Mental Health Conference

Positive outcomes, which enable recovery and resilience

26th April 2018

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make every day amazing

ExE Consultant Services

Experts by Experience

"Getting Better, Staying Better"

How the **7 Principles of Public Life** (aka the *Nolan Principles*) can support a framework for improved outcomes.

Presenter: Wayne Saville
Expert by Experience

The 7 principles of public life were first set out by Lord Nolan in 1995.

They apply to anyone who works as a public office-holder,
but the principles also apply to all those in other sectors that deliver public services.

(Source: leadinggovernance.com, 2013)

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They apply to anyone who works as a public office-holder,
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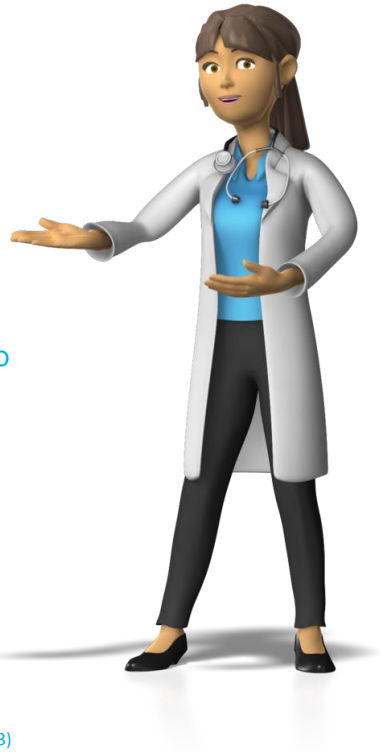
(Source: leadinggovernance.com, 2013)

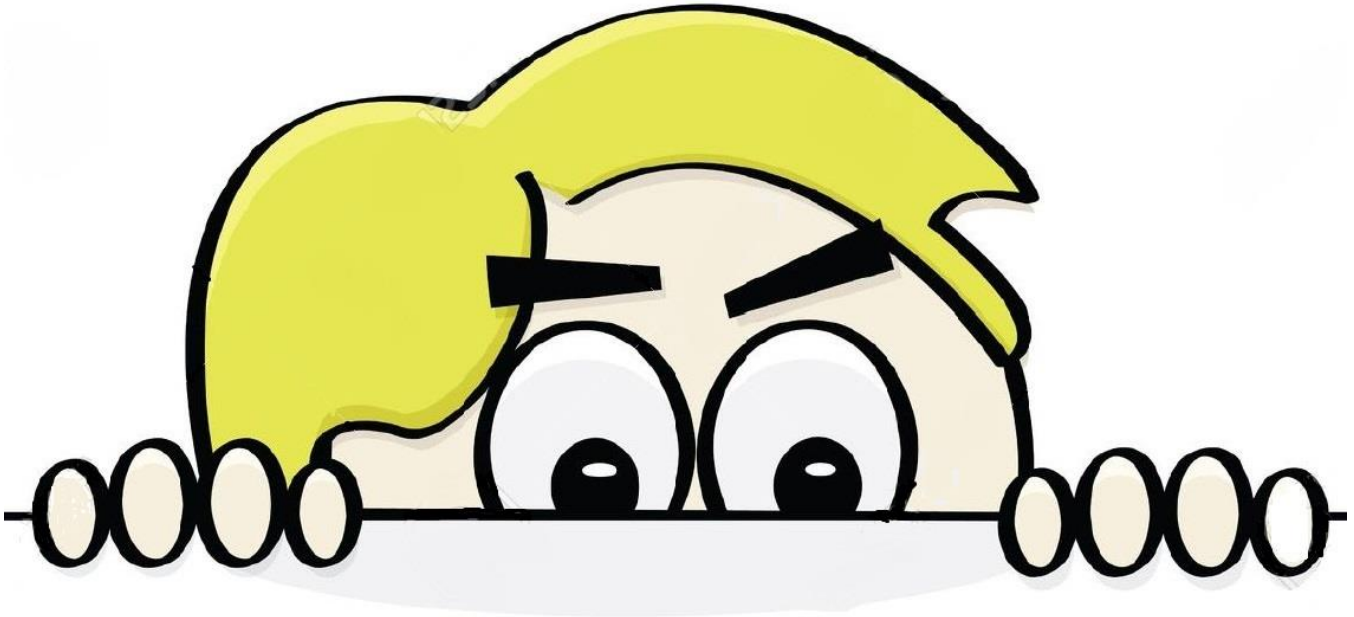
The Nolan Principles

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

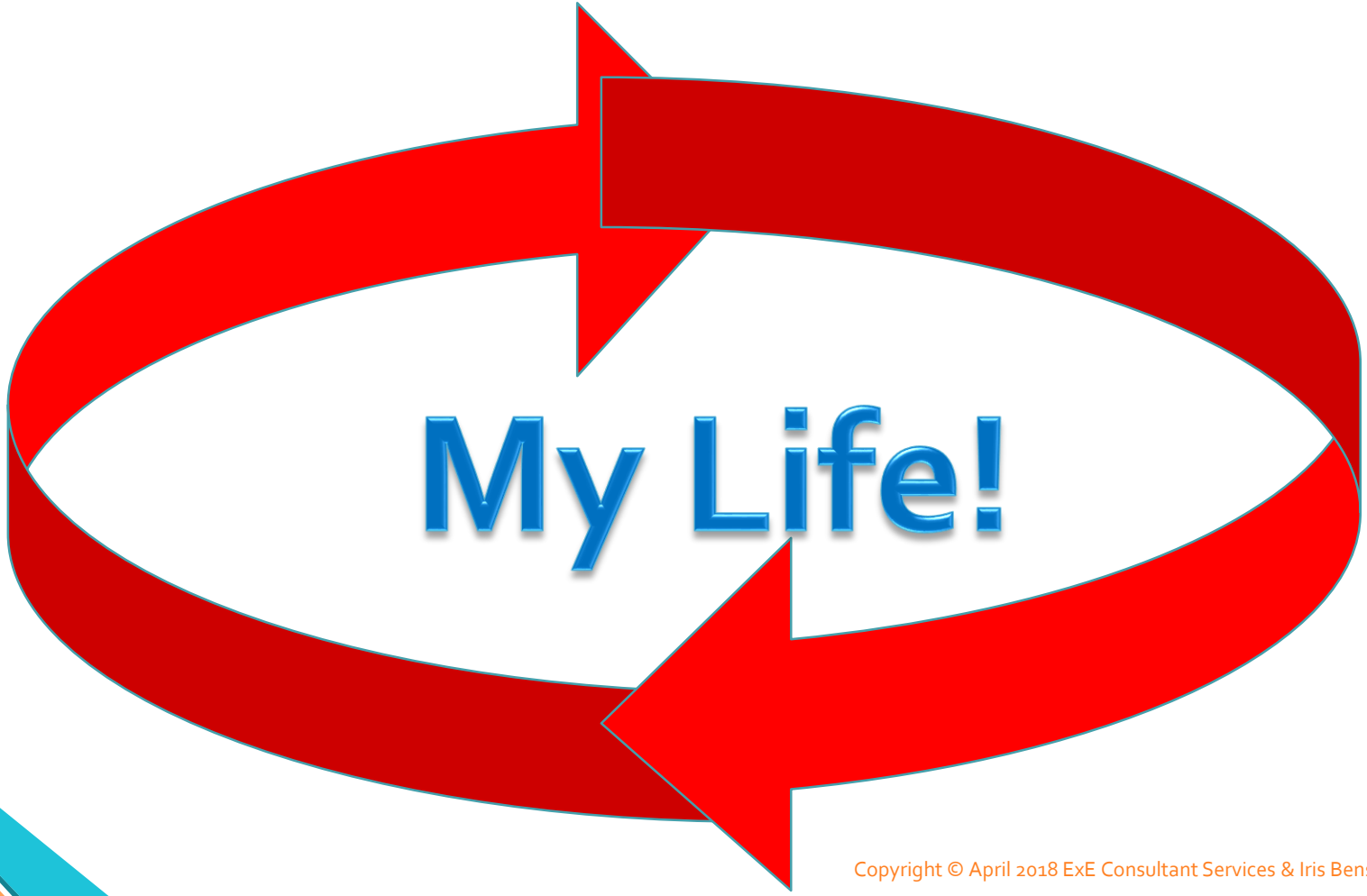


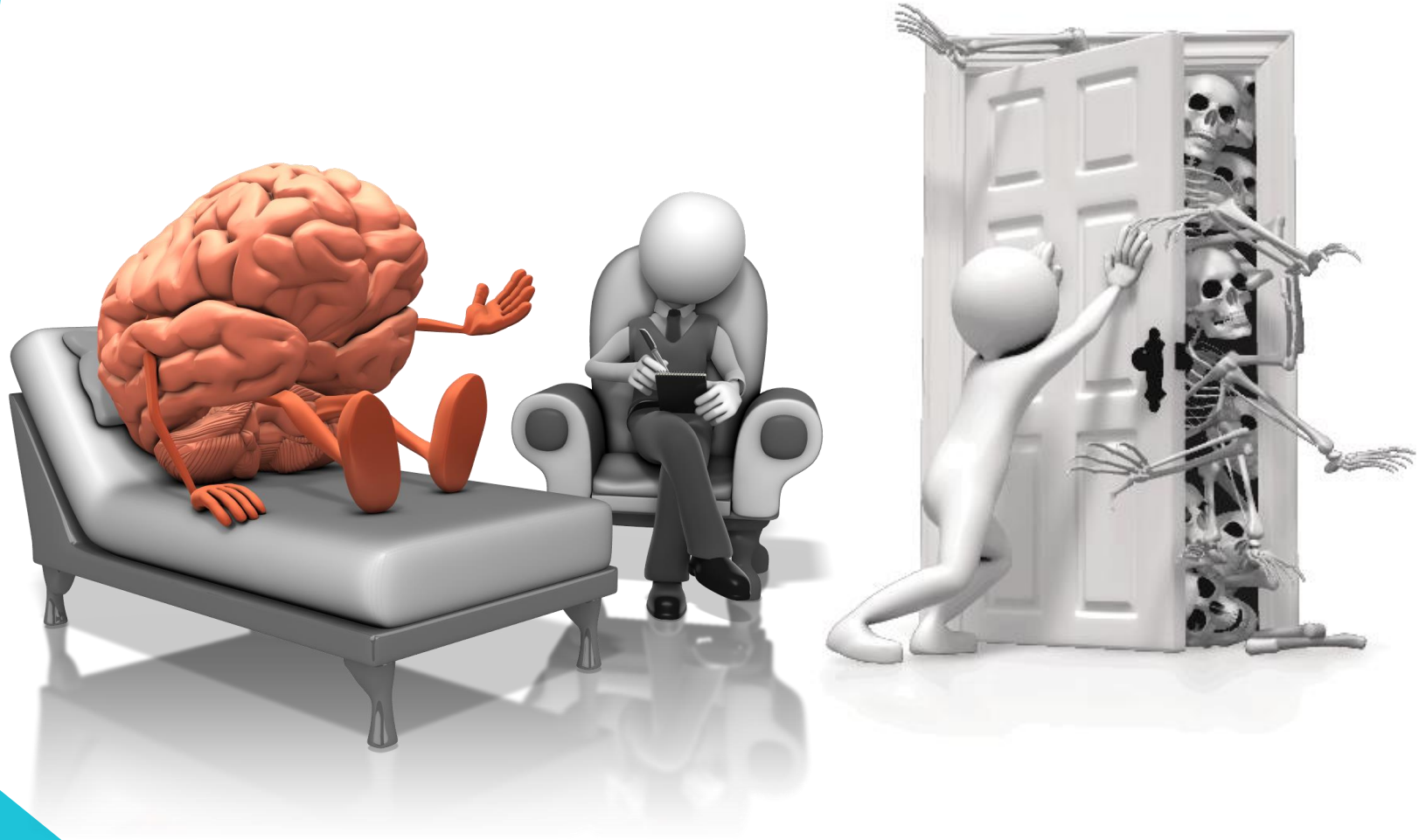
(Source: leadinggovernance.com, 2013)

How did we get here?



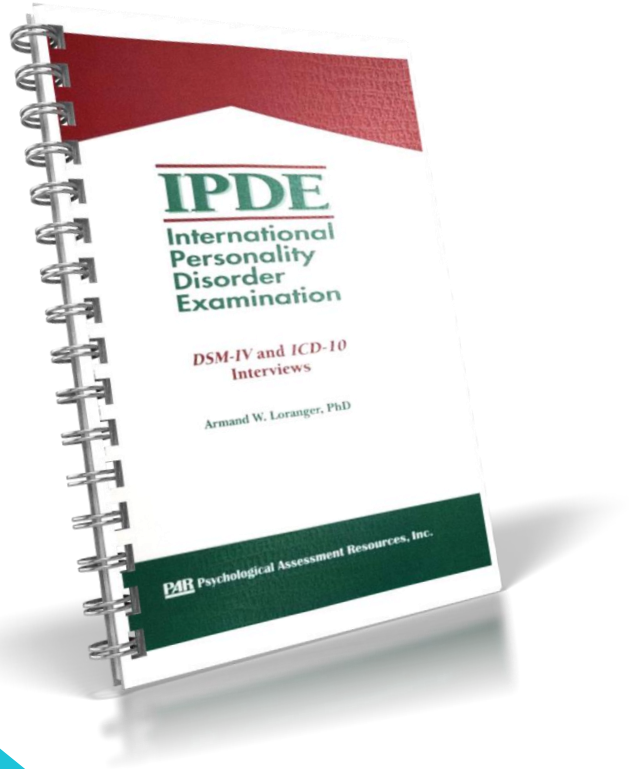
Empathy and Nurture…..what's that?

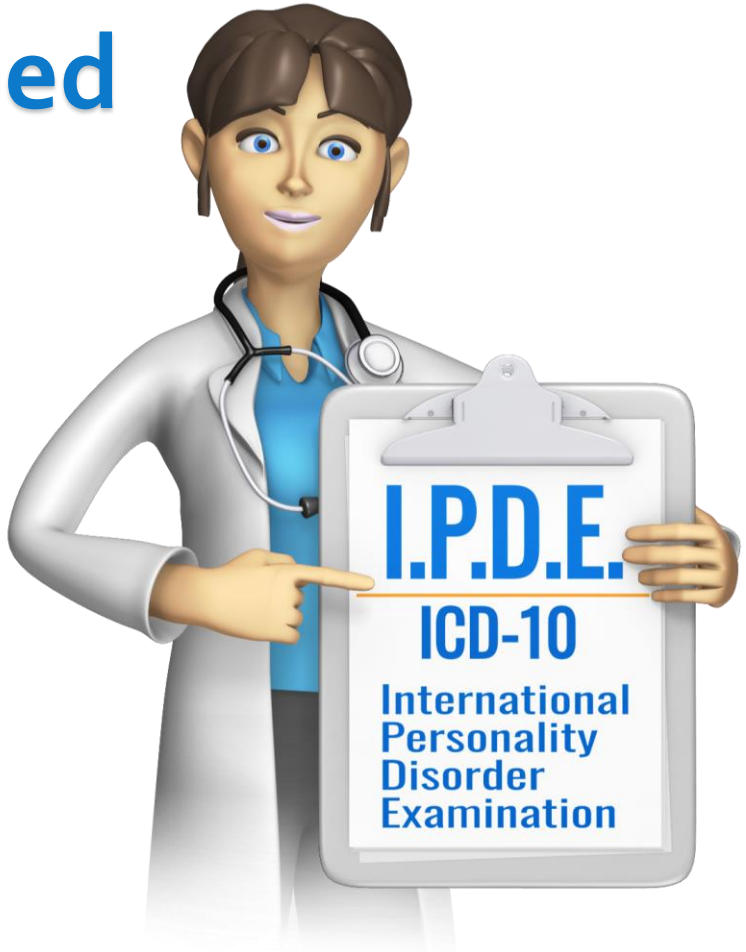


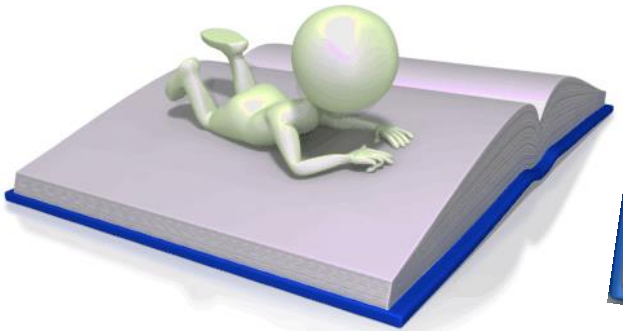


- Schizoid
- Paranoid
- Narcissistic
- Antisocial, or Dissocial
- Avoidant (aka Anxious/Avoidant)
- Borderline, or Emotionally Unstable
- Obsessive-Compulsive (aka Anankastic)

Diagnosis Explained





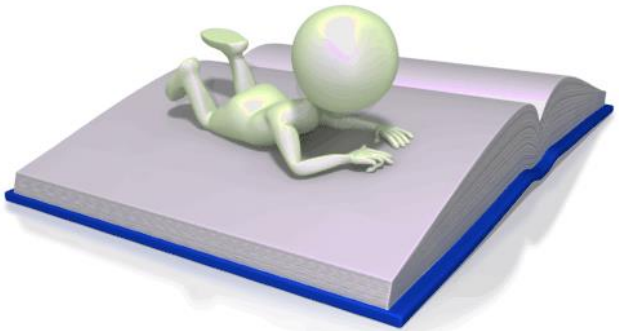


Wayne's diagnosis

- Antisocial Personality Disorder
- Schizoid Personality Disorder
- Paranoid Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Obsessive-Compulsive Personality Disorder

N.B.

This copy of the IPDE is for the service user to retain in his personal records.



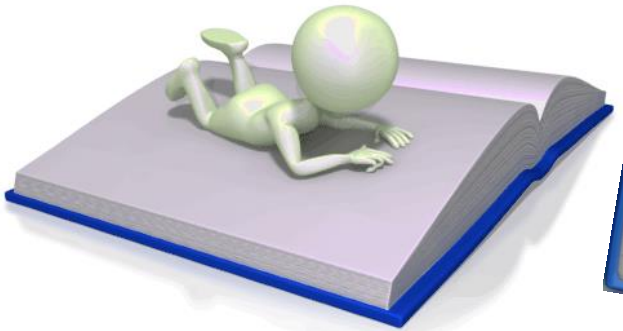
IPDE diagnosis

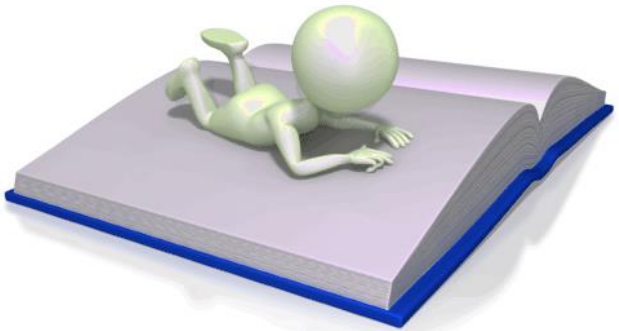
Antisocial Personality Disorder

Antisocial personality disorder (ASPD)
You will be at least 18 years old. You may:

put yourself in dangerous or risky situations, often without considering the consequences for yourself or for other people
behave dangerously and sometimes illegally
behave in ways that are unpleasant for others
feel very easily bored and act on impulse – you may find it difficult to hold down a job for long
behave aggressively and get into fights easily
do things – even though they may hurt people – to get what you want, putting your needs above theirs
have a criminal record
feel no sense of guilt if you have mistreated others
believe that only the strongest survive and that you must do whatever it takes to lead a successful life because if you don't grab opportunities, others will
have had a diagnosis of conduct disorder before the age of 15.
This diagnosis includes 'psychopathy'. This term is no longer used in the Mental Health Act but a 'psychopathy checklist' questionnaire may be used in your assessment.

Mind, August 2016





IPDE diagnosis

Paranoid Personality Disorder

Paranoid personality disorder (PPD)

You may:

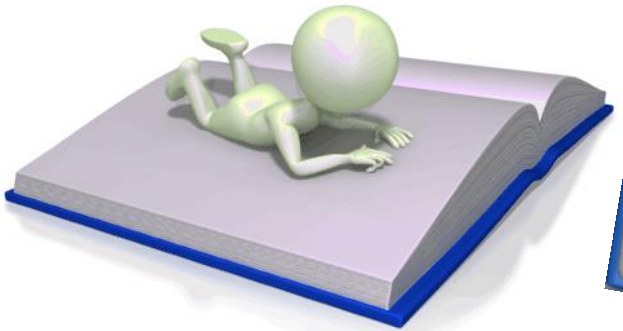
find it hard to confide in people, even your friends
find it very difficult to trust other people, believing they will use you or take advantage of you
watch others closely, looking for signs of betrayal or hostility
read threats and danger – which others don't see – into everyday situations.

Mind, August 2016

You may feel very suspicious of others but without a reason if you have been diagnosed with paranoid personality disorder. This can make you feel other people are lying to you or using you. This can make it difficult to trust others, even friends. You may find it difficult to forgive insults and will bear grudges.

Your doctor should rule out schizophrenia, psychosis, and mood disorders if you have been diagnosed with paranoid personality disorder.

Rethink



IPDE diagnosis

Narcissistic Personality Disorder

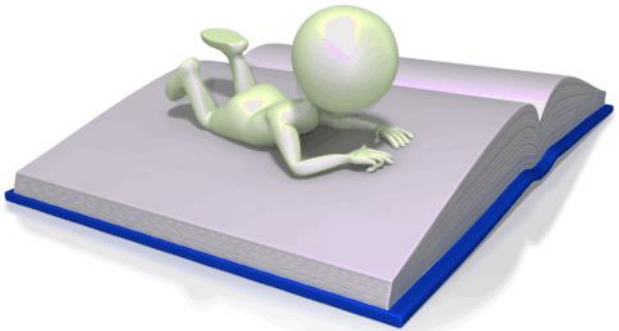
Narcissistic personality disorder (NPD)
You may:

believe that there are special reasons that make you different, better or more deserving than others
have fragile self-esteem, so that you rely on others to recognise your worth and your needs
feel upset if others ignore you and don't give you what you feel you deserve
resent other people's successes
put your own needs above other people's, and demand they do too
be seen as selfish and 'above yourself'
take advantage of other people.

Mind, August 2016

Narcissistic personality disorder can mean you have a high sense of self-importance. You may fantasise about unlimited success and want attention and admiration. You may feel you are more entitled to things than other people are. You might act selfishly to gain success. You may do this because inside, you don't feel significant or important.

Rethink



IPDE diagnosis

Avoidant Personality Disorder

Avoidant (or anxious) personality disorder

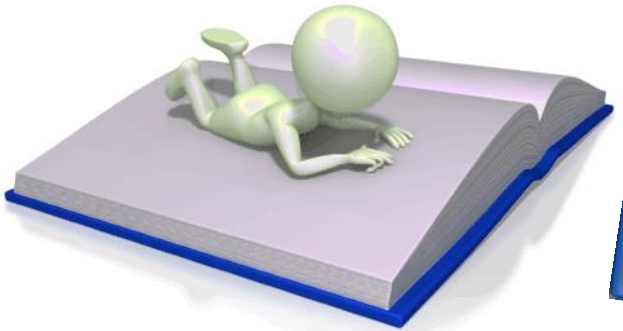
You may:

avoid work or social activities that mean you must be with others
expect disapproval and criticism and be very sensitive to it
worry constantly about being 'found out' and rejected
worry about being ridiculed or shamed by others
avoid relationships, friendships and intimacy because you fear rejection
feel lonely and isolated, and inferior to others
be reluctant to try new activities in case you embarrass yourself.

Mind, August 2016

If you have avoidant personality disorder, you may have a fear of being judged negatively. This can cause you to feel uncomfortable in social situations. You might not like criticism, worry a lot and have low self-esteem. You may want affection, but worry that you will be rejected.

Rethink



IPDE diagnosis

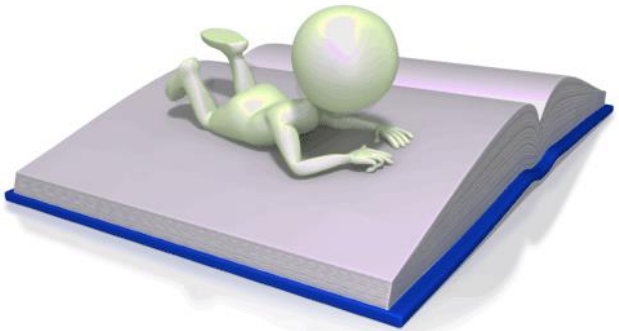
Borderline Personality Disorder

Borderline personality disorder (BPD)
You may:

feel very worried about people abandoning you, and would do anything to stop that happening
have very intense emotions that last from a few hours to a few days and can change quickly (for example, from feeling very happy and confident in the morning to feeling low and sad in the afternoon)
not have a strong sense of who you are, and it can change depending on who you're with
find it very hard to make and keep stable relationships
act impulsively and do things that could harm you (such as binge eating, using drugs or driving dangerously)
have suicidal thoughts or self-harming behaviour
feel empty and lonely a lot of the time
get very angry, and struggle to control your anger.

When very stressed, sometimes you might:
feel paranoid
have psychotic experiences, such as seeing or hearing things that other people don't
feel numb or 'checked out' and not remember things properly after they've happened.

Mind, August 2016



IPDE diagnosis

Obsessive-Compulsive Personality Disorder

Obsessive compulsive personality disorder (OCPD)

You may:

need to keep everything in order and under control
set unrealistically high standards for yourself and others
think yours is the best way of making things happen
worry when you or others might make mistakes
expect catastrophes if things aren't perfect
be reluctant to spend money on yourself or others
have a tendency to hang onto items with no obvious value.

OCPD is separate from obsessive compulsive disorder (OCD), which describes a form of behaviour rather than a type of personality.

