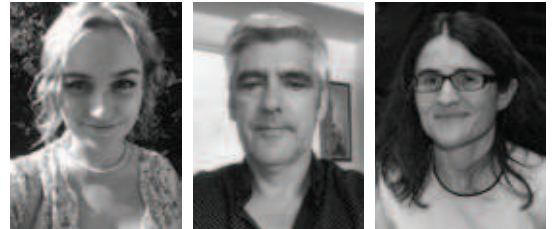


Recovery co-design and peer workforce development in the acute inpatient setting



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A pioneering program at a Melbourne hospital set out to reduce restrictive interventions in the acute inpatient unit. It set up a new team, led by a peer worker, to provide information and support to people in the Emergency Department while they were waiting for admission into the unit. This report explores and analyses consumer perspectives about the intervention.

For many people suffering from acute mental health episodes, the Emergency Department (ED) is not only a space for crisis assessments and support but also often the main access point for various clinical services including mental health in-patient units (Jelink & Andrew-Starkey 2015; Hamilton & Love 2010).

A key priority of Victoria's Department of Health and Human Services is to improve patient care, wait times and experiences within EDs (2009). This priority recognises that the ED can be a very stressful environment for those who work in it and those who access it, which is intensified by people presenting with mental health issues. For those who present with these issues in an already distressed state, the ED can be a traumatising experience (Hamilton & Love 2010). Although there have been significant studies focused on changes that can be made within mental health wards to reduce seclusion rates, many people are regarded to require seclusion as they arrive (Trauer, Hamilton, Rogers & Castle 2010).

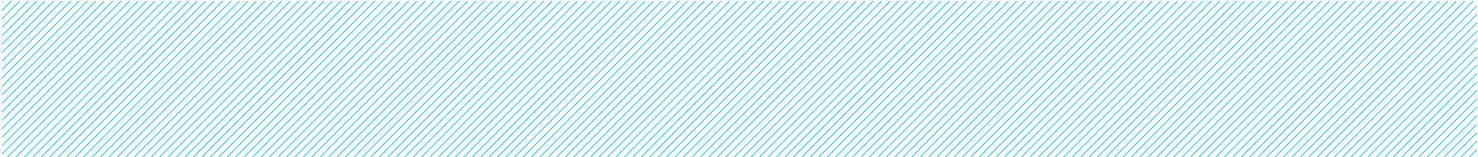
Background to the study

Consumers who have experienced restrictive interventions, such as seclusion, have reported feeling punished, abandoned, frightened and re-traumatised (Holmes, Kennedy & Peron

2004; Cleary, Hunt & Walter 2010; Kontio, Valimaki, Putkonen, Kuosmanen, Scott & Grigori 2010; Ross, Campbell & Dyer 2014; Hamilton & Love 2010). Humanistic ideology underpinning interventions that are focused on developing trust and rapport have been shown to reduce restrictive interventions in other mental health settings (Safewards 2015; Bowers 2014; Kontio et al 2010).

Informed by Victorian Department of Health and Human Services policy '*Providing a safe environment for all: Framework for reducing restrictive interventions*' (2013), Victorian hospitals were funded to develop strategies and interventions which aimed to reduce restrictive interventions. Recovery-orientated practice underpins this framework. This utilises lived experience and aspirations of consumers to inform best practice and aims to support individuals to live an automatic and meaningful life (Bland, Renouf, & Tullgