse that leaves these tender hearts with difficult scars that take a great deal of care and expert attention to heal.

The Child and Adolescent Team would spend hours discussing a child. It was fascinating to see different ways the team members would formulate the problem and offer possible solutions. It appeared to be a giant puzzle which everyone was trying to help put together with no definite answer. There were emotionally disturbing moments when I would be worried about the well being of a child. I would listen to the unforgivable behaviour of adults and the horrendous circumstances that the children were living in. They

would be blamed for no fault of their own. This was a new situation for me as I had learnt to keep my professional emotional boundaries in the past.

I would look at the scenario from three angles: the parent who would justify his behaviour in terms of striking a balance between family, work and personal life; the psychiatrist who has to limit himself to the help available, depending on resources; and, often most difficult, thinking as a human which does not allow any excuses for denying help to these children. I learnt that the child is rarely at fault. They are like mirrors: it is the way that so called 'grown ups' behave which reflects in the behaviour of children.

The Team were amazingly helpful. They support each other with work that can be emotionally draining. I was listened to patiently, like a naive teenager, and guided appropriately. Under one roof, I was exposed to family therapy, psychodynamic psychotherapy, art therapy & CBT. I also had the opportunity to visit in-patient units in Cambridge and Oxford.

Most difficult was the moment when I was asked to conduct an initial assessment of a 15 year old. I worried about his 'dialect', his values and the possibility of him seeing me as somewhat foolish. Although I was very anxious, I soon started enjoying the play. I would work at their level and quietly conduct my assessment. Once again, I was a kid. The experience brought back the memories of school, childhood and fantasy play. I learnt more about current comic characters, such as the 'fantastic four'. At Christmas, I even began to wish for a Nintendo or Sony PSP, just like all the children I was seeing.

In a nut-shell, this was a roller coaster ride. I understood my daughter much more during these 6-months than I did in three years. There were the usual bumps and falls but for those intending to follow, be wary of 'coffee addiction', as the team can be too courteous!

Staff Induction within Services for People with a Learning Disability

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SERVICE DEVELOPMENT

Introduction

Services for People who have a Learning Disability (SPLD) have developed induction processes at different levels, for all new staff.

These levels are:
Learning Disability Awards Framework (LDAF) Induction;
LDAF Foundation;
Service Induction Pack.

LDAF Induction Programme

The LDAF was first identified in the Government's White Paper, *'Valuing People – a new strategy for learning disability for the 21st Century'* (DH 2001). The Government recognised that the level of skills, training and qualification within the learning disability workforce needed to be raised. The LDAF was introduced, in April 2001, to provide a recognised route to qualification and career progression for care workers in learning disability services. The Government target was for all new entrants to learning disability care services to be registered for qualification on the LDAF. The Commission for Social Care Improvement (CSCI) target was for all new entrants to learning disability care services to be registered and to complete the LDAF Induction Programme within six weeks of commencing their employment. Initially, the SPLD did not meet this standard due to a large number of staff that needed to complete the programme.

The SPLD ran the first LDAF Induction Programme from May 2002 – this has been provided on a bi-monthly basis ever since. The induction programme was accredited in August 2003 with the Training and Accreditation Support Services (TASS UK) and our candidates were registered with City & Guilds. All candidates that had completed the programme prior to the course being accredited were offered the opportunity to complete the work necessary to achieve the LDAF Induction Certificate.

The induction programme runs over seven days and includes all mandatory training, including fire training, moving and handling, food hygiene, cardio-pulmonary resuscitation and any other topics that are deemed necessary for enabling staff to be safe practitioners in their work areas.

Since the induction programme has been running, 197 candidates have attended the course. Of these, 89 candidates are still employed by the service, having achieved the LDAF Induction and been awarded with their certificate from City & Guilds.

LDAF Foundation

The LDAF Foundation Programme was accredited with TASS UK in December 2005. All staff that have completed and achieved the LDAF Induction are eligible to complete the LDAF Foundation Programme, which is offered over three days. The CSCI have set a standard for candidates to complete the LDAF Foundation Programme within six months of commencing employment. The SPLD have yet to meet this standard.
The first LDAF Foundation Programme took place in February 2006.

LDAF Initial Award: a forthcoming development

In the summer of 2006, a new programme is to be offered by City & Guilds, which will combine the LDAF Induction and Foundation Programmes and will be known as the LDAF Initial Award. This course will be made mandatory for all new starters at support worker and senior support worker (in in-patient areas) level.

SPLD Service Induction Pack

In the first six months of 2005, staff representing all areas of SPLD formed a group to explore the process of induction across the service. The outcome was the production of a core Service Induction Pack. This pack is held centrally and updated as necessary. Managers request a copy prior to each new starter taking up their post and work through it with the member of staff. Each area has devised an additional induction pack, which is specific to their area of work. Each area has the responsibility of updating their specific pack.

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The Ten Essential Shared Capabilities: reflecting on the pilot of a learning and development initiative with a group of Adaptation Nurses

Chelvanayagam Menna
Trainer Facilitator in Mental Health
Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust

REFLECTIVE ACCOUNT

Ten Essential Shared Capabilities (Hope 2004: 4-5)

'The aim of the ESC is to set out the shared capabilities that all staff working in mental health services should achieve as best practice…
…the ESC should form part of the basic building blocks for all staff who work in mental health whether they are professionally qualified or not and whether they work in the NHS, the social care field or the private and voluntary sectors.'
'…The development of the ESC is a joint NIMHE and SCMH Project. It builds on the work of the SCMH CPF (Capable Practitioner Framework)…'
It is important that the ESC are adopted as a framework not only for the development of education curricula but also as a framework for Personal Development Planning (PDP), Training Needs Analysis…

Introduction

Bedfordshire & Luton Partnership Trust (BLPT) was selected to participate in a national learning and development pilot of the ten essential shared capabilities, in collaboration with the National Institute for Mental Health in England. Nominated as the Trust representative to participate in the Train the Trainer programme for this initiative, I found the learning material very useful. Considering my years of mental health nursing and training, this was the first time that I had experienced the unique situation of attending a residential course where I was sharing, exchanging and communicating information. Furthermore, ideas from a very mixed group of participants, which included service-users, health and social care professionals, proved very stimulating and thought provoking. Receiving training from a service-user on a day to day basis refreshed my thoughts, views and vision. The experience energised me to question and review my beliefs, values and practices in mental health and cascade them amongst other health and social care professionals: prioritising service-users and carers in every aspect of mental health practice was and is my first and foremost positive intention.

The aim of providing and undertaking training in the 'Ten Essential Shared Capabilities' was not only to train the trainer but to enable the trainer to be able to enthuse his future audience with the values and practices learned and experienced and to encourage them to train service-users and other health and social care professionals within the mental health field.

From the first three days of my residential training I had a better understanding of what was expected of me and discussed this with my Assistant Director. His aim was that all health and social care professionals and service-users become involved in this training initiative and he felt that, as a Clinical Trainer, I had the experience, energy and enthusiasm to work and co-ordinate this initiative with colleagues and service-users. There was a commitment from the Trust to enable and enhance people who would become future trainers.

Developing the local Pilot Initiative

The aims and objectives of the training initiative were circulated via personal e-mails to the BLPT address list and the learning & development department assisted by sending a flyer to all Trust departments.

I clearly communicated to all management teams the need to give a commitment to this initiative.

Pilot Phase: my short term plan was to:
- target a specific training group
- provide an intensive 16-hour training programme over 2½ days
- offer the programme to a group

of adaptation nurses (mental health), who were already following a programme of supervised practice and assessment designed for nurses trained outside of the UK and the European Union who want to become registered on the Nursing and Midwifery Council (NMC) professional register – my intention was to enhance their programme with the ten essential shared capabilities, as knowledge that would underpin and assist them to gain the requisite experience to help them become established within the local mental health care service
- provide individual assistance and support
- make available assistance and support for the initiative through telephone and e-mail contact at all times

My long term plan was to:
- provide training for identified service-users, carers and mental health professionals
- provide training packs, access to CD-ROM resources and enable access to internet-based resources which support the training initiative
- provide Trust intranet-based training materials for those without access to training packs
- make available assistance and support for the initiative through telephone and e-mail contact at all times

Rationale and Action Plan for the Training Initiative

The second residential training session

enabled me to have close and further discussions within the classroom setting, through group work and individual presentations. Informally, discussions continued during social periods with mental health colleagues, service-users and carers, which proved stimulating and enriching.

I considered my target audience for the training initiative, which I felt needed to be a wide circle of health and social care professionals, at all levels, and service users and carers, with representatives from the NHS, independent and voluntary sectors. As it was agreed that the target audience needed to be mixed, I invited a cross section of people from the above sectors to take part in the pilot. I also planned to include those whom I thought would cascade the training to others, although it transpired that this was not possible within the time-scale of the pilot and this therefore remains as part of the long-term plan.

Training packs were issued to prospective participants, with individual support, and there was a commitment from the service managers involved to enable their staff to participate.