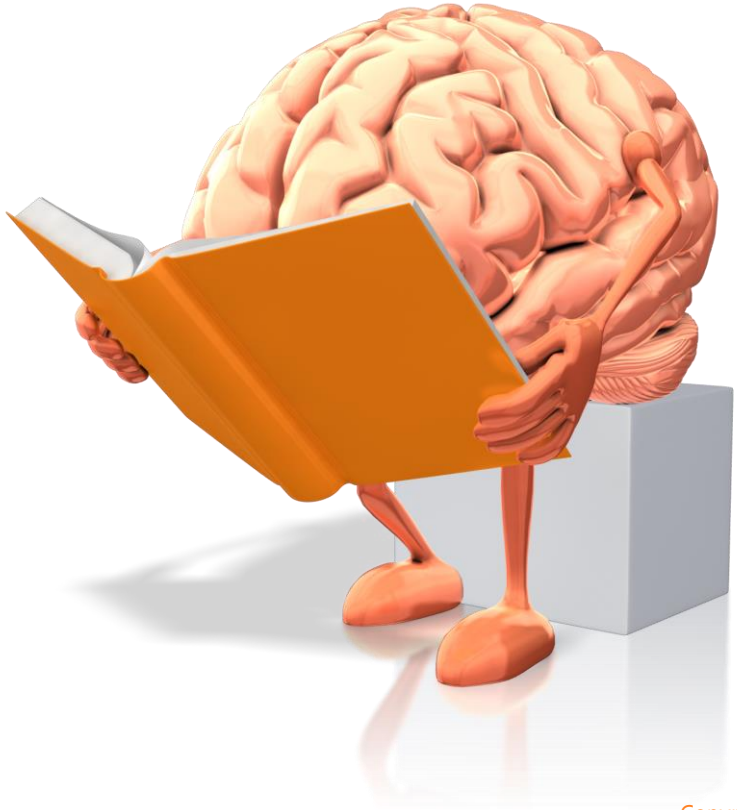
Mind, August 2016

Obsessive-compulsive personality disorder is different to obsessive-compulsive disorder (OCD).

If you have obsessive-compulsive personality disorder, you may believe your actions are justified. People with OCD tend to realise that their behaviour is not rational.

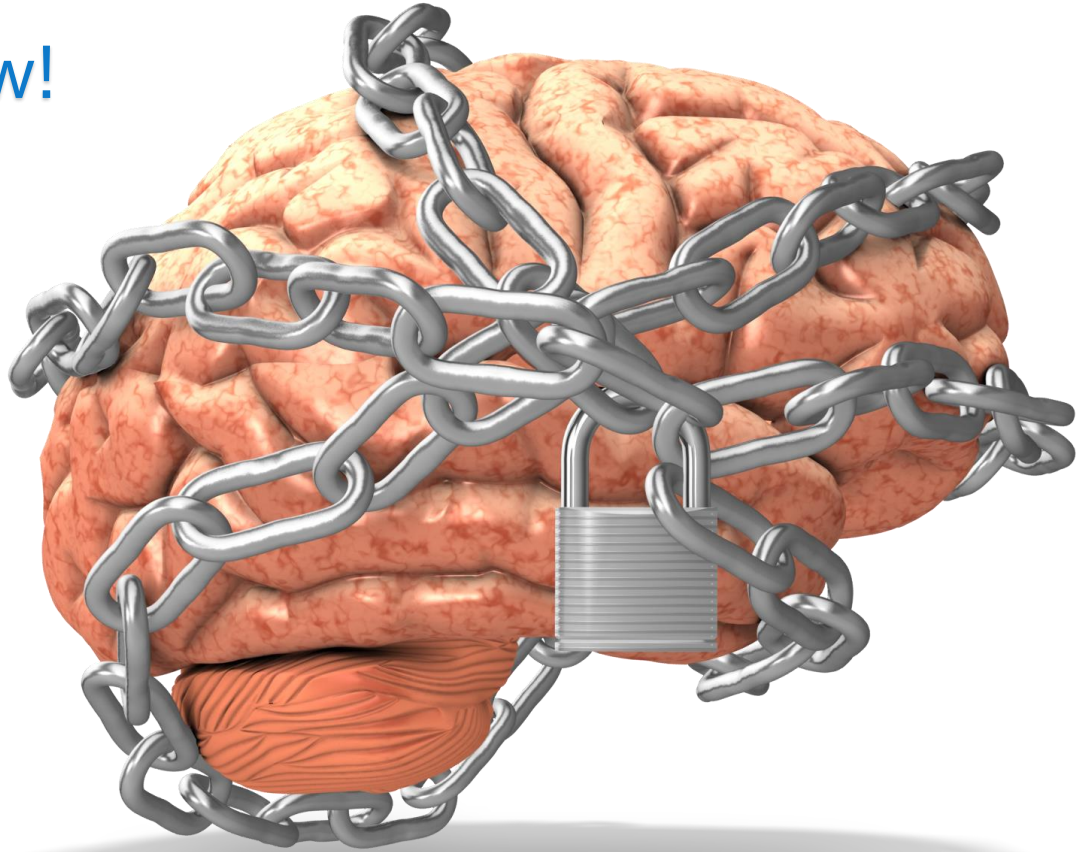
Rethink

I.P.D.E. International Personality Disorder Examination



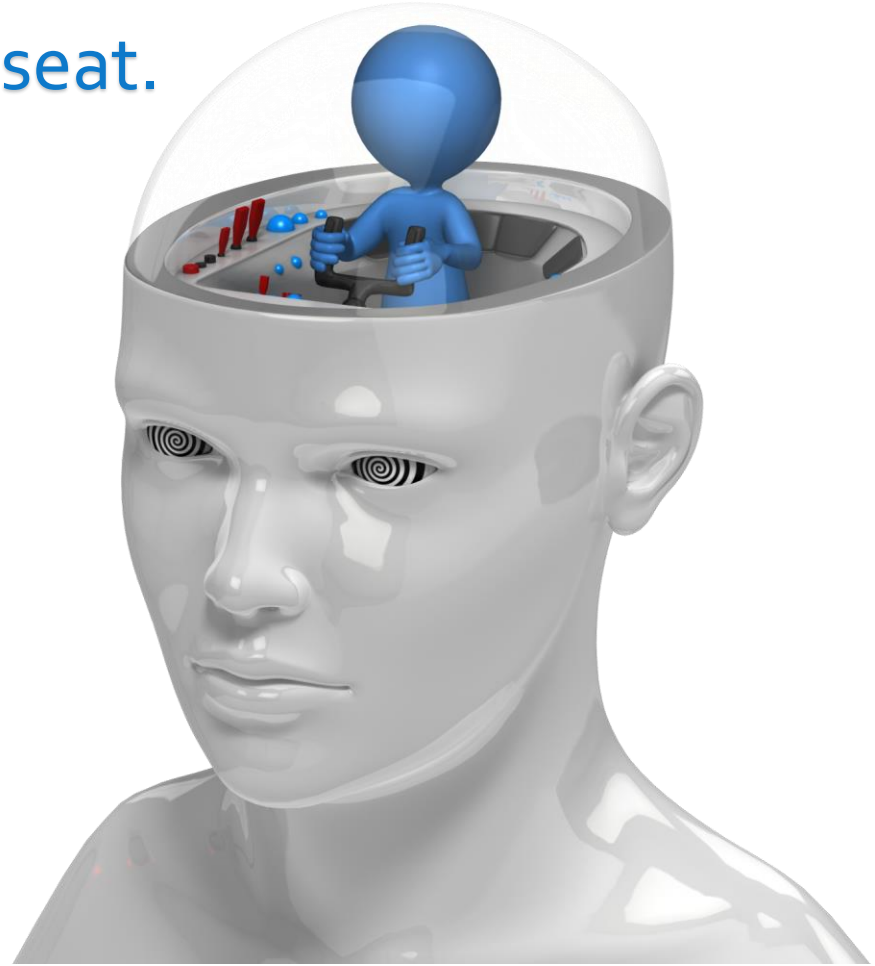
Who's in control?

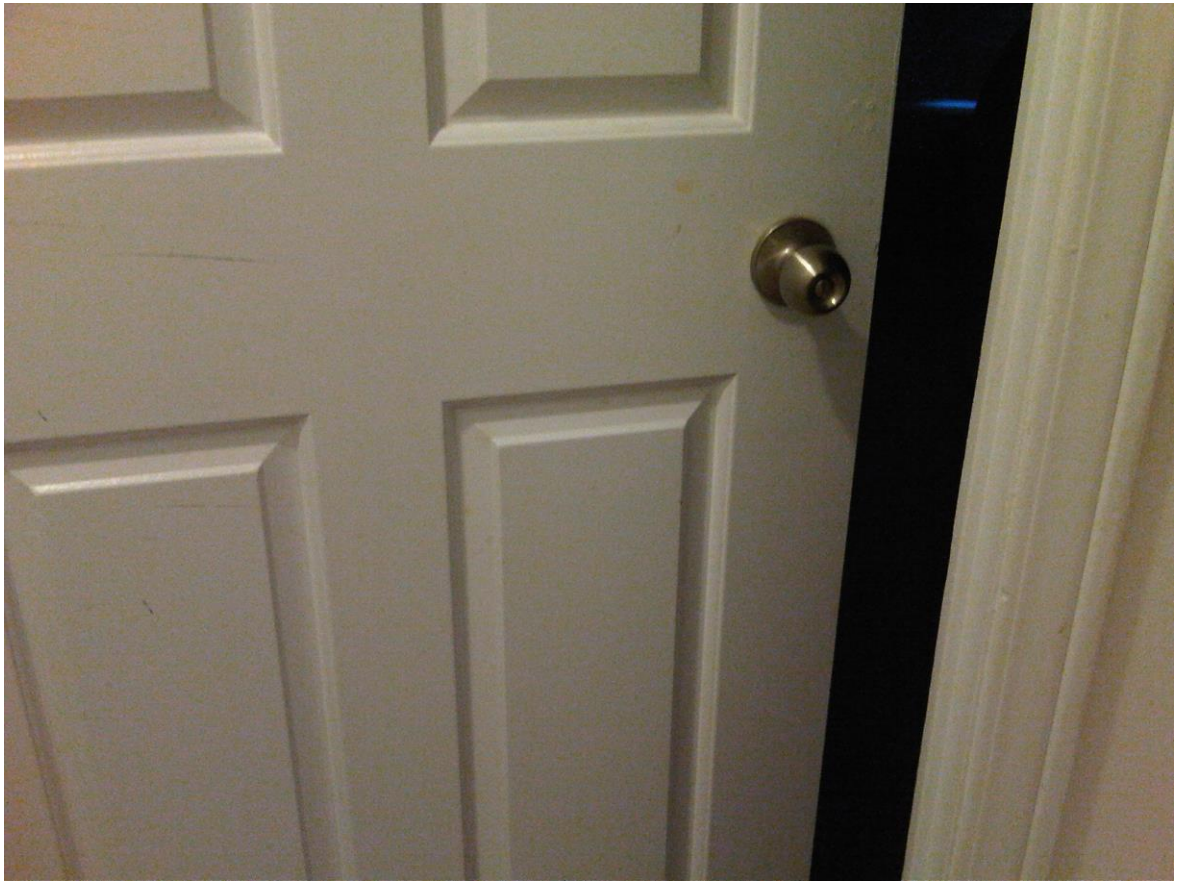
I am now!



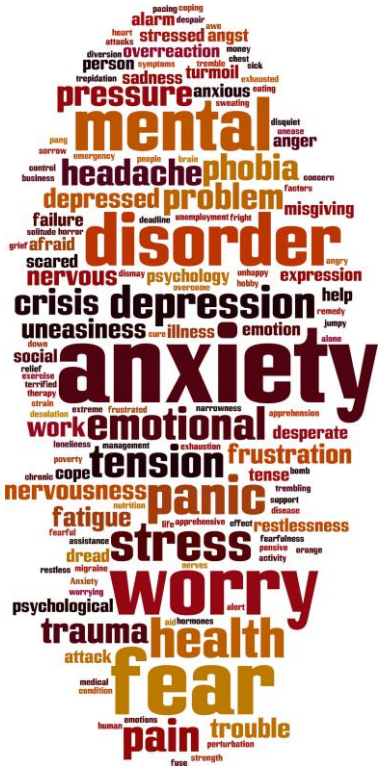
Staying in control.

I’m in the driving seat.





Managing anxieties isn't easy …it's exhausting



Safewards Implementation

What is Safewards?

1. Clear Mutual Expectations
2. Mutual Help Meeting
3. Talk Down
4. Soft Words
5. Know Each Other
6. Discharge Messages
7. Calm Down Methods
8. Positive Words
9. Bad News Mitigation
10. Reassurance

Cygnet Health Care

Safewards

A website **Safewards.net** *contains* all the information needed for implementation with further informational webinars on YouTube.

Meet the Team

Angela Pereira

Preceptorship and University Partnership Lead

diagnosis in minute detail. This was the first time in my life, that I really understood what my diagnosis of Multiple Personality Disorder meant and how I could finally make sense of the last 30 years of my life.