I felt that in the short term it would be more productive to train individuals with enthusiasm for the purpose of this train the trainer course, who would enable the project to move forward and reach a wider audience. In the long term, and for the purpose of the pilot, the plan is to introduce e-learning, one to one support, group workshops and team presentations.

For the purpose of the Train the trainer programme, I had an agreement with the Human Resources Manager to carry out the seven modules of the Ten Essential Shared Capabilities over sixteen hours as 2½ days over three consecutive weeks, with participants spending the final half day on a different programme with another trainer, as a way of maximising the use of scheduled training time. The Human Resources Manager attended the final training session to assess my presentation and the individual participants' presentations. This feedback was both very positive and valuable, and it was highly recommended that the training be accessed by all mental health workers and newly qualified staff. This training pack and programme is now being considered for accreditation by the Nursing & Midwifery Council and by Universities in the UK.

For the purpose of this pilot initiative, I focused on the short term plan and prepared to offer the course over 2½ days. Progress evaluation was conducted via telephone and e-mail contact and through the completion of Trust training evaluation questionnaires, which were analysed by the Learning & Development Department.

Providing the Training Initiative

As outlined above, the programme was divided into three days, with a fourth reflective module component (focused on feedback) to be completed independently and returned within a one week period, which would allow participants to reflect by making reference to the seven modules in their pack. The module for each facilitated day followed a specific plan, which involved:

- ice-breaker
- introducing the pack
- emphasising application
- practical exercises (through individual & group work)

- reading
- accessing additional resources for more advanced study (CD ROM / Internet-based)
- relevance to personal development requirements
- focus on national priorities for mental health
- reflections and evaluations

Over the three facilitated training days, the modules of the Ten Essential Shared Capabilities, as supported by specific teaching materials (Faulkner & Basset 2002, Basset 2000) were covered as follows:

Day 1: Module 1 (Getting Started) & Module 2 (Ten Essential Shared Capabilities):
I particularly emphasised the personal development aspects of the programme, highlighting the need for and value of reflecting on learning, self evaluation, self assessment and achieving learning goals using the Ten Capabilities. I encouraged participants to prepare personal action plans using this programme and worked through the activity sheets in the package.

Day 2: Module 3 (Involving Service-Users and Carers), Module 4 (Values-based Practice) & Module 5 (Race Equality & Cultural Capability)

Day 3: Module 6 (Developing Socially-Inclusive Practice) & Module 7 (Personal Action-Planning & Learning Review)
Day 3 was completed with individual participant presentations on the Ten Capabilities and socially inclusive practices.
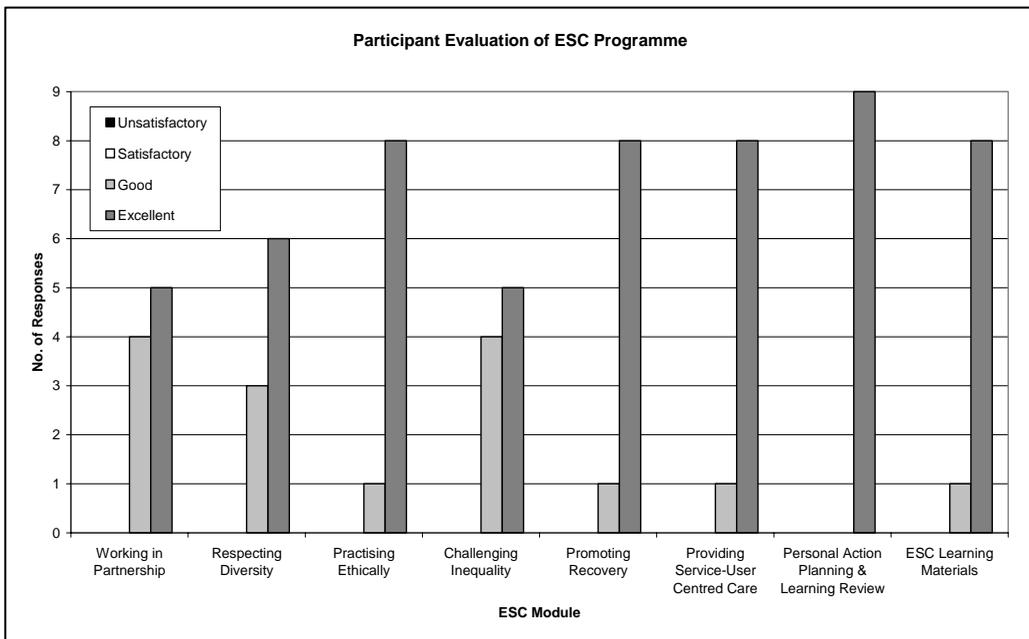
Evaluation

On a sessional basis, in accordance with the teaching plan (as outlined above), an opportunity to reflect upon and evaluate the teaching was offered, with an evaluation form being completed and returned to the Learning and Development Department.

Self assessment forms and goal scoring records were distributed during Day 3 (Module 7), for completion on an individual basis. A review of achievement, with reference to the self assessment forms and goal scoring records, was undertaken.

In addition, an evaluation of the individual's understanding of each module was conducted upon their completion of the module, which involved the following ratings: 1 = Unsatisfactory; 2 = Satisfactory; 3 = Good; 4 = Excellent. Participant ratings for the various modules are shown in Chart 1.

The average evaluation rating was 3.79 over the 7 modules, leading me to believe that the participants were very satisfied with the training received. This is reflected by the recommendation of the Human Resource Manager to continue and expand further applications of this training in other areas. Working closely with the participants was based upon the values and beliefs of the Ten Essential Shared Capabilities. Throughout most of the discussions where experiential learning was demonstrated and acknowledged by the participants, the inclusion of service-users and carers, and their wishes, was acknowledged and discussed.

Chart 1: Evaluation

Participant Evaluation of ESC Programme

Self Evaluation and Reflection

In discussing my plans for this training initiative with both the Assistant Director and the Human Resource Manager, I explained the values of the Ten Essential Shared Capabilities and their relevance to the adaptation nurses, who are from different cultures and nationalities and are just at the point of entry to the profession within the UK. The views expressed by the adaptation nurses led me to believe that there was a gap in their approach to the treatment and care of service-users who experience mental health problems. Their knowledge base of the available forms of treatment and care was, in some instances, antiquated, highlighting the importance of introducing the Ten Essential Shared Capabilities upon entry to nursing in the UK. Their enthusiasm for learning and development was

obvious and I felt justified in my choice of participants as an initial training group. Some participants were astonished with our modern approach to mental health care and treatment. The Ten Essential Shared Capabilities promote the beliefs and values of service-users, carers and mental health professionals and also the benefits that can be derived for these groups.

It is expected that the introduction of this programme will enable individuals who enter and engage in employment in the future, given the constraints of professional responsibility and accountability, to understand the beliefs and values of service-users, carers and other mental health professionals. It is also expected that the benefits to service users, carers and participants will be reflected in the findings of clinical / practice audit.

It is worth noting that participants became quite excited about the project as they progressed through the contents of the training pack, leading them to understand the underpinning knowledge and related skills required for the treatment and care of service-users and carers. The participants and trainer shared experiences, competencies and challenged the inequality of practices. I encouraged participants to pass on the knowledge gained and to consider becoming trainers, themselves, for their clinical areas. The participants formed a very cohesive and creative group.

One of the most important messages to emerge from this training programme was the enjoyment of sharing the ten capabilities, as they very much reflect the needs of the service-users, carers and mental health professionals. The seven modules explored each individual's views, expectations and professional practices. The residential training days proved to be very informative, exploring learning theories, teaching and learning methods. As a clinical trainer, the experience of being trained by a service-user was quite unique and the reflections of the trainer's experience proved highly valuable. Sensitive issues and feedback discussed by the trainer were both very helpful and enlightening. I gained very positive responses from sharing my experiences with the participants.

Conclusion

I explored the skills of working in partnership and its merits through the self-assessment of modules. Questions for clarification were asked by participants about whether the beliefs and values expressed through the ten capabilities were currently practised by mental health workers. I was unable to alleviate their concerns in respect of other mental health workers. However, this led me to feel positive that the project could ultimately cascade to all mental health workers over the coming years.

I have learned that it is important to respect individuals, respect diversity and to practice ethically. Respect for autonomy acknowledges the rights of individuals to make informed choices in relation to health care, mental health promotion and protection. Non-maleficence asserts an obligation not to inflict damage, either physical or psychological, and has often been associated with the maxim, to do no harm'. Beneficence, which is closely related to non-maleficence, refers to the obligation to benefit individuals and yet it may not be beneficial for everyone. Traditionally, priorities seem to be set solely on the basis of clinical need and are based on the premise that the 'doctor knows best'. However, this principle does not take account of other issues, nor provides any solution to problems relating to health care systems as a whole (NICE 2005).

A participative style of learning and development is vital for mental health professionals, particularly if involving service-users and carers and enabling an understanding of the wider issues of service users and carers. Promoting recovery, challenging equality, identifying people's needs and strengths, and providing service-user centred care in practice is more likely to be improved or achieved if all concerned in mental health understand the thinking and needs of service-users and carers. Promoting safety and risk taking offers opportunities to achieve autonomy, build trust and confidence with service-users

and the carers of those who are recovering. This approach will therefore promote ethical practice.

This innovative and creative type of training which involves service-users, carers and mental health professionals will make a difference to the modern way of delivering mental health services. I have learnt how to adjust myself to adapt according to the needs of all trainees and to be able to offer support sensitively. It is clearly important to establish ground rules that account for the varying needs of the trainees, whether service users, carers or mental health workers.

Clearly, I needed to be flexible about my training plan, which needed to be modified in light of discussions with my managers: focusing more upon achieving my short-term plan. This proved more realistic for the specified time limitations of the pilot initiative. The intervals between the three training days were very useful in allowing participants the time to confer and explore further the capabilities with service-users and colleagues. This also allowed me the opportunity for adjusting my style of presentation, for developing and strengthening good relationships with the participants, for sharing my experiences, their experiences and for reflecting serious issues related to mental health service-users and carers. It enabled me to consider my own practice, to challenge my own / others' views, to learn from others' experiences and elevated my confidence to withstand the pressures of being a trainer. Generally, I felt that the programme was successful, such that I will endeavour to involve a service-user / carer in my future training programmes. This will help me to demonstrate the importance of participation, involvement,

collaboration, an awareness of issues important to service-users / carers, and appreciate the obstacles and barriers encountered by service-users, carers and professionals, whilst achieving a balance of sensitivity for all concerned.

The knowledge gained from participating in this pilot initiative has given me the courage and confidence to look at training special audiences and to be able to stand-alone and co-facilitate training across the mental health field. The transference of skills, knowledge, experiences and their application in ways that are relevant to the needs of the trainees will hopefully reflect in their individual practices.

Empowering and valuing service-users and carers to look forward in promoting moral, ethical and humane values and beliefs will be a theme for future training programmes in mental health.

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Jackie Pool Assessment: a baseline audit within the Mental Health for Older People Service

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CLINICAL AUDIT

Introduction

'You don't stop doing things because you grow old. You grow old because you stop doing things'
(Dame Thora Hird 2002)

The National Service Framework refers to age discrimination, person centred care, prevention, rehabilitation and increased choice (DH 2001). Standard 8 emphasises the health and well-being of older people, highlighting the need to improve and aspire to enhanced services that promotes an improving quality of life for our older citizens.

Occupation promotes health for people of all ages. In fact, the art and science of occupation now underpins the theories of occupational science (Hurtly 2004), reinforcing the view of humans as occupational beings.

During recent years, services for older people within the Trust have been changing and evolving in accordance with national legislation towards person-centred practice. Occupational therapists can influence and support the necessity for the occupational involvement of service-users with other disciplines. Furthermore, the responsibility for occupational engagement does not need to remain exclusively with occupational therapy.

A recent development guide from the Department of Health reinforces the necessity for appropriate regular therapeutic activities for service-users in enhancing their recovery. For this, adequate staffing is a vital requirement (DH 2005).

Historically, there have been limited occupational therapy resources. There is currently only a small staffing establishment to meet the Trust's developing demands. Occupational therapists have therefore needed to be creative in exploring ways of bringing about a cultural change that involves care staff in being more proactive in the daily occupation of service-users.

Perrin (2004) challenges the 'old culture' that activities are not just the remit of occupational therapy but the remit of all disciplines in the care setting. Any care worker with good interpersonal skills should have the ability to engage a person in an activity. Care staff, irrespective of discipline, empower, negotiate and facilitate towards a therapeutic end. The sharing of personal resources thus leads to mutuality and a satisfactory conclusion.

This paper explains the theoretical background to the occupational profile and outlines an important practice and audit initiative, from which a series of conclusions and actions have been developed.

The Pool Activity Level Instrument

The Pool Activity Level (PAL) Instrument was first published in 1999 and is intended as a practical resource for carers of people with cognitive impairments (Pool 2002). It is designed to enable carers at home and in formal care settings to use the PAL Instrument to engage people with cognitive impairment in meaningful occupation. Although it was originally designed for people with dementia, it is now being used to form occupational profiles for people who have had strokes and those with learning disabilities.

The PAL Instrument includes:
- a *Life History Profile*
- a *Checklist* that describes the way that an individual engages in occupations
- an *Activity Profile* with general information for engaging the person in a range of meaningful occupations
- an *Individual Action Plan* that includes directions for facilitating

the engagement of the person in activities of daily living
- an *Outcome* sheet

The PAL Instrument draws from several models of understanding human behaviour: the Lifespan Approach to human development (Erickson); the Dialectical Model of a person-centred approach to the interplay of social, neurological and psychological factors (Kitwood); and, the Cognitive Disability Model (Allen). The instrument combines the information from Allen's Cognitive Disability Model with Vygotsky's insights into the importance of providing appropriate assistance and support to the individual while s/he engages in the activity. It also combines the Cognitive Disability Model with the Socio-Psychological Model by focusing the user on the biography of the individual and using this information as a guide to facilitating activities that are meaningful to him/her. It is presented in a form that is accessible to those without an occupational therapy qualification and provides the user with a self-interpreting assessment in the form of guides for creating and maintaining environments.

The assessment entails a close study of the person's activity in order to gauge an accurate picture of their personal schedules, routines, behaviours and preferences. By completing these, practitioners and carers are able to accurately determine the person's capacity and hence able to assign activities that are more suited to their capabilities – for example, assessments may reveal that the person has a greater ability than previously detected. This can help staff to more effectively and appropriately identify the person's occupational needs and plan their future care.

Aim

To evaluate the effectiveness of using the Jackie Pool Assessment Tool.

Objectives

- To ensure that all staff are confident in using the tool.
- To improve the use of the tool across all staff groups.
- To identify staff training needs.
- To assess staff views on the effectiveness and appropriateness of the tool within the day hospital and in-patient settings.

Methodology

The tool was originally implemented during a pilot phase with service-users of Sheridan Day Hospital and Farley Hill Day Hospital, and was then extended to service-users of Fountains Court. One of the carers at Fountains Court was very interested in the Jackie Pool Assessment Tool and subsequently attended the staff training programme and joined the audit group, which provided a valuable carer perspective.

The audit group felt that it would be interesting to monitor how the instrument would develop in the in-patient setting of Fountains Court, as residential care would enable a process of continual and consistent assessment that is not always viable with those who attend a day hospital.

Although staff felt competent at completing checklists, there were some concerns regarding the complexity of the checklist for carers who may have had to complete these on their own at home. It was therefore agreed that the Clinical Audit Department (CAD) would produce a simplified version. These were then sent to teams for distribution. The CAD

also began work on constructing a draft questionnaire for surveying staff opinions and attitudes on their impressions of the tool and for gaining feedback regarding it's implementation. CAD members visited Fountains Court to conduct individual interview sessions with staff who had participated in Jackie Pool assessments, using the approved questionnaire.

Progress was slow within the day hospitals due to staff shortages, staff changes and pending service closures. This affected staff enthusiasm towards this project and reduced the number and completeness of assessments. Although the same questionnaire format was used to collect the opinions of day hospital staff, sections of the questionnaire were not applicable as staff had not always completed full assessments.

Some carers were also approached at the day hospitals as staff had frequently reported on the positive comments received from them, particularly around the completion of life histories. Life histories are assessments which focus on retrieving information about the service-user's past – some teams had created elaborate folders for these with illustrations and photographs, so as to create a memento which service-users could retain for the future.

Findings

The main findings of the evaluation survey are summarised in Table 1.

Of the members of staff who had been surveyed, most had attended the internal Jackie Pool training. Most staff felt more confident at completing the assessment checklists than at retrieving personal histories. Of those staff who attended the training, some felt the

Table 1: Summary of Findings

No	Criteria	Fountains Court N=5	Sheridan Day Hospital N=3	Farley Hill Day Hospital N=4
1	Staff attending Jackie Pool training (Including trainers)	80%	66.6%	75%
2	Staff feeling very confident/confident in taking personal history from clients	50%	100%	50%
3	Staff feeling very confident/confident in completing checklists	100%	100%	100%
4	Staff feeling that there were areas of training which needed expanding	75%	0%	0%
5	Staff experiencing unexpected difficulties in implementing the tool, which were not addressed at the training	75%	66.6%	50%
6	Staff having the opportunity to have any queries answered by way of follow up training	100%	50%	50%
7	Staff finding the assessment a bit time consuming or difficult to fit in alongside their daily tasks	60%	100%	100%
8	Staff finding the completion of the 2 week assessment quicker and simpler as they became more experienced	80%	100%	100%
9	Staff stating that all/most of the checklists were relevant to their client group	60%	100%	50%
10	Staff stating that all/most of the checklist sections were pertinent to their client group	60%	100%	50%
11a	Staff who feel they have learned more about their client's personal history	100%	100%	100%
11b	Staff who feel they have learned more about their client's likes and dislikes	80%	100%	100%
11c	Staff who feel they have learned more about their client's abilities	60%	100%	100%
12	Staff feeling that they have learned something to focus or improve the care of a particular client	40%	100%	100%
13	Staff feeling that using Jackie Pool has enabled then to improve the care or focus attention on clients who have not yet been assessed	60%	100%	100%
14	Staff feeling that conversations with carers and relatives of assessed clients have improved since using Jackie Pool	40%	100%	100%
15a	Staff having cases where treatment changed subsequent to Jackie Pool assessments to improve care delivered	20%	100%	75%
15b	Staff having cases where treatment was unchanged subsequent to Jackie Pool assessments as assessment reinforced best care already in place	100%	100%	100%

No	Criteria	Fountains Court N=5	Sheridan Day Hospital N=3	Farley Hill Day Hospital N=4
16	Staff feeling that Jackie Pool is very beneficial/beneficial in comparison to previous assessment systems	40%	100%	N/A
17	Staff feeling that we should continue to use Jackie Pool	60%	100%	100%
18	Staff thinking that changes need to be made to the personal history section	40%	66.6%	50%
19	Staff thinking that changes need to made to the checklist sections	40%	0%	50%
20	Staff thinking that changes need to made to the checklist options	60%	0%	0%

session could have been more extensive and comprehensive.