Inspirational figure and/or quote

My inspirational figure has always been a gentleman called **Ian Callaghan**. Ian is the Recovery and Outcomes Manager at Rethink Mental Illness. It was Ian who I used to listen to when I attended the regional ROG as a Service User. There was something different, genuine and heartfelt in the presentations that Ian delivered to a room full of service users and their support teams, who sat and mingled as equals. When I eventually realised that Ian was an ex-service user, everything started to make sense. It compelled me to refocus on my own outlook and strive for something that he (Ian) had shown me was possible to achieve. **A new life!**

Meet the Team

Wayne Saville

Expert by Experience Lead- North

What is an Expert by Experience (EbE)?
An EbE is someone who has "lived experience". This could include: a service user, a family member, a carer or even a friend. In my case, I am an ex-Service User diagnosed with Multiple Personality Disorder, with lived experience of secure services.
My role within Cygnet, is predominantly to represent the interests of our Service Users. Embedded within every level of the decision making process, whether it be at local hospital / ward level or at Executive Board level, Cygnet has a dedicated and committed team of Experts by Experience who work alongside our Service Users and staff, to ensure the interests and opinions of our service users are voiced appropriately.

My life changing / defining moments

It was the time a Modern Matron at the medium secure facility that I was sectioned at, completed the International Personality Disorder Examination (IPDE) on me. Afterwards, she handed me a full copy of the report. This was the first time in 30 years of accessing mental health services, that anyone had provided me with a written copy of my full diagnosis in minute detail. This was the first time in my life, that I really understood what my diagnosis of Multiple Personality Disorder meant and how I could finally make sense of the last 30 years of my life.

What I do to relax / chill-out

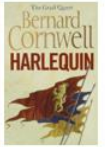
Anything with an engine basically. Motorcycling is my passion. I started riding in Motorcycle Trials Competitions when I was 10 years old. The love of 2-wheels has never left me since, but throughout my life, I have restored classic cars and motorcycles, as well as building some custom cars and bikes.

Inspirational figure and/or quote

My inspirational figure has always been a gentleman called **Ian Callaghan**. Ian is the Recovery and Outcomes Manager at Rethink Mental Illness. It was Ian who I used to listen to when I attended the regional ROG as a Service User. There was something different, genuine and heartfelt in the presentations that Ian delivered to a room full of service users and their support teams, who sat and mingled as equals. When I eventually realised that Ian was an ex-service user, everything started to make sense. It compelled me to refocus on my own outlook and strive for something that he (Ian) had shown me was possible to achieve. **A new life!**

Favourite book / author or film

I'm a war-monger when it comes to books and films. Any war/conflict, any era, any nationality.
My favourite authors are **Bernard Cornwell** and **Conn Iggulden**.



personality disorder

knowledge & understanding framework

NHS England

Offender Personality Disorder Services

Her Majesty's Prison & Probation Service

- Stigma
- Discrimination
- Disclosures

Realistic goals, lead to positive outcomes.

What would I know….?

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Experts by Experience

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Mental Health Secure Care Services
&
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The Value of Peer support and sharing experience in building resilience

Gayle Woodcock: Quality Lead Lakeside and East of England Recovery Lead

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What is it?

"Key elements of Peer Support in mental health include that it is built on shared personal experience and empathy, it focuses on an individual's strengths not weaknesses, and works towards the individual's wellbeing and recovery"

Mental Health Foundation

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- Listening
- Mentoring
- Tutoring
- Emotional and practical support

Keep in touch
Good relationships are crucial to our mental health. Friends and family can make you feel included and cared for. There is nothing better than catching up with someone you care about face to face but that is not always possible. You can also give someone a call, drop them a note or chat to them online instead. It is worth working at relationships that make you feel loved or valued. However if you think being around someone is damaging your mental health, it may be best to take a break from them or call it a day completely.

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- Peer support encompasses a personal understanding and serves to help someone recover through making sense of what has happened and moving on.
- Shifts emphasis from identifying and eradicating symptoms and dysfunction.
- It is through this trusting relationship, which offers companionship, empathy and empowerment, that feelings of isolation and rejection can be replaced with hope, a sense of agency and belief in personal control.

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Recovery & Outcomes

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- Set up in 2012
- Group of dedicated staff & patients
- Steering group
- 9 Regional Groups across the country;
  200-300 attendees per quarter
- Annual conference
- Joined with Rethink Mental Illness

Recovery and Outcomes

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- **PERSONAL: sharing of experiences, learning & inspiring**
- **SERVICE: Working together, sharing best practice, networking**
- **NATIONAL: Policies, programmes, output**

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Smoke free initiative
Stigma & discrimination
Restrictive practices/blanket rules
Access to technology
Individual support/interventions
Medication
CPA
Physical wellbeing
Individual recovery stories

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- Happiness & Hope
- Right relationships
- MoJ
- Recovery colleges
- Recovery pathways
- CQUINs
- Patient Experience measures
- Involvement in the secure care programme
- National Service User Awards

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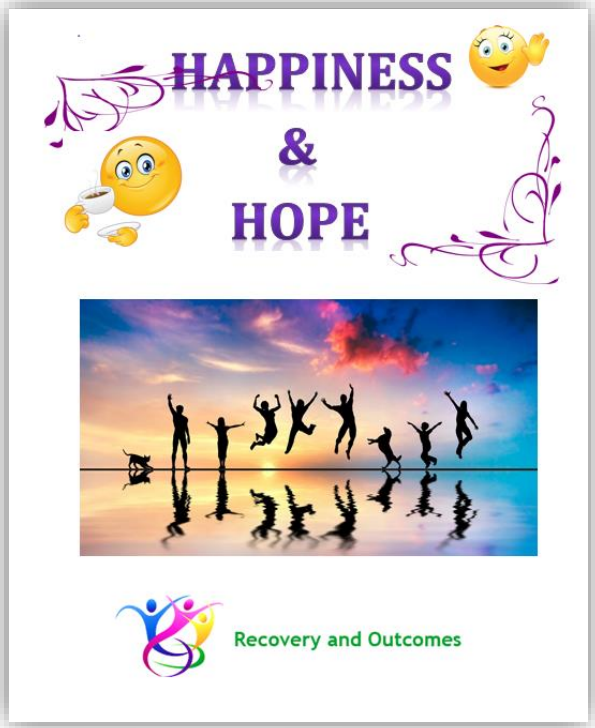
Happiness & Hope



Communication: Listen, politeness, open & honest, share ideas

Activities: Positive things together, games, community, trying new things

Peer support: Random acts of kindness, inclusion, encouragement, buddy

Understanding: Respect, space, acceptance, considerate, tolerance, privacy

Attitude: Morale, empathy, small details, happy aura, engaging,

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OUR JOURNEY

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Building Resilience

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ImROC
Implementing Recovery through Organisational Change

A joint initiative from Centre for Mental Health and Mental Health Network NHS CONFEDERATION

Briefing

5. Peer Support Workers: Theory and Practice

Julie Repper
with contributions from Becky Aldridge, Sharon Gilfoyle, Steve Gillard, Rachel Perkins and Jane Rennison

"offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations" (Mead et al., 2001).

It is through this trusting relationship, which offers companionship, empathy and empowerment, that feelings of isolation and rejection can be replaced with hope, a sense of agency and belief in personal control.

- 'informal' (naturally occurring) support;
- peers participating in consumer, or peer-run, programmes alongside formal mental health services;

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1. **Mutual**: Shared experiences, common challenges such as being defined by illness and the hopelessness that can ensue.

2. **Reciprocal**: no claims to such special expertise, but a sharing and exploration of different world views and the generation of solutions together.

3. **Non-directive**: recognise their own resources and seek their own solutions. "Peer support is about being an expert in not being an expert and that takes a lot of expertise."

4. **Recovery focused** :

- ✓ inspiring HOPE: they are in a position to say 'I know you can do it' and to help generate personal belief, energy and commitment with the person they are supporting
- ✓ support to take back CONTROL of personal challenges and define their own destiny
- ✓ facilitating access to OPPORTUNITIES that the person values

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5. **Strengths based**: not being afraid of being with someone in their distress. Seeing within that distress the seeds of possibility and creating a fertile ground for those seeds to grow, seek out their qualities and assets, identifies hidden achievements and celebrates what may seem like the smallest steps forward.

6. **Inclusive**: understanding the meaning of experiences within the communities of which the person is a part. This can be critical among those who feel marginalised and misunderstood by traditional services.

7. **Progressive**: not a static friendship, but progressive mutual support in a shared journey of discovery. both 'travellers' learning new skills, developing new resources and reframing challenges as opportunities.

8. **Safe**: Provide emotional safety by discovering what makes each other feel unsafe, sharing rules of confidentiality, demonstrating compassion, authenticity and a non-judgemental attitude and acknowledging that neither has all the answers.

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“The first time I went to the Recovery and Outcomes groups I was Immediately inspired but Ian who was running the groups! The fact that he used to be in hospital like I was made me realise that it was possible to recover and make something of your self and live a life worth living.

East of England service user recovery lead

I am now the East in England service user lead and I attend our ROG and the steering group. It is amazing to sit along side people who have had such resilience and managed to pick themselves up from a really dark place and make something out of their recovery and life. This in itself helped me gain my own resilience..

It has also aided my recovery and knowing that I have these commitments coming up helps me keep my life on track.

Peer support is such an important thing to have as if you can see that someone else has managed to recover you feel that is possible for you. Having people who have very similar experiences to you helps you open up to that person”.

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ImROC
Implementing Recovery through Organisational Change
Briefing

Centre for Mental Health
Mental Health Network NHS CONFEDERATION

7. Peer Support Workers: a practical guide to implementation

Julie Repper
with contributions from **Becky Aldridge, Sharon Gilfoyle, Steve Gillard, Rachel Perkins** and **Jane Rennison**

INTRODUCTION

Our experience with the ImROC programme has led us to the conclusion that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services. In the first paper on this topic (Repper, 2013) we discussed the theoretical background, core principles and the range of potential benefits. In this paper we will discuss practical issues of implementation in more detail.

When developing peer worker posts, it is useful to think of four sequential phases. The first involves **preparation** – of the organisation as a whole, of the teams in which peers will be placed, and, perhaps most obviously, of the peers themselves. The second phase involves **recruitment** of peers to the posts that have been created or existing posts that have been modified for peer workers. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, the whole process needs careful support. Thirdly, there is the safe and effective **employment** of peer workers in mental health organisations. Finally, the **ongoing development** of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. These different phases are shown in Box 1 below.

Mental wellness not illness

Maggie Rose Clinical Team Leader

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Mental wellness not illness

The Past

Isolation .....asylum out in the countryside...out of home area

Medication .....too much not monitored properly.....side effects

Illness and diagnosis get this labelled and define a person by this

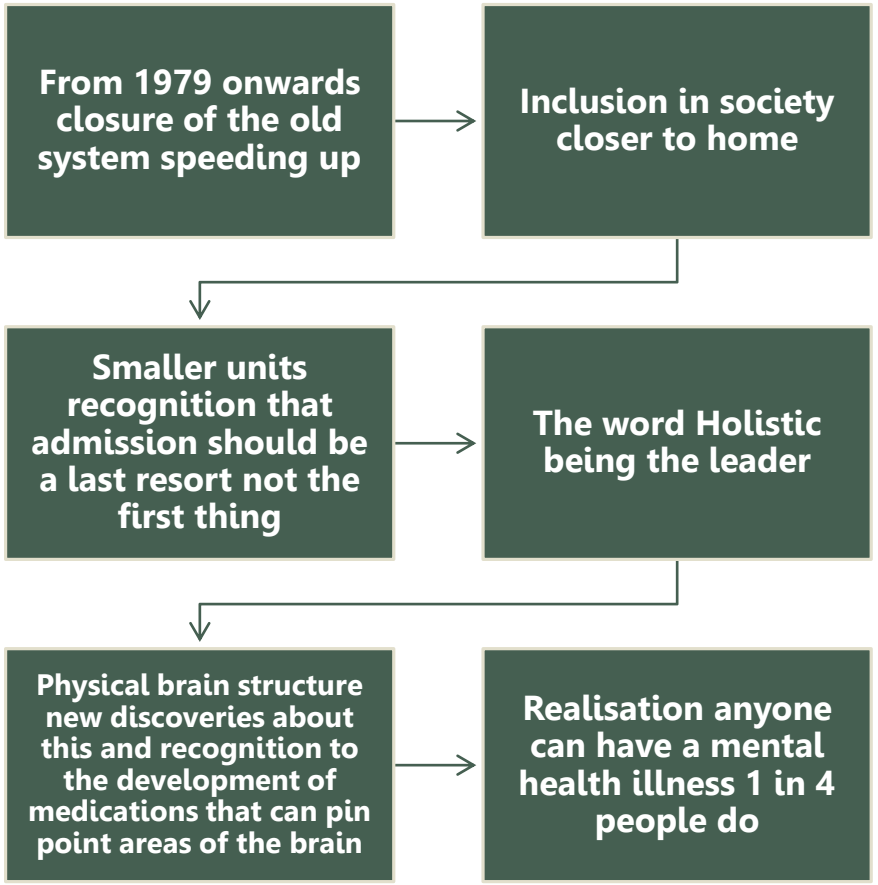
Problem focussed lets contain this rather than try and fix it