Verbal feedback highlighted a need for an update or regular update sessions, particularly if this could include staff from other bases who were using the Jackie Pool tool. Some staff experiencing unforeseen difficulties, highlighting the need for a training update. Most staff felt that they had experienced some unexpected difficulties in implementing the tool, much of which related to uncovering aspects of the person's history that were distressing to them and the consequent difficulties of dealing with this. Other staff commented on the importance of 'bringing' service-users back to the present day by reminding them that they had just participated in an activity, a recalling/reminiscing exercise, to ensure that they do not remain within that historical time frame.

Although the majority of staff felt that assessments were time consuming and difficult to fit in with daily activities, they found that completion became easier as they became more experienced over the two-week period. However, there was mixed opinion with regard to the relevance and pertinence of checklist sections and checklist options for particular client groups. Day hospital staff commented on the irrelevance of the 'Bathing and Washing' / 'Getting Dressed' sections, as these activities take place before service-users arrive at the day hospital.

The majority of staff felt that by completing Jackie Pool assessments they acquired more information regarding their service-user's personal history, preferences and abilities. Some staff felt that because the Jackie Pool tool is such a thorough assessment, it revealed more about the person that helped in finding activities more suited to their needs and preferences. However, staff at Fountains Court felt that they already had a good understanding of their service-users and that the tool was just a more formal way of recording this information. This may be an effect of residential care, in having much more contact time to develop insights into their service-users. The treatment for Fountains Court in-patients was therefore largely unaltered as best care systems were already in place. Staff reported that discussions with carers and relatives, subsequent to the completion of assessments, were improved.

There was some variation in staff opinion regarding the advantages of PAL in comparison to previous systems, with some staff claiming that it was very beneficial, whilst others claimed that it was not very beneficial or that there was no change. Interestingly, some staff stated that there were no previous systems with which PAL could be compared.

The majority of staff stated that they would like to continue using the Jackie Pool assessment, with the remaining staff agreeing to use the tool if it was amended to increase it's appropriateness for the client group. Most staff thought that the 'Personal History' section was adequate and that it covered most areas well. Some members of staff did point out that previous likes and dislikes may not be reflective of the person's current likes and dislikes and so some of the information collected may not be as relevant. Verbal feedback suggested that staff found the 'Life Histories' section particularly worthwhile, with service-users and carers finding them enjoyable and rewarding to complete. Reminiscing was pleasant for both carers and service-users and presented an opportunity for staff to learn about them. By following the question format for the life history section, staff triggered undesirable memories, on occasions, which caused some upset to the person. It is therefore important that staff are prepared and able to manage these situations when they arise.

Some staff felt that the statements in the checklist sections could be altered as they were too broad and too general, whilst some felt that it was difficult to allocate service-users to one category as their skills fell either into or between two categories or fluctuated between two categories at different times.

Comments were made regarding the lack of time to pilot the assessment – some staff felt two weeks was not sufficient enough to complete a thorough assessment, particularly when it needs to be completed alongside all of their normal daily tasks and duties. Checklists need to be more refined and adapted in ensuring their suitability for older people.

Staff also felt that Jackie Pool wasn't just a tool for Occupational Therapy, that all staff can use this tool – thus a need to involve others and develop enthusiasm about the use of the tool.

Some staff commented on the variation in ability and mental state of the service-user within MHOP, as behaviour can vary quite significantly over the course of even a day and the recording of these fluctuations may therefore give an inaccurate picture of the person.

Carers were very positive about the use of PAL. Carers had generally only participated in completing the 'Personal Histories' section, but found these as being enjoyable, both for them and their relative/friend. They also felt that this was something that they could continue and further develop at home. Carers also commented on how creative and supportive staff had been in compiling personal histories.

It must be noted that the sample size for this audit was relatively small, owing somewhat to the problems encountered by day hospitals. This impacts on the extent to which the findings of this audit can be generalised.

Conclusions

Staff attending training feel more confident in completing Jackie Pool

assessments but feel that the training needs some expansion and that follow-up sessions may be useful, particularly if this includes staff from other bases for sharing experiences and exchanging learning. However, staff did feel able to approach the project lead / other members of staff if they experienced problems or had queries.

Staff felt that completing the assessment alongside daily staff was somewhat of an issue, but less so as time progressed.

Day hospital staff were much more positive about their learning from the Jackie Pool assessments, mainly because they could use it as a method of gaining a better understanding of their service-users. In-patient staff at Fountains Court already have this understanding due to the amount of time they spend with their service-users, which may account for why they found the tool less useful than day hospital staff.

Treatment and care on the whole was not altered as service-users were already being given the best care possible. Staff therefore expressed varying viewpoints and opinions of the Jackie Pool tool, although most agreed to continue using the tool, with some believing that it would be more useful if it was amended to suit the client group.

Developing personal histories is a clearly useful strategy as this captures the person's history and is stimulating and pleasant for families and carers to partake in, although it is important to be aware that this may not always be reflective of the person's current preferences and may uncover some sensitive or emotional issues.

Most staff felt that Jackie Pool is a useful tool for staff of all disciplines and that by creating more awareness and providing more training other staff will also become interested.

There are some concerns regarding the accuracy of the interpretation of assessments, as these may be misleading for new staff due to variation in the service-user's mental state over time. Some staff also added that for those without family or friends, there is no way of verifying the details that the service-users give during life history sessions.

Recommendations

1. To commend staff on their great efforts in completing the pilot alongside the demands of their normal working day, particularly day hospital staff who also had the pressures of service closures and job insecurities to contend with.
2. For the project lead to discuss the audit findings at the MHOP Clinical Improvement Group (CIG) in deciding upon how to facilitate the implementation of PAL across MHOP, if deemed to be appropriate.
3. For the audit group to meet and discuss the format and required revisions to the tool in promoting suitability for the client group.
4. As Pool (2002) advocates PAL as being beneficial for people with learning disabilities, the CAD are to share the results of this audit with the Services for People who have a Learning Disability (SPLD) directorate.
5. To consider the possibility of providing additional PAL training sessions, to include staff from

various locations.
6. To produce a leaflet to inform staff of some of the unexpected difficulties that can arise when completing PAL assessments e.g. uncovering sensitive issues and how to deal with these, and the need to de-brief service-users at the end of life-history sessions.

Current Progress

- This paper was presented at the Trust's 'Celebrating Success' seminar in December 2005.
- The Jackie Pool life histories and checklist is being used within in-patient settings following Dementia Care Mapping activity. Training is being given to care staff.
- Life history and biographical work is being undertaken in the community by Occupational Therapy staff.

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Personal Experiences: *the Luton Crisis Resolution & Home Treatment Team*

by two service-users and a carer

PERSONAL REFLECTION

> **Editorial Comment:**
>
> In one of our previous issues (Vol. 2(2)), Maggie Hodgson provided a carer perspective of the local Crisis Resolution & Home Treatment Teams (CRHTs) which were established within Bedfordshire from December 2004. As a follow-up to Maggie's creative description of this service, we are delighted to be able to include three short personal accounts of the Luton CRHT, some 18-months on. In order to preserve confidentiality, pseudonyms have been used for our three contributors – two service-users and a carer. *(John Butler – Chair of Editorial Group)*

A Personal Experience: no. 1
by Diane – a service-user

'My second child was 3 months old when I suffered a post-natal psychosis that I feel was aggravated by a number of other issues going on in my life at the time. Everything happened very fast and in the space of a week, I went from one GP telling me I needed 'time-out' to having serious hallucinations and my brain almost exploding with complete fear! Having gone to the GP showing signs of great distress, the Crisis Team were called and I was introduced to them for the first time at the surgery.

'Scared as I was when I had my psychosis, I never once doubted the team that was looking after me. It is quite obvious why they are called the Crisis Team – they were there, whenever needed, virtually at our beck and call. Not just for me but my family too.