Contribute to a system loss of the individual

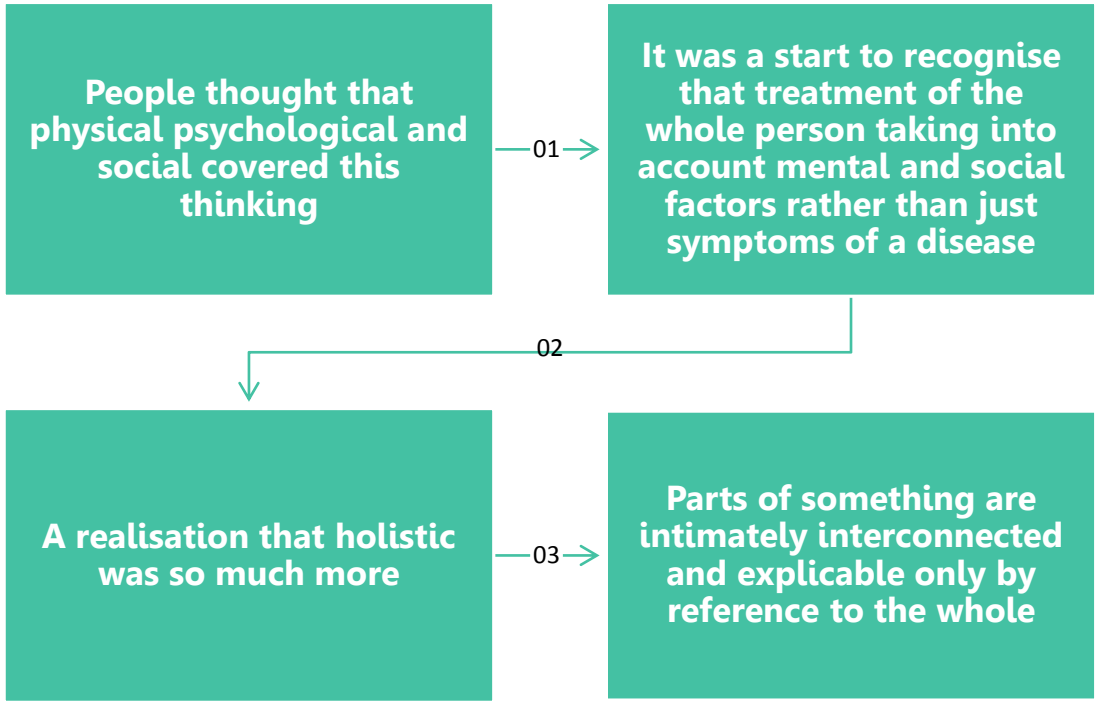
Clothes chosen for you

Institutional existence staff too bakery farm shop cinema canteen.....no need to leave

Now!


From 1979 onwards closure of the old system speeding up
Inclusion in society closer to home
Smaller units recognition that admission should be a last resort not the first thing
The word Holistic being the leader
Physical brain structure new discoveries about this and recognition to the development of medications that can pin point areas of the brain
Realisation anyone can have a mental health illness 1 in 4 people do

Holistic


People thought that physical psychological and social covered this thinking
01
It was a start to recognise that treatment of the whole person taking into account mental and social factors rather than just symptoms of a disease
02
A realisation that holistic was so much more
03
Parts of something are intimately interconnected and explicable only by reference to the whole

Uniqueness

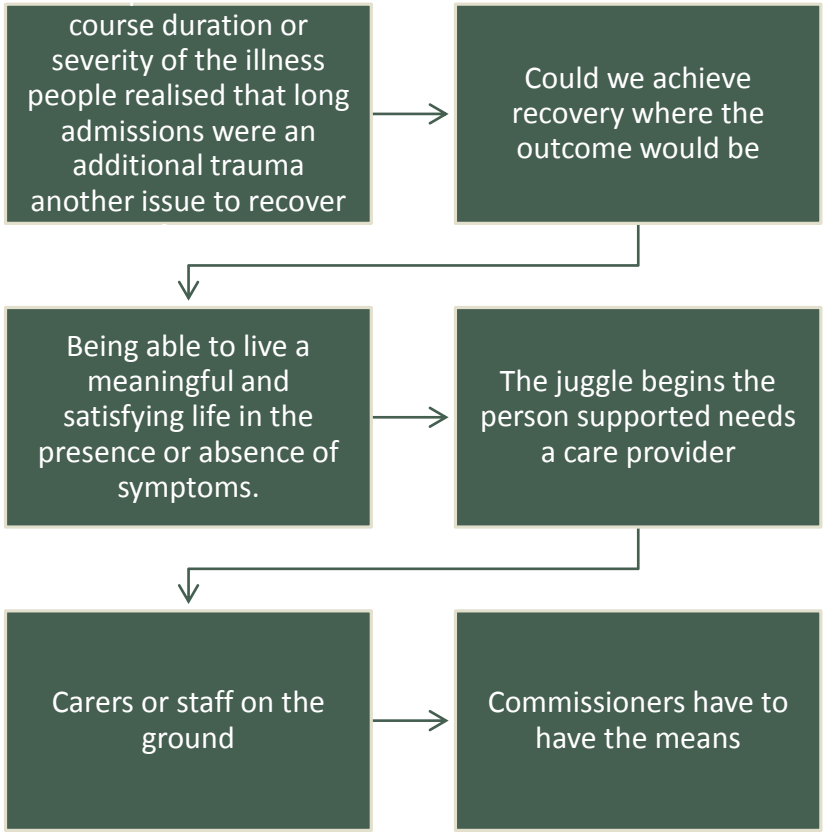
Ever heard that Mental Health care is fascinating?

You meet so many people that have completely different stories for the same diagnosis.

It is an honour when people let you in to get to know them and to share a tough journey.

You travel together sorting life out building a future maintaining the present.

Every persons experience of mental health problems or illness is different



Support

Support

We have to prove we are effective as staff

We have to have evidence for what we say

Self management is to be encouraged

Reflective practise then leads to service improvements

Care models that reflect this evidence are helpful.

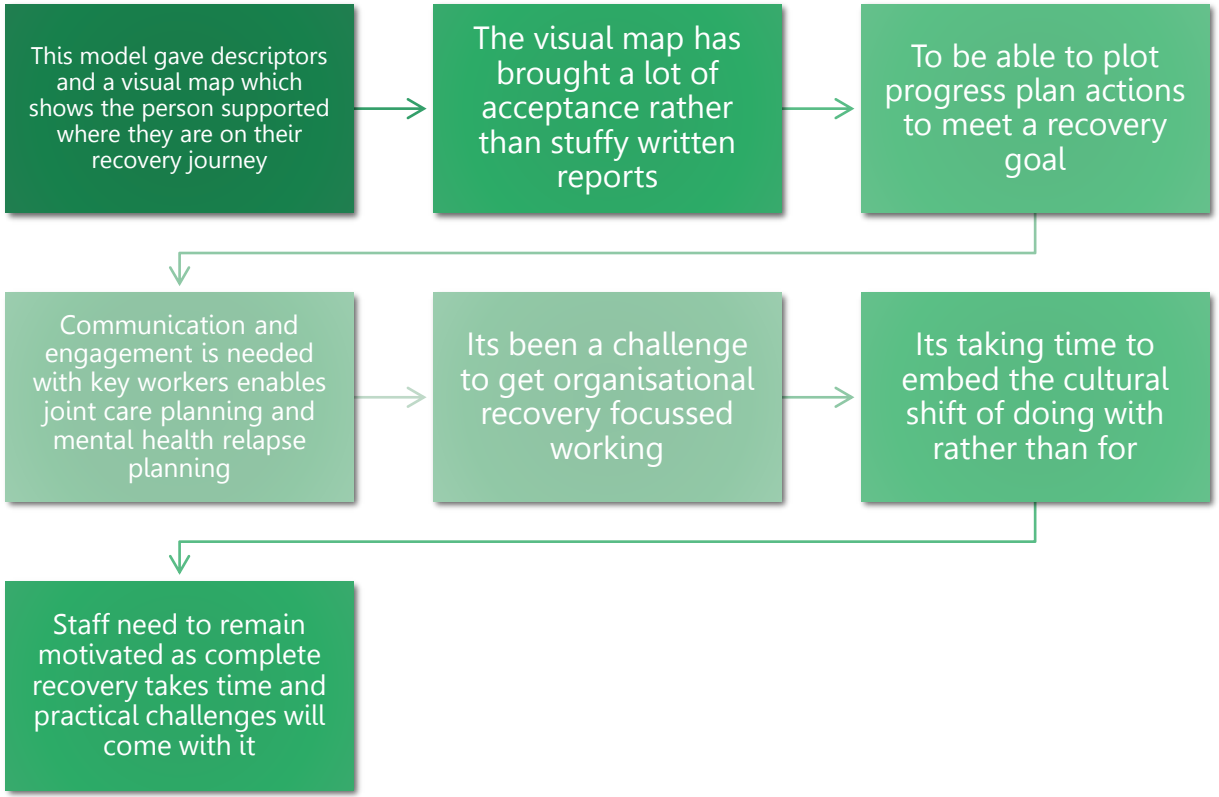
TO achieve the list above we needed a model that would quantify

Describe progress so as an organisation we can effectively

Capture measure and summarise change and service effectiveness across a range of people supported and from

Different projects.

THE RECOVERY STAR



Relational Responding

A Journey of Discovery

Dr Victoria Vallentine (Consultant Clinical Psychologist & CAT Therapist)
Elise Stephen (Principal Clinical Psychologist & Accredited DBT Therapist)

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Rationale

And background

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Rationale

- Effective team working is essential for quality MH services (West, 2012)
- Unhelpful relational patterns between clients and services unintentionally reinforce the clients difficulties (Kerr, 1999)
- Ineffective team working leads to splitting stress and burnout (Main, 1957)

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Organisational issues identified

- Staff burnout
- Increased incidents
- Patient dissatisfaction
- Complaints
- Therapies not supported
- Judgments/negative attitudes towards patients expressed
- Witnessing poor/inconsistent boundaries
- Low morale/powerlessness

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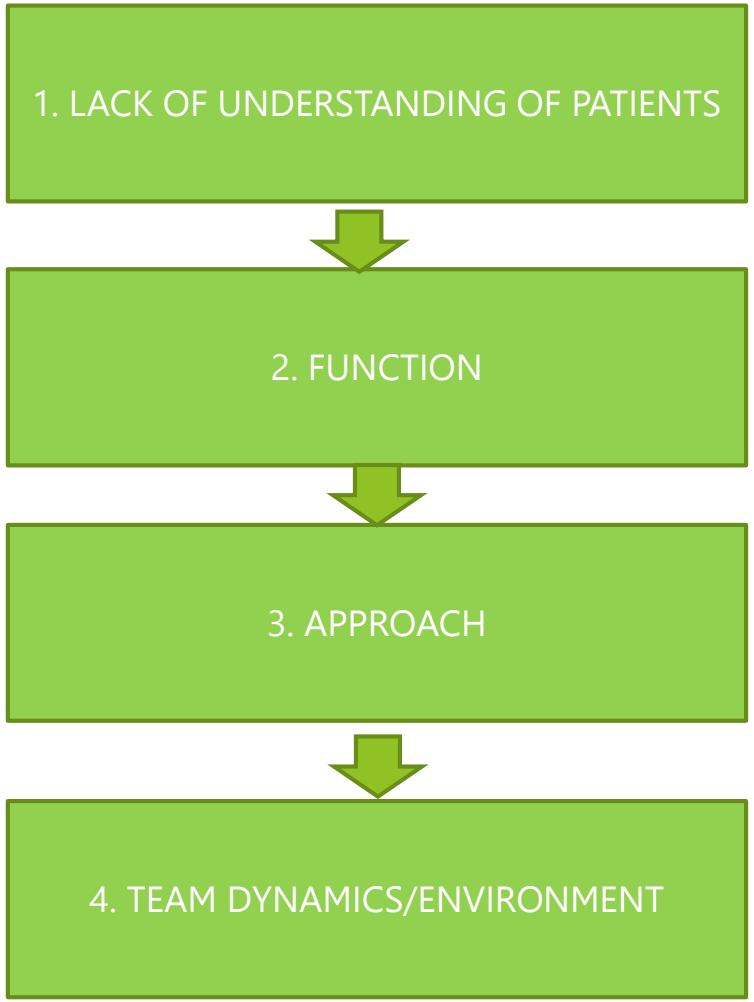
Organisational Formulation