'Due to my state of mind, I was very wary as to who these people were as nothing seemed real to me and yet, I had an instinctive sense of trust in them. What meant more than anything else in the world was that I was able to be treated in my own, familiar, surroundings and even to this day, it scares me to think I may have been admitted to a unit that at the time, I feel, would have slowed down my recovery.

'I developed a medical condition as a result of the drugs I was taking and I think this meant that I was in touch with the Crisis Team for a relatively long period of time. Thank goodness they were there for me once I was admitted on to a medical ward, as I really feel that

the hospital had no understanding and were not geared up to treat somebody who also had a mental illness.

'When I was in Calnwood Court, I remember another patient complaining about the Crisis Team. Her issue was that you never got to see the same person twice. This was a little frustrating, as information wasn't always relayed between the team and communication did let them down at times. However, overall I feel privileged to have been cared for by such a vast number of people. The only other criticism I would have is that it wasn't always made clear what each person's role was and, at times, this confused me even more (perhaps a leaflet about their role, would have been sufficient). I wasn't exactly in a position to question, however, so I accepted these people for the job they were doing and I'm sure I was right to do so.

'There were times during my illness that I was absolutely on the edge and I didn't think I'd get through another hour, never mind another day. However, at every crucial point, it took one phone call to the Team and they were there for us all in a very short space of time. (My goodness, I'm getting emotional writing this – it's good therapy I guess!).

'Once I was on the road to recovery, it was great knowing that the Team were still there for me. I felt that as much as I trusted them, they also trusted me and that helped me build my strength up.

'I sincerely hope that I won't ever need to use the Crisis Team again (in the nicest possible way, guys!) but I would have every confidence in them if I did. They are a great bunch of people and that goes right through from the Doctors, the Care Workers, Nurses to the Admin

staff. The support I received was tremendous and I feel that Luton should be very proud of having such a resource for those in need.

'As a postscript and from a personal point of view, the only thing missing at this time is the chance to talk to others who have been in a similar situation and come out the other side. If this opportunity does exist, I would welcome contact.'

A Personal Experience: no. 2
by Jayne – a service-user

'I am writing regarding my treatment by the Luton Home Treatment / Crisis Resolution Team. I have nothing but praise for the work of the team who provided me with care on several occasions between' late '2004 and' early '2006. The treatment meant that I avoided admission to the acute psychiatric unit on various occasions. This was excellent as I have never felt that in-patient treatment helped me – in fact I often ended up feeling worse as a result.

'I valued the support and empathetic approach of the team-members and was very impressed that they had an understanding of both my depression and chronic fatigue syndrome (CFS). One of the team even took the time to borrow a book on the condition to find out more about CFS. I always found my appointments with the team's Consultant and Senior House Officer helpful and really felt they genuinely cared about my well-being. I was offered six sessions of cognitive behaviour therapy which alongside medication helped also.

'I cannot say that it was always easy to be treated at home instead of hospital

even though I wasn't keen on admission, however it provided me an opportunity to take responsibility for my own mental health.

'I also received treatment in the crisis beds unit in' early '2006 – this was an excellent alternative than having to go into' the acute in-patient unit. 'It provided me with a safe environment following a relapse in my chronic fatigue syndrome and a worsening of my anxiety and depression. I valued the respect, trust and understanding of all the staff at the unit and was there for four days.

'To me, the crisis team helps to empower you to get better; they aren't soft in their approach and have strong boundaries, which is sometimes tough. I realize the importance of this and have a great deal of respect for them. They have a dynamic way of working which isn't just involved in prescribing medication, which I feel is very forward thinking. I am pleased to report that I am recovering from my chronic fatigue syndrome, and my anxiety and depression, whilst still there, is becoming more manageable. The crisis team is an excellent service which I hope will continue in its work in keeping people at home rather than in hospital.'

A Personal Experience: no. 3
by Geraldine – a carer

'At Christmas my daughter had a psychotic episode, she was extremely ill, and was transferred to the Crisis Team. Every day two members of the team came out to see her two or three times a day. Also the consultant came a couple of times. Her medication was reviewed constantly until she became more stable. The team came out on Christmas Eve and also on Boxing Day. They were

going to come out on Christmas Day but we persuaded them that we would manage without them for one day. Even so they still telephoned us to check that everything was fine.

'As none of our family had ever dealt with mental health problems we were very upset and distressed by my daughter's behaviour. Nothing was too much trouble for the team and any questions we had were always answered. It was only with their help and care that my daughter was able to remain in her home. As a result of which, the road to recovery was made much less traumatic for her.

'My daughter still cannot remember what happened during that time and feels that she has lost two weeks of her life. As a mother I will never forget those two weeks for the whole of my life. I will also never forget the help and support we received from the Crisis Team, without them we would have had a much tougher time. Thank you.'

Overcoming Adversity – people can think for themselves: *a recent two-day Conference on Recovery and Social Inclusion* (April 2006)

Brenda Queeley
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Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust

CONFERENCE REPORT

Introduction

The philosophy of *Recovery* should be the focus for anyone involved in mental health services. As professionals, we should be teaching people skills that will empower service-users to take control of their lives. Wellness Recovery Action Planning (*or WRAP*) is one of many tools that can help people manage themselves.

Recovery is a very individual process. It is the belief that people can recover from mental ill health – this does not mean the absence of symptoms, but rather a process of being able to manage your symptoms and have control over all aspects of your life. The journey of recovery is not linear. It is a process of regaining one's life and the mindset that develops as a result. You become the person you are today because of the experiences and challenges that life has thrown at you. Some of us develop resilience and are able to manage ourselves, instinctively, especially through the difficult times. With the added burden of mental health problems such as psychosis or depression that process is ever more challenging.

The message I wanted the conference to give is that people who use our services are survivors – some have come through their own journey of recovery and therefore have something to teach us all about what services work and what services hinder recovery. The message for professionals is that we need to focus on partnership and equality: try and see the person as the expert in their care and value their mental health experience.

Conference 2006

The conference was held over two days and was attended by over 200 people, of whom over 50% were service-users. The feedback has been tremendous, with many people saying that it was the best Recovery Conference they had ever been to!

We had a range of speakers from a range of backgrounds, which included local and nationally-renowned speakers. Some even had dual roles as service-users and service providers! More than half of the speakers spoke openly about their mental health issues – a real evangelical event!

I wanted each speaker to be accessible and to be seen as individuals with their own unique outlook on life, and so I asked them to each choose a piece music that had a particular meaning to them. Music is a great leveller and people were pleasantly surprised about some of the choices made. I also wanted to show that the process of recovery can apply to anyone, so each speaker was asked to write a brief personal summary about the things they do to keep well – (*a brief WRAP*!)

Paul Mullin, Chief Executive of the Trust, opened the Conference. He, again, for the second year running, voiced his commitment to Recovery and Social Inclusion. He also shared some of his own mental health issues. Recovery is firmly on the agenda in the Trust – the concept or philosophy will be the thread that runs through everything we do to improve patient care.

Selected Conference Presentations & Workshops: *a short summary*

Our key-note speaker for Day 1, Piers Allott (National Fellow for Recovery, CSIP), explained the history, concept and philosophy of recovery, before co-facilitating a workshop with Karen Colligan (Assistant Fellow for Recovery) on Recovery training and Wellness Recovery Action Planning (*WRAP*). Demonstrating how each of the component parts of WRAP are inter-related, making WRAP a very dynamic system, participants had a go at writing their own WRAP. Mental Health Recovery and Wellness Recovery Action Planning (WRAP) initiatives are currently ongoing in every region of England.

The values and ethics of the practice of Mental Health Recovery and WRAP

educators were explored, emphasising: the need to honour all participants as unique, special individuals; valuing self-determination and giving choice; promoting equality; realising that there are 'no-limits' to a person's Recovery; the importance of instilling a sense of hope and validating personal experience; and creating an environment where people work together to increase their understanding and promote wellness. The goals of Mental Health Recovery and WRAP training clearly involves teaching people recovery and self-management strategies, promoting increased levels of wellness and hope for recovery, and shifting away from illness towards wellness to prevention and Recovery. The efficacy of this training was clearly highlighted with reference to comparative data from Vermont (1997-99) and Minnesota (2002-03), which found a significant increase in the preference for using natural supports and wellness tools and self management approaches.

Our key-note speaker for Day 2, Rachel Perkins (Director of Quality Assurance and User / Carer Experience, South West London and St. George's Mental Health NHS Trust) spoke about her experiences of using mental health services and some of the prejudices she has had to endure as a service user. She then hosted a workshop on challenging inequalities and prejudice in health care. In a mixed group of more than 30 people, users and carers raised the issue of ward rounds – most found them intimidating and would prefer to see the doctor and others working with them separately. There was a lively exchange of views about the purpose of the ward round and alternative ways of achieving its aims that would be preferable to those on the receiving end.

Although no conclusions were reached, all agreed that we must think about tailoring all that we do around the needs, wishes and convenience of those who use our services and their relatives / carers. This will become increasingly important for all providers as people have an increasing amount of choice between different services.

Clive Travis, who has used mental health services in Bedford for many years, spoke about his own Journey of Recovery and how he has overcome adversity. Clive talked about what helped him in terms of non-medical aids to recovery, including advance directives (or advance agreements / living wills). He explained that for many patients their treatment was so intolerable that they took their own lives. He went onto identify the improvements in mental health services, concluding by playing a song with a particular meaning for him: *Joy Division's 'She's Lost Control'.*

Robin Murray-Neill (Direct Payments Lead, CSIP) provided a presentation on recovery through direct payments. Direct payments mean that money is given directly to people to meet their assessed social care needs. Direct payments came about as a result of campaigning by disabled people for greater choice and control in their lives. Robin went on to host a well-received workshop that focused on how to put direct payments into practice. Direct payments were viewed as the way forward and it was felt that people should not be limited to services provided by mental health services. By 2025, it is expected that direct payments will be the norm, enabling people with disabilities to have full opportunities and choice as equal members of society.

Laurie Bryant (Service User Lead,

National Service Improvement Team, CSIP), spoke about his experiences of living with bipolar affective disorder, or mania, as he prefers to call it, his experience of using mental health services, and the support he received that enabled him to make informed choices about his care and work towards his goals and aspirations.

Local Trust speakers included Vivienne Gayfor (STR (Support Time & Recovery) Coordinator) and Simon Bound (STR worker), who spoke about their role in enabling people to live meaningful lives. Simon, designer of the 'Think Outside the BLPT Box' logo, spoke about how he has been able to use his own experience of mental health services to help others.

Conference 2007: *planning ahead*

The 2007 Recovery and Social Inclusion Conference will be entitled '*Make it Mainsteam!*' This will hopefully be a community focused event over a period of one week.

If anyone would like to offer their support in any way, please don't hesitate to contact Brenda on 01234-310253 or by e-mail: brenda.queeley@blpt.nhs.uk

Information on Alcohol and Substance Misuse: an audit of referrals to community mental health teams

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CLINICAL AUDIT

Introduction

Hazardous alcohol intake and related disorders are a major public health issue. According to the World Health Organisation's (WHO) collaborative project on psychological problems in general health, alcohol dependence or harmful use of alcohol (as defined in the 10th revision of the International Classification of Diseases (ICD-10)) is present in about 6% of primary care attenders, making it the third most common problem after major depression and generalised anxiety (Goldberg & Lecrubier 1995).

In 2000, the estimated prevalence of alcohol dependence in the United Kingdom was 11.9% among men and 2.9% among women (Singleton et al 2001). The public costs of heavy drinking in England and Wales are about £18,000m ($32,438m; €26,424m) (Leontaridi 2003). Some 300 advice and counselling services, 100 day programmes, and nearly 200 residential programmes meet the resulting demand for treatment (Alcohol Concern 2002).

The national treatment outcome study showed that 25% of those entering drug services had suicidal thoughts, 25% had been admitted to general medical wards, and 10% had been admitted to psychiatric wards (Gossop et al 1995). Other studies suggest that over 50% of drug dependent individuals in the community have mental health problems, and rates of mental health problems are significantly higher among those entering treatment services (Hall & Farrell 1997).

The management of alcohol and substance misuse is quite different from that of pure psychiatric illnesses. The intervention needs to be urgent in order to commence harm minimisation as soon as possible.

A Community Mental Health Team (CMHT) receives referrals from various sources, including GPs, the Accident & Emergency (A&E) department, other CMHTs, the police and probation services, medical and surgical specialities and other sources. These referrals are discussed in the multidisciplinary team meeting once a week. During the discussion, depending upon the clinical or social circumstances, a decision is made about: the urgency; and, the input required for assessment and future care – whether medical, psychological or social. This is based on the information available within the referral letter.

In view of this fact, it is important to receive relevant information upon referral regarding alcohol and substance misuse in order to commence the most appropriate intervention at the earliest stage. It was therefore decided to conduct an audit of the information received upon referral to the CMHT (see *Box 1* for the aim and objective of this audit).

BOX 1:

Aim: To conduct an audit of referrals to the CMHT, to establish the availability of information about alcohol and substance misuse.

Objective: to evaluate the adequacy of information about alcohol and substance misuse within the referral letters received by the CMHT; to propose appropriate remedial measures to improve the adequacy and appropriateness of referrals regarding the availability of information about alcohol and substance misuse.

Method

A structured proforma was developed as a brief audit tool for screening the referral letters received by the Luton South West CMHT during the period from 1st October 2005 to 31st December 2005. The data gathered was then analysed.

Findings

Of a total of 100 referrals received by the CMHT for the above period: 81 were from GPs; 10 were from the Luton and Dunstable Hospital A&E Psychiatric Liaison Service; 2 were from the medical and surgical specialities; and, 7 were from other sources.

Of those referred, 54% were females and 46% were males.

The majority of referrals were from the 25-34 year age group (31%), followed by the 35-44 year age group (22%) and then the 15-24 year age group (19%).

Alcohol Misuse
There was no mention of alcohol misuse in 78% of referrals. Of the remaining 22 referrals (22%), in which alcohol misuse was mentioned, 21 (95%) of them contained adequate information.

Only 16% of the GP referrals provided adequate information about alcohol misuse compared with 80% of the A&E liaison service referrals.

Substance Misuse
There was no mention of substance misuse in 83% of referrals. Of the remaining 17% of referrals, in which substance misuse was mentioned, only 10% of the GP referrals had provided adequate information about substance misuse compared with 60% of the A&E

liaison referrals. Of the other sources of referral, 43% had provided adequate substance misuse information.

The most common substance of misuse was found to be cannabis, as shown in the Chart 1.

As shown, it was specifically mentioned that referred service-users were not misusing any illicit drugs in eight cases (8%).

Conclusions

GPs were the main source of CMHT referrals. There was a higher proportion of service-users in the 15-44 year age group being referred to CMHTs (72%). Almost a third (31%) of referred service-users were in the 24-35 year group.

The majority of referrals did not provide any information about alcohol (78%) or substance/ illicit drug misuse (83%).

Recommendations

The Royal College of Physicians made a recommendation that every person seen in general practice or in hospital should be asked about their alcohol intake as a matter of routine, as well as being asked about smoking and medication, with their subsequent responses being recorded (Royal College of Physicians 1987). Unfortunately these simple procedures are overlooked in both medical and psychiatric practice.

This may be due to the time constraints at GP surgeries: the average consultation time provided by a GP per patient is seven minutes. Hence it may be difficult for GPs to take a detailed history of alcohol and substance use / misuse. In addition, the assessor may not be using a structured proforma that

Chart 1: Frequency of Reported Substances

Reported Misuse of Illicit Drugs
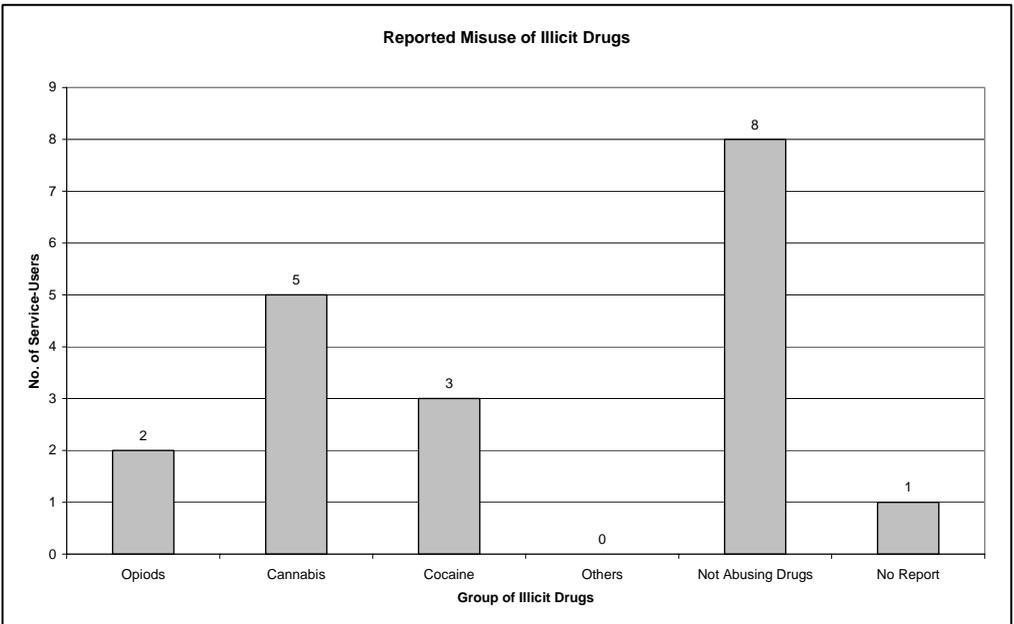
includes questions about alcohol and substance use / misuse.

To overcome some of these constraints, we recommend that when service-users are waiting to be seen by a clinician or professional, they should initially be asked to complete:

- The Alcohol Use Disorders Identification Test (AUDIT) (Babor et al 1989). Information regarding alcohol can be easily obtained by using a self-rating version of AUDIT. The WHO devised this 10-item questionnaire that has a distinct advantage in detecting both formal alcohol disorders and hazardous alcohol intake.
- A simple questionnaire containing two questions about illicit drugs. This would give the clinician a fairly good idea about the person's alcohol and/or substance use / misuse. Any subsequent referral of a service-user to a CMHT could then include this valuable and essential information.

Action Plan

The self-report version of AUDIT will be used by the CMHTs at the time of out-patient review. In addition, a simple questionnaire on drug misuse will be given to patients when they are waiting to see a clinician or professional. We plan to evaluate the usefulness of these questionnaires, following which we will forward an outcome report to referring GPs, doctors of Luton & Dunstable Hospital and A&E Psychiatric Liaison Services, so that they can hopefully apply these questionnaires as part of their future practice.

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Protecting Children is Everyone's Business

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CHILD PROTECTION

Introduction

For those of you who work in adult services, how much time do you give to consider the needs of the children involved in the lives of your clients or patients? How aware are you of the dependent children of the adults with whom you come into contact? Do you have concerns about some adults with mental health difficulties caring for children? Who do you think should be protecting these children? A report by the Royal College of Psychiatrists (CR120 2004) states that, 'Child abuse and neglect are now recognised as being everybody's business. Aspects of prevention, recognition, assessment and treatment of child maltreatment all fall within the various branches of psychiatry'.

Recent research provides statistics on the relationship between parental mental illness and child abuse. Mental health difficulties in a parent may have implications for the outcome of dependent children. 'A conservative estimate is that one-third of children living with a mentally ill parent will themselves develop significant psychological problems or disorders. A further third will develop less severe emotional and behavioural difficulties, which may nevertheless be significant for their long term development' (Crossing Bridges 1998). At least 25% of children who are the subject of a child protection conference have a parent with a mental health problem. When we also consider that 30% of adults with mental health problems have dependent children and almost 4% of all parents with dependent children will have mental health problems at any one time, then it is clear that we need ensure that we extend our focus beyond the client to their family situation.

There are also significant links between substance misuse, parental mental illness and child abuse or neglect. Evidence from research suggests that a child's basic needs may be neglected: parents can be emotionally unavailable and live a life style which is lacking in routine. 'In a series of 13 Part 8 case reviews carried out because of child deaths, 4 mentioned substance misuse as a major factor leading to the child's death' (Substance Misuse and Child Care 2000).

However, although the majority of parents with mental illness do not abuse their children, there is evidence that some parents are unable to meet their children's needs or need ongoing support to enable them to provide good enough parenting. 'Mental illness in a parent does not always have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family …the adverse effect on children of parental mental illness are less likely when parental problems are mild, last only a short time, are not associated with family disharmony, and do not result in the family breaking up. Children may also be protected when the other parent or family member can help respond to the child's needs. Children most at risk of significant harm are those who feature within parental delusions, and children who become targets for parental aggression of rejection, or who are neglected as a result of parental mental illness.' (DH, HO and DfEE 1999)

The Children Act 1989 places a duty on the legal system to give priority to the needs of the child. In the case of safeguarding children this overrides all other legislation. Section 27 of the Children Act 1989 states the need for co-operation between authorities and directs any Health Authority or Trust to comply with requests for information in relation to children known to them. The new Children Act 2004 reinforces this requirement for necessary communication relevant to a child and the expectation that Health Partnerships with be involved at all levels with local Safeguarding Children Boards to improve the well-being of children.

Child abuse and neglect can impact on a child's health and development, physically, emotionally, intellectually and socially. There is no overall definition of child abuse but research, experience and practice have informed guidance on how to recognise child abuse. There are four main categories of abuse identified by the Working Together document: physical abuse, emotional abuse, sexual abuse and neglect. The Children Act 1989 introduced the concept of 'significant harm' to provide a threshold to justify intervening in family life. Judging significant harm is not based on clear written guidelines but requires Children's Services to make an independent assessment in each case to consider the degree, duration, frequency and nature of the abuse and consequently the risk to the individual child. As adult workers you are not expected to be experts but you will need to have a grasp of the effect of parental mental illness on dependent children. It may be helpful to take a moment to consider some of your clients and how the symptoms of their mental distress could impact on others living with them. Bear in mind a child's vulnerability and that their needs are paramount.

Working Together to Safeguard Children 2006 outlines responsibilities for workers in Adult Mental Health Services when a child is identified as being at risk of significant harm. It identifies the need to share relevant information, which would include making a referral to children's services where you have concerns about a child's welfare. It may be necessary to provide information to social services about a child or family as part of a child protection investigation or be involved in the assessment process. As part of a plan for a child your service may need to specify the support or intervention that you are providing which should be recorded on the client's care plan. When a parent is discharged from

hospital or is given leave the impact on the child needs to be taken into account.

If you are concerned about a child's welfare you need to be clear how to proceed. The Common Law Duty of Confidentially permits the disclosure of relevant confidential information when it becomes necessary to safeguard a child. The Human Rights Act 1998 states in Article 8 that everyone has a right to privacy of home, family and correspondence. However, this right can be breached for the protection of the rights and freedom of others. Under Section 47 of the Children Act 1989, if someone believes that a child is at risk of suffering significant harm then their concerns must be referred to the local social services department. However, the threshold for significant harm is not always clear cut. In these circumstances professional judgement is needed to assess the possible outcome for the child if a referral is not made. If you are unsure, discuss the issues with your manager, a trust child protection practitioner or call the local children's services department for advice. When there is a risk to a child permission to refer does not have to be sought from the parent although the parent should be informed unless it would place a child at further risk.

A child may also be considered to be a 'child in need' under Section 17 of the Children Act. In these circumstances a referral might be made to social services because without extra support the child's development may be impaired. This could apply to parents with mental health difficulties when their illness impacts on the care of their children. In these circumstances a referral could be made, with the permission of the parent, to obtain extra support for the family.

One of the principles of the Children Act is to keep families together. Following a referral, a social worker will undertake a holistic assessment which will include the child's development, parenting capacity and environmental factors, in order to provide appropriate support where necessary to maintain the child in the family home. Your input would provide part of this assessment.

If you have any concerns about children there are guidelines to help you make decisions about how to proceed. By now you should have received an e-mail or laminated flyer for your team, explaining the referral process. Referral forms for Luton and Bedfordshire Social Services are available on the intranet in addition to all current polices and procedures in relation to safeguarding children.

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Satisfaction with Acute Mental Health Services: a local survey of service-users

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USER SATISFACTION

Introduction

A satisfaction survey was introduced within the Trust's five acute inpatient mental health units / wards in July 2004 after approval by the Working Age Mental Health Clinical Improvement Group (WAMH CIG). The survey was specifically developed to encourage service-users, at the point of discharge from an acute mental health unit / ward, to provide personal feedback about the service they received whilst an in-patient. Service-users were encouraged to take a questionnaire upon going home, and to return completed questionnaires to a central point: the clinical audit, and more recently the clinical governance, department. Survey questions were included to take account of all aspects of their care, from their admission to a unit / ward through to their discharge.

From April 2005, it was agreed to complete an audit report of all completed questionnaires on a six monthly basis: the first report was completed in October 2005 and a further report was recently completed in May 2006.

Following the first audit report, individual unit / ward reports were produced which identified local issues for action-planning. The audit group met to develop an action plan in December 2005. As a consequence, it was decided to change the format of the survey questionnaire, in ensuring a more user friendly style. Furthermore, it was agreed to break the original questionnaire into two parts, with part 1 to be distributed and completed 7 – 10 days after the service-user's admission, and part 2 to be distributed and completed within 2 – 3 days of their planned discharge (see Figs. 1 & 2). It was also decided that each unit / ward would produce their own action-plan aimed at quality improvement.

Aim

It was agreed to continue to conduct a concurrent survey to evaluate the satisfaction levels of service-users who have accessed the acute inpatient units / wards, with a view to improving patient care where indicated.

Figs. 1 & 2

part 1 survey

&

part 2 survey

Objectives

It was agreed to:

- ensure that service-users can feedback their views of their stay in an acute inpatient unit / ward;
- make changes to the service, where possible and where indicated, based upon the feedback of service-users, in order to improve their experience on the ward / unit;
- ensure that staff-members are aware of the necessity of encouraging service users to complete the survey questionnaires as an important and tested way of gaining service-user feedback;
- raise awareness among staff-members of service-user views of both good practice and areas that might be improved.

Methodology

As already highlighted, the audit group met in December 2005 to discuss how the questionnaire could be improved

and how service users could be encouraged to complete it. The group also discussed the areas of strength and weakness, as identified through the previous audit report, which led to specific action-planning.

Unit / Ward Managers agreed to introduce the revised two-part survey with all service-users: the part 1 survey to be given to all service-users within 7 – 10 days of admission; the part 2 survey to be given to all service-users within 3 days of planned discharge.

Findings

The response rate achieved for the most recent audit period (October 2005 – end March 2006) was significantly higher than for the previous audit periods. Data had not been received for a significant percentage of people eligible to complete the questionnaire during previous audit periods, suggesting that it is more effective to ask service-users to complete the part 1 questionnaire within 7 – 10 days and part two within three days of discharge. The new format of the questionnaire, which is considered

more user-friendly may have also encouraged greater numbers of service-users to complete them.

In summarising some of the key findings of the most recent two-part survey, as shown below, the % shown in *italics* relates to the comparative findings for the previous audit period (April – end Sept 2005):

- 180 questionnaires were returned from the five acute inpatient units / wards during the six-month period (Oct 2005 – end March 2006): 98 part 1 surveys and 82 part 2 surveys
- 90 (90%) *(78%)* services-users said that they were made to feel welcome upon admission
- 77 (79%) *(77%)* service-users said that the reasons for their admission was explained to them
- 77 (79%) *(68%)* service-users confirmed that they were shown around the facilities, with 78 (80%) *(76%)* feeling that the hospitality nurse was organised and efficient
- increasing numbers of service-users indicated that they had enough contact with key professionals: 67 (74%) *(73%)* for the Consultant Psychiatrist*;* 76 (82%) *(70%)* for the named-nurse; 54 (67%) *(58%)* for the Occupational Therapist; 30 (50%) *(31%)* for the Community Mental Health Nurse / CPN; 50 (74%) *(56%)* for the Drama / Art Therapist; 28 (42%) *(31%)* for the Social Worker; 60 (70%) *(73%)* for the Patient Benefit Officer
- 80 (86%) *(81%)* said that staff-members paid sufficient attention to their individual needs
- 48 (69%) *(74%)* said that staff

were sensitive to their cultural and religious requirements
- 66 (69%) *(59%)* service users reported always feeling safe in the unit
- 65 (81%) *(71%)* reported that the activities and therapies were helpful and 46 (53%) *(47%)* said that there were enough activities
- 62 (71%) *(61%)* said that they were offered the opportunity to participate in patients meetings
- 55 (56%) *(58%)* service-users said that the diet they required was always available, with 69 (70%) *(62%)* saying that the menu was usually of good quality
- 63 (64%) *(62%)* agreed that meal portion sizes were just right, with 70 (71%) *(71%)* saying that the food was always served at the appropriate temperature
- 60 (63%) *(56%)* service-users confirmed being told that information about their care could be shared within the team, with 54 (61%) *(46%)* being made aware of the various services available to them e.g. day centre or voluntary services
- 72 (87%) *(70%)* service-users felt involved in planning their discharge
- 59 (72%) *(34%)* knew which level of care they had received, with 37 (45%) *(39%)* confirming that they were given a copy of their care plan
- 50 (61%) *(44%)* said that their care plan was explained to them and 45 (55%) *(41%)* felt that their care plan reflected their individual needs
- only 34 (40%) *(46%)* service-users were asked if they were aware of the Advocacy Service,

with 17 (19%) *(25%)* confirming that they had used the Advocacy Service, 27 (38%) *(48%)* feeling that they had enough contact and 23 (38%) *(48%)* saying they were happy with the service they had received

A summary of selected key findings is shown within the appendix.

Conclusions

Although the survey response rate has increased, it is important to continue to encourage service-users to participate in the survey. In most areas where there are comparative results, it is encouraging to note that the satisfaction level has increased, and quite considerably in some areas. It is also noteworthy that the survey findings are more positive for some of the units / wards than for others, which highlights the importance and potential value of sharing strategies for practice and service improvement.

Recommendations

1. For the project lead to discuss the findings and report at the Directorate Clinical Improvement Group.
2. For the unit / ward specific audit report to be given to each respective staff team in order for each team to identify their own areas of concern and specific actions.
3. For Unit / Ward Managers to share the findings of the audit report with their staff team at planned team meetings.
4. For the audit group to meet to discuss the findings and to devise an action plan aimed at further improving the service-user experience of acute in-patient care.
5. For the project lead to distribute the findings and report to relevant Trust staff teams and groups.
6. To complete a further audit report in October 2006.

For a copy of the full audit report, please contact Dorothy Oakley: Dorothy.Oakley@blpt.nhs.uk

Appendix: summary of selected key findings

Chart 1: Bedfordshire Acute Care Survey for Oct 2005 - end Apr 2006
key findings

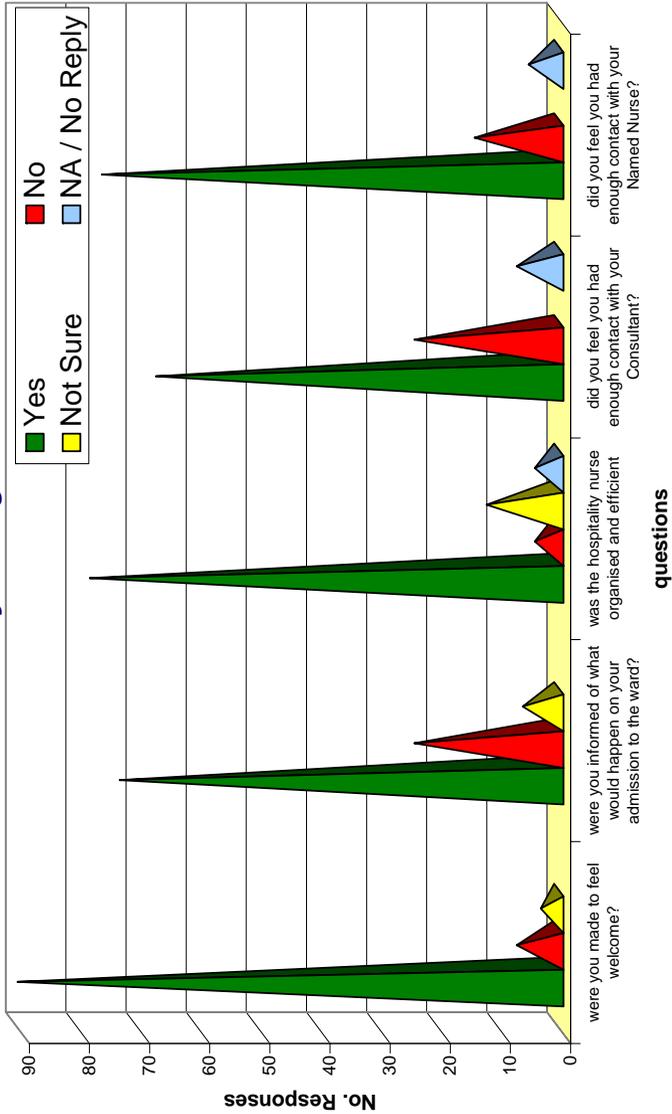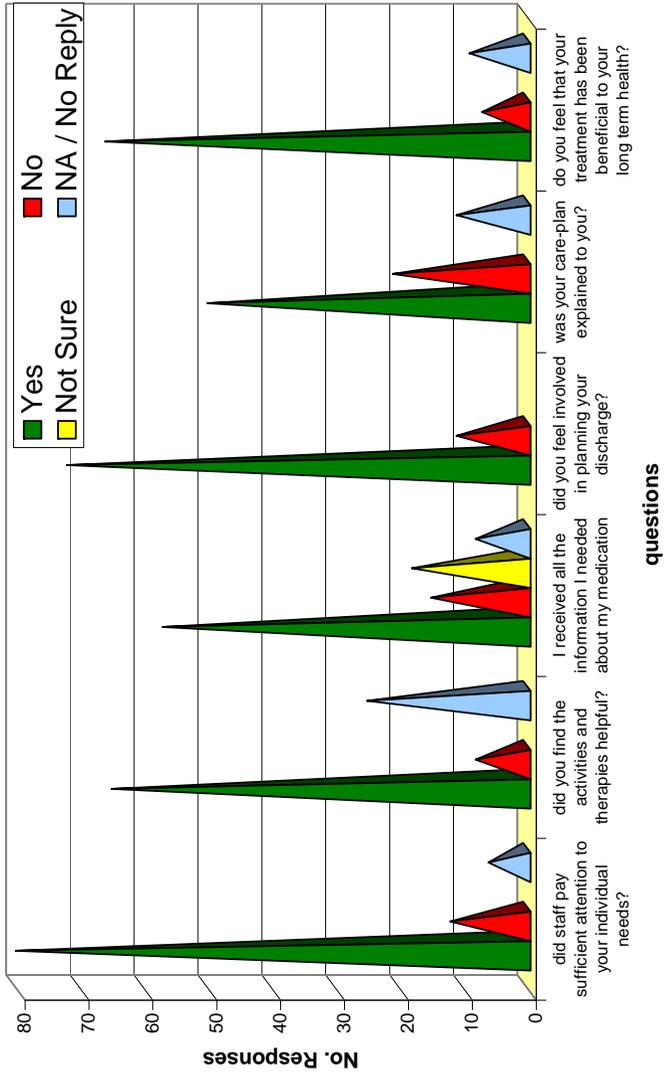Chart 2: Bedfordshire Acute Care Survey for Oct 2005 - end April 2006
key findings