1. Lack of understanding

- History
- Background
- Formulation
- Theoretical Models

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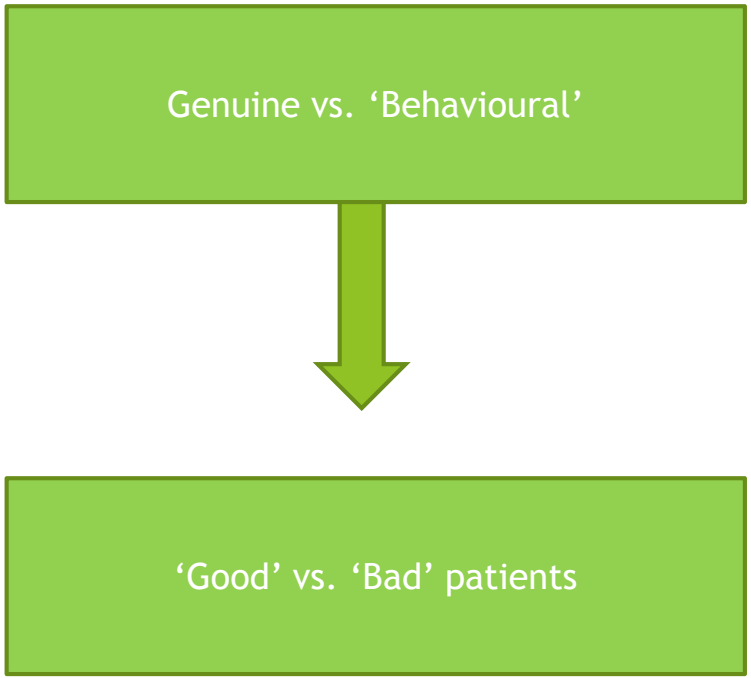
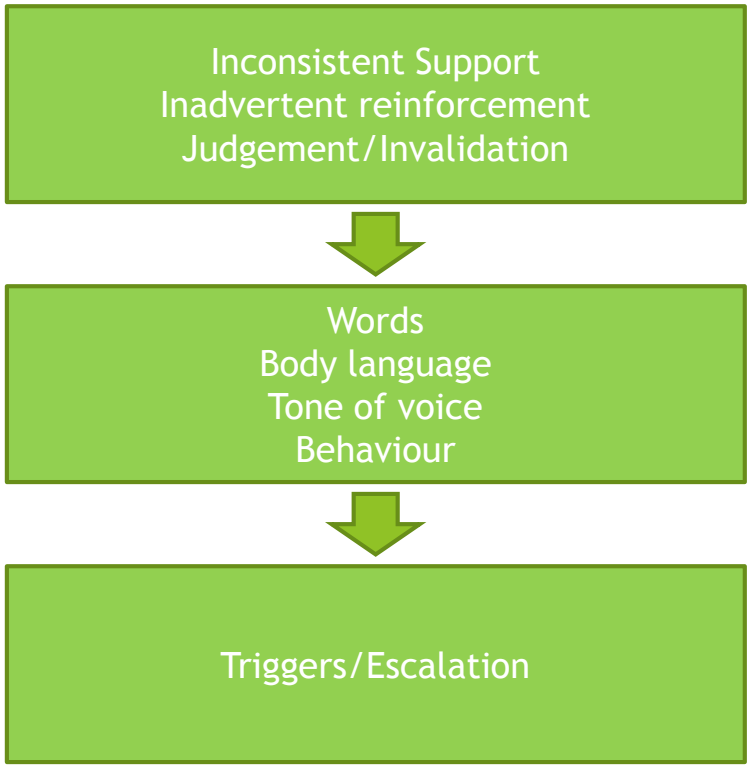
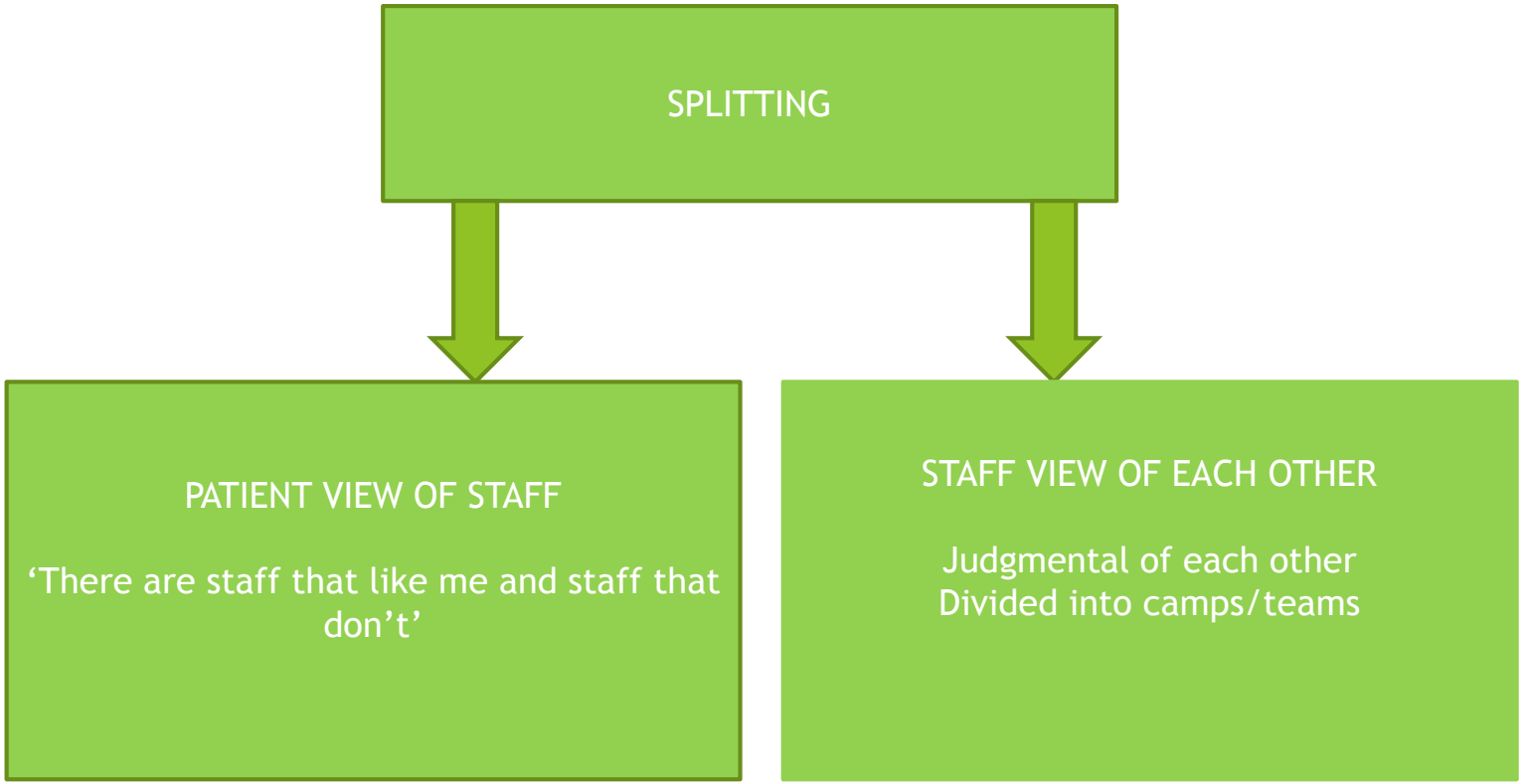
2. Function



3. Approach


Inconsistent Support
Inadvertent reinforcement
Judgement/Invalidation
Words
Body language
Tone of voice
Behaviour
Triggers/Escalation

4. Team dynamics/environment



Two different directions?!

- 2 different psychologists working in 2 different parts of the service
- …from 2 different theoretical orientations
- Led to 2 different directions to solve what were perceived to be 2 different problems

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Overview of Staff Training

Dialectical Behaviour Therapy (DBT)

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Why use DBT?

- DBT encourages the use of the same strategies used to treat the client to treat the staff, to improve their motivation and capability to treat the client (Swales, 2010)
- Validation and letting go of judgements of the patient is essential in DBT (Linehan, 1993)
- DBT is a team-based approach that reduces staff burn-out and stigma (Haynos et al., 2016)

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Aims for training

1. Tackle staff lack of understanding of patients
2. Tackle understanding function of behavior
3. Tackle problems with approach
4. Tackle problematic team dynamics and environmental issues

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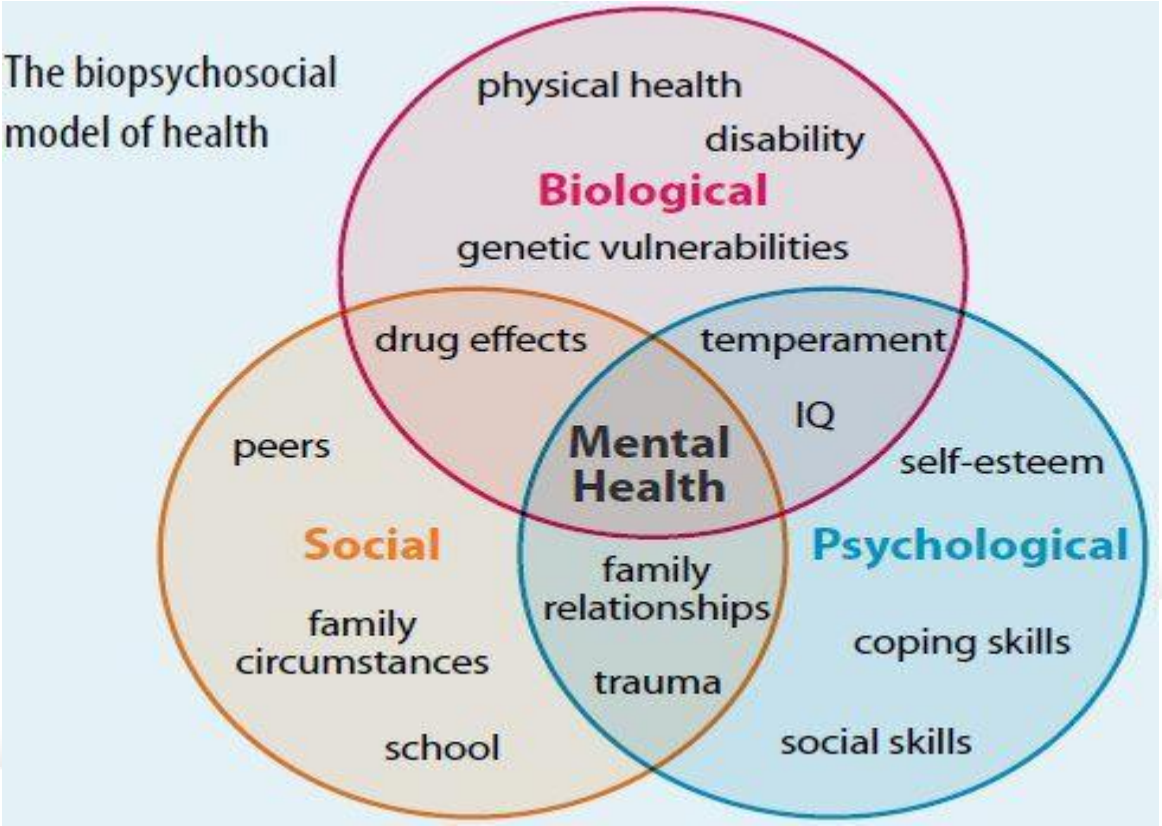
1. Improving understanding of patient presentations

Impact of invalidating environments being **key** to understanding



2. Improving understanding of function of behaviour

- Concept of reinforcement

- Dialectics
  - Patients are doing the best they can, AND need to do better, to get **essential human care needs** met and **create a life worth living**

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3. Improving approach

Avoiding replication of the invalidating environment

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3. Improving approach

- Teaching validation:
  - Listening
  - Reflecting Back
  - Articulate non-verbalised emotions, thoughts, behaviour patterns
  - Validate in terms of past learning/biological dysfunction
  - Validate in terms of present context/normative functioning
  - Radical Genuineness
- Teaching how to reinforce desired behaviour and reduce reinforcement of undesired behaviour

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3. Improving approach

- Teaching staff DBT skills
  - Practical skills
  - When and how to support

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4. Improving team dynamics and environment

- Normalising staff individual difference (however need for reflection and conscious change)
- Linking increased understanding of patient histories/formulations to importance of boundaries and consistency
- Being 'liked' versus doing the best for the patient
- Holding hope for ALL patients
- Consultation to the patient versus fostering dependency/sending message of incompetence
- Getting patients on board to improve relations with staff
- Reflective practice – having patients attend and with DBT therapist help, address issues with staff openly

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Benefits

- Improved approach with patients (boundaries, non-judgmental stance)
- Improved buy-in for DBT (getting patients to group, help with homework etc)
- Improved ability to support patients with DBT skills
- Improved team work and functioning

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Overview of Staff Training

Cognitive Analytic Therapy (CAT) Training

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Why use CAT?

- Staff report CAT is an accessible relational model which aides psychological understanding (Thompson et al, 2008)
- CAT can inform effective risk management and prevention (Shannon, 2012)
- CAT provides a containing framework which empowers teams to work effectively with clients (Candice and Bennett, 2012)
- CAT helps them staff to express and make sense of their reactions to clients
- CAT supports staff to build and maintain empathy
- CAT can promote understanding of working with boundaries (Hamilton, 2010; 2014)
- Previous experience
- Current management

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Aims for training

1. Increase staff understanding of patient presentations
2. To understand what underpins their behaviour
3. To develop skills to better manage patient behaviour
4. Improve team working and consistent approach around boundaries

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Application of CAT: What we did

- Teaching the basic theory
  - The importance of early experiences
  - Common reciprocal roles in this population
  - Boundary see saw
  - Case studies
  - Risk management

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The importance of early experiences

- Analogy using 2 babies
- The development of self and our views of others and the world via our relational experiences
- Reciprocal Roles (ways of relating)

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Good Enough Care

- What does this baby learn about themselves? Others and the world?
- What ways of relating are they likely to internalise?

I am loved/worthy of love/safe

Others are loving, care for me, keep me safe, protect me

The world is safe, reliable

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Early abuse/neglect

- Imagine what a child with experiences of abuse/neglect is likely to learn?

I am unlovable/unwanted/not worthy of love

Others are unreliable, will hurt me, can't be trusted

The world is dangerous, unpredictable

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Common Reciprocal Roles (ways of relating) in forensic mental health patients

- Controlling-Controlled
- Abusing-Abused
- Neglecting-Neglected
- Abandoning-Abandoned
- Blaming-Blamed
- Rubbishing-Rubbished

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Application of the theory to case examples

- Reviewing background information
- Live mapping Reciprocal Roles
- Link to understanding presenting behaviours

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Who needs to change first?

Do we expect the patient to change first or do we need to change how we approach things first?

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Using CAT MAPS: predict, plan, protect

- Using the formulation to predict a client's response and therefore plan risk management effectively
- Plan how to approach the individual to reduce likelihood of triggering problem procedures
- Plan risk management going forward

Using CAT maps: Avoid the dance

- Self awareness- knowing your own RRs and triggers
- Invitations to respond in a certain way-testing/controlled response/known place to be
- Sensitivity to certain responses e.g. rejection/abuse (transference)
- Different presentations to different staff – both/and not either/or
- Stepping out of the dance

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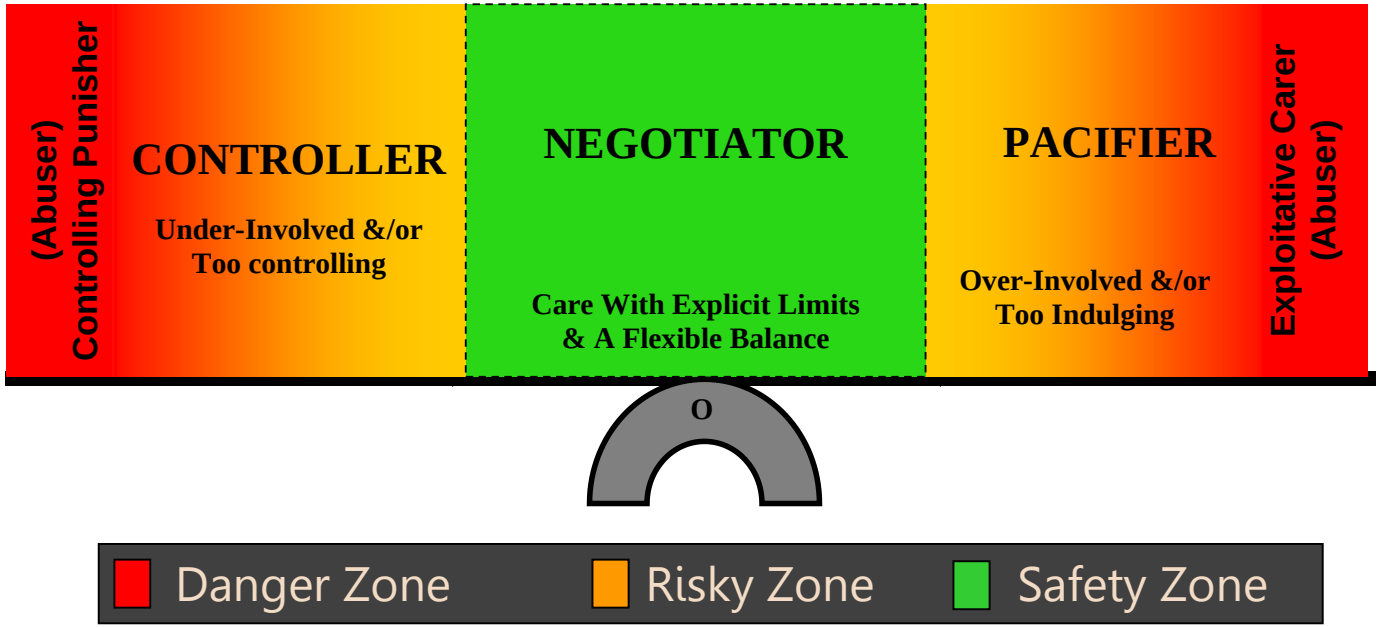
Boundary See-saw – Hamilton 2010, 2014



Laura Hamilton (2010) in 'Using Time, Not Doing Time'

Focus on Cultural Change

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Benefits

- Improved understanding of patients and behavioural function
- Improved interactions, identifying unhelpful ways of relating, initiations to enter the dance
- Increased awareness of potential ways of relating that may activate RRs
- Increased consistency in approach and reduction in splitting
- Encouraged staff to express and make sense of their reactions to clients building on and maintaining empathy
- Insert links to the relational security wheel

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Our Story

And forward directions

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Realisations!

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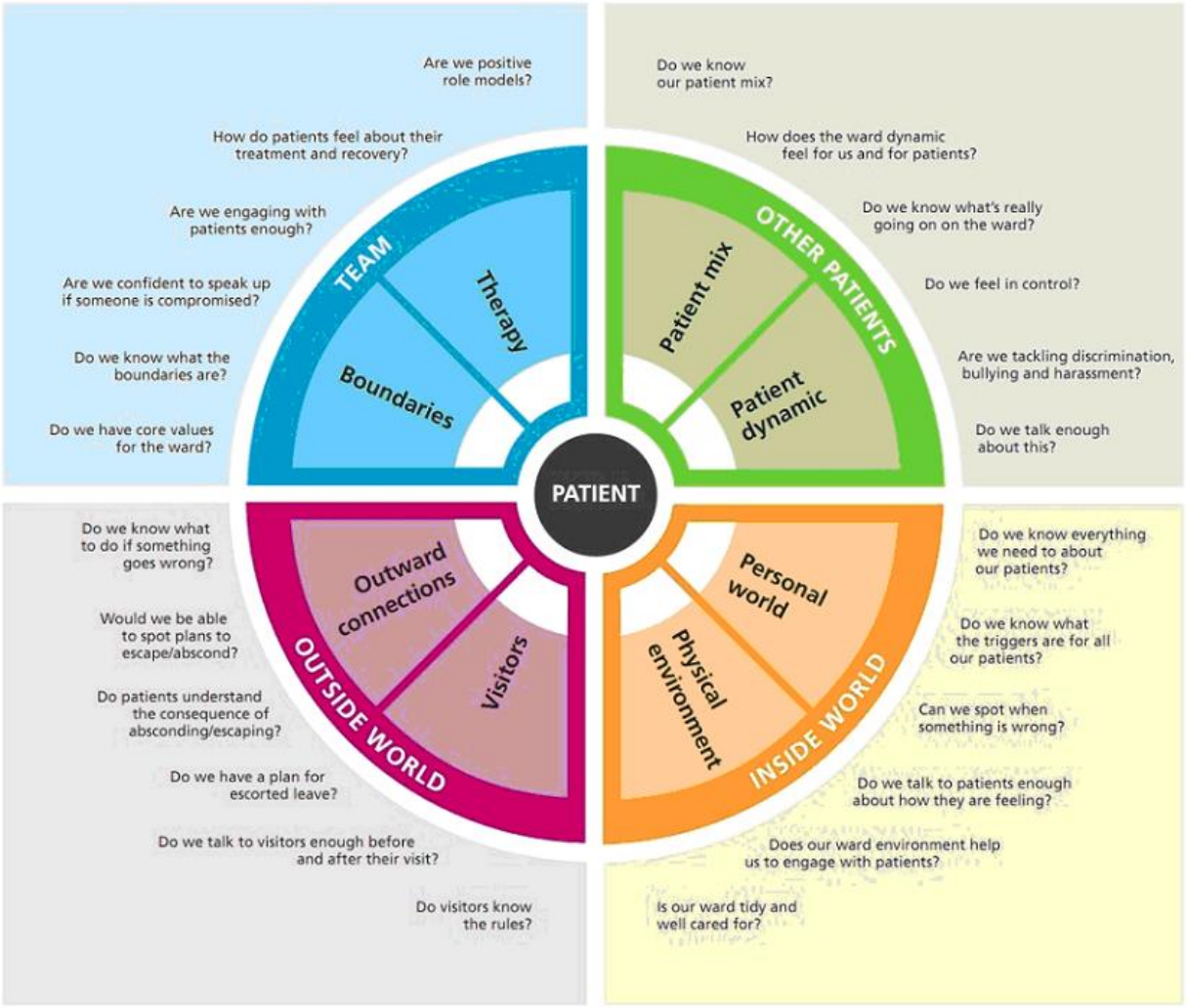
RELATIONAL SECURITY EXPLORER

See

Think

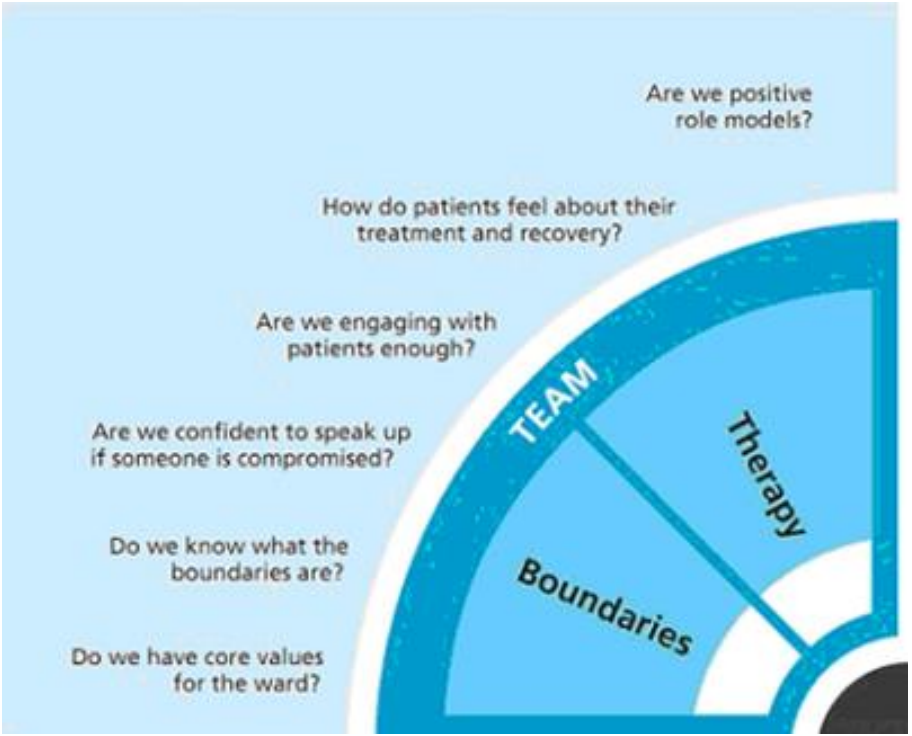
Act



Keep everyone safe act on it

DBT

- Boundaries
- Staff confidence
- Therapy engagement
- Role modelling (validation, boundaries, skills practice)



CAT

- Boundary See-saw
- Engaging patients without activating RR

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DBT

- Understanding patients
- Dynamics (boundaries, reduced splitting)
- Lack of judgment
- Talking and reflecting
- Staff confidence

CAT

- Mapping to understand patient dynamics
- Reflecting on early experiences and possible RRs

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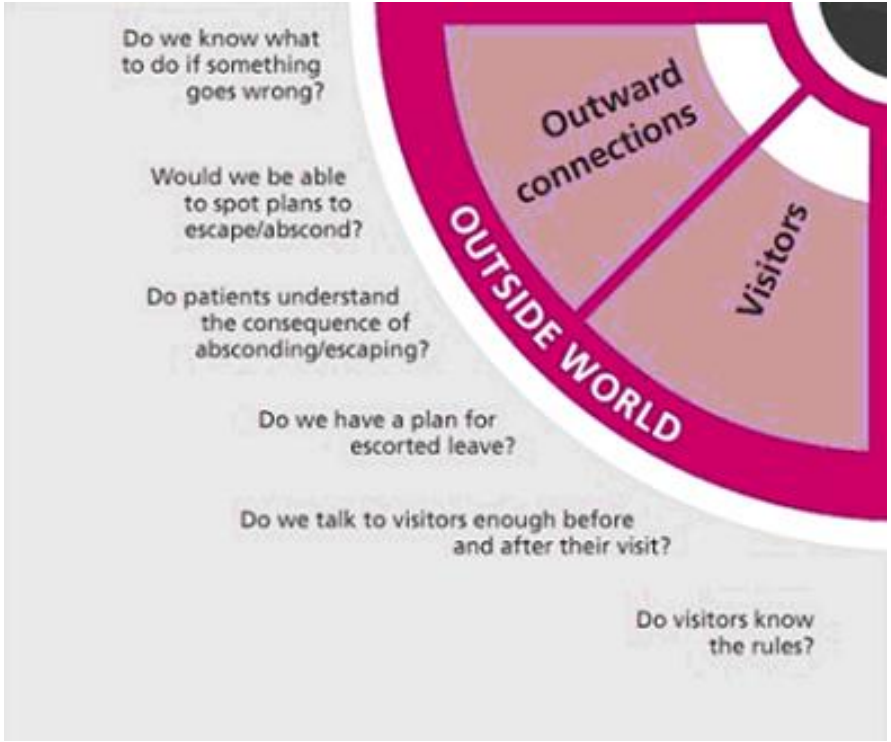
DBT

- Behavioural approach considers reinforcement
- Whole system involvement
- Reflection and human fallibility



CAT

-Early experiences- family dynamics and triggers

- Predicting and managing Risk

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DBT

- Environment as a therapeutic milieu
- Bio-psycho-social model and behavioural understanding of triggers
- Skills to talk to patients

CAT

- Early experiences
- Mapping potential RRs
- Stepping out of the dance
- Under-standing function of behaviours
- Plan, Predict, protect

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Relational Responding Training

- Developing new training
- CAT formulations
- Integrating teaching of DBT skills
- Using CAT boundary see-saw
- Reflective nature – CAT (and built into reflective practice)
- Reinforcement principles/non-judgmental stance - DBT
- Team building from both models
- Building on staff knowledge gained from See Think Act training

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New DBT Service at Lakeside

Female EUPD/DBT Unit

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DBT/EUPD specialist unit

- Lakeside are proud to introduce our new specialist Dialectical Behavioural Therapy (DBT) service.
- This is a female, 12-bedded, in-patient unit for women with diagnostic features of Emotionally Unstable Personality Disorder (EUPD).
- The unit is led by an accredited DBT therapist and the team consists of 6 intensively trained DBT therapists.
- All unit staff are trained in the model at skills level.
- This is a therapeutic ward underpinned by DBT principles.

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Aims of the new unit

- The aim of the service is to equip women with the necessary coping skills that will enable them to live successfully in the community, thereby reducing the risk of harmful and unhelpful behaviours that may lead to multiple placement breakdown and frequent hospital admissions.
- This is a time-limited therapeutic intervention, usually delivered over a 12-month cycle (additional treatment cycles can be commissioned if required).
- A discharge plan will be developed upon admission and when a patient is nearing readiness for discharge, we will support them to return to their own home, or work alongside social care teams to identify a suitable community placement.

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Thanks for Listening!

Questions/comments?

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Welsh Centre for Action on Dependency and Addiction

WCADA

Canolfan Gymraeg am Weithredu ar Ddibyniaeth

Inspiring Change Achieving Potential

Change

Samantha Drohan

Change

- Who can do it?
- And by how much
- Out of 100%?

Change

- Behaviour change is something we all experience
- In a professional capacity
- And personally
- Change does not always happen quickly
- It is cyclical
- It is a process
- It is difficult

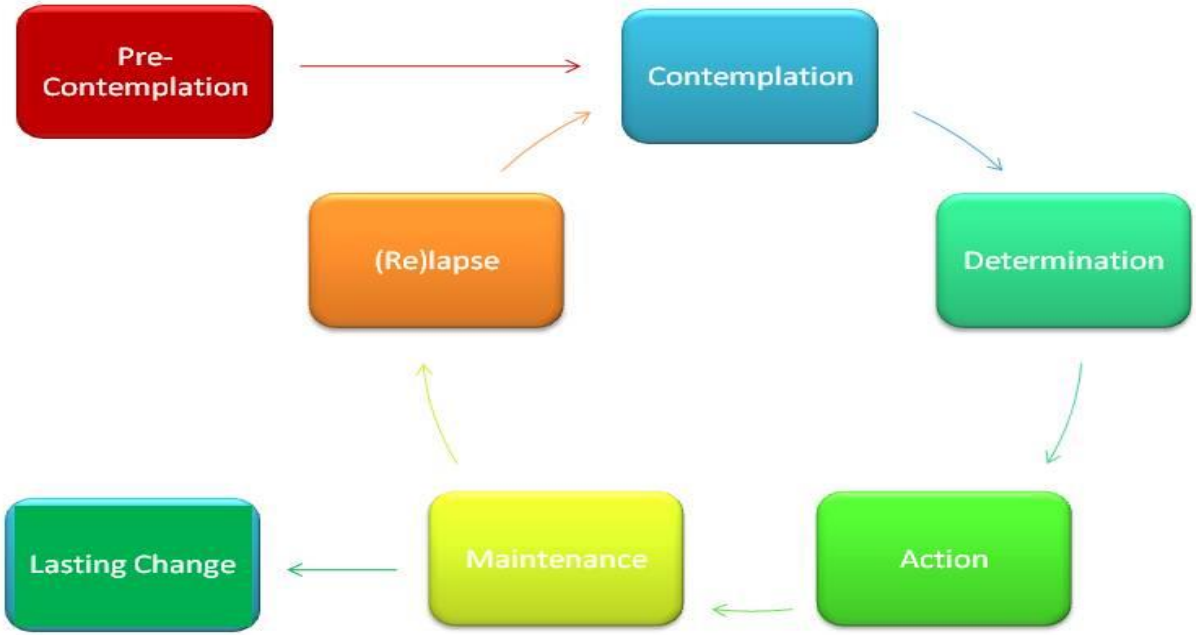
Dangerous assumptions

- This person ought to change
- This person is ready to change
- This person's health is their prime motivating factor
- If they do not decide to change the behaviour the consultation has failed
- People are motivated to change or not
- Now is the right time to consider change
- A tough approach is always best
- I'm the expert – "they" must follow my advice

The spirit of motivational communication

- Quiet & eliciting communication style
- The ‘counsellor’ is directive in helping to examine ambivalence
- Resistance to change not a trait, but a product of interpersonal interaction
- Motivation to change elicited from the person, not imposed from without
- Direct persuasion not effective for resolving ambivalence
- It is the individuals task to articulate and resolve ambivalence

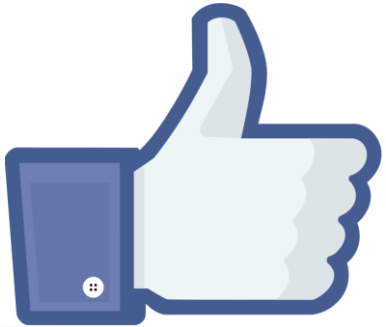
Cycle of Change



Prochanska & Diclemete, 1986

Thank you

- You can also find us on: www.wcada.org
- samanthadrohan@wcada.org



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Inspiring Change Achieving Potential

Transitional Support Model

A Progressive Supportive Pathway towards Independence and Recovery

Sue Hullin Quality and Service Development Director

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The Recovery Star Model

- places value on people's perspectives and enables empowerment and choice
- provides belief that positive growth is a possible and realistic goal
- focuses on people's potential rather than their problems
- provides holistic support, covering all the dimensions of recovery
- self-management of mental health and relapse prevention is the ultimate goal

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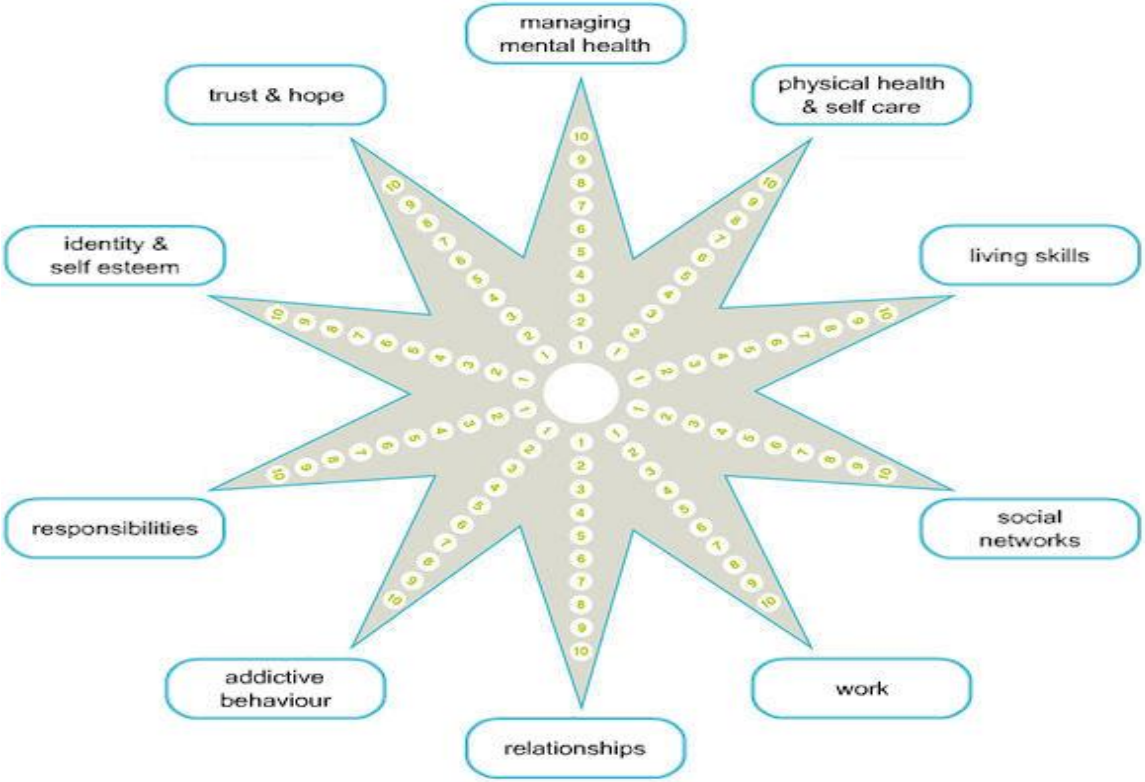
The Recovery Star Model (developed by Triangle Consulting)



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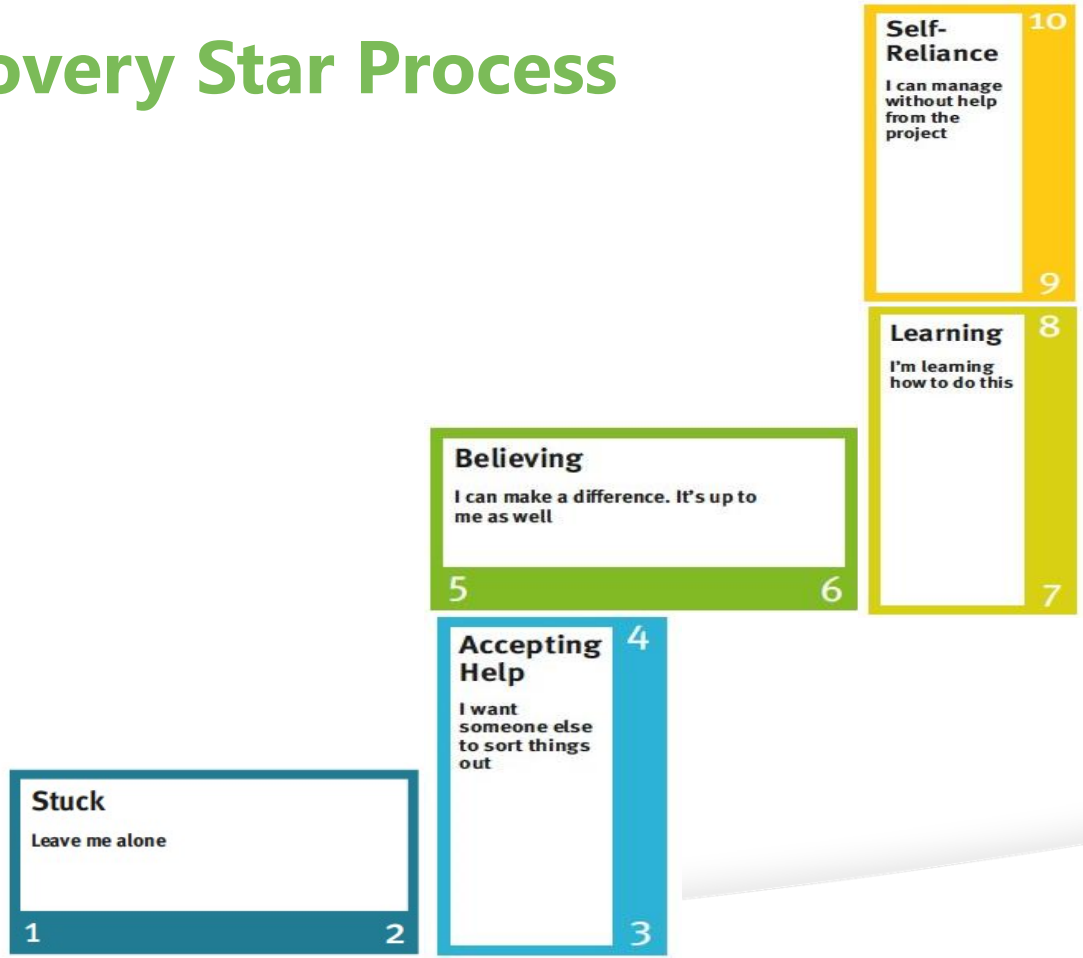
The Recovery Star Process



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Fifty four people have successfully journeyed through our transitional models on to more independent living over a period of two years.

The guiding principle of recovery is **HOPE** – the belief that it is possible for someone with a mental illness to regain a meaningful life.

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Transitional Residential Support

Closing Words

Peter Battle
Chief Executive Officer

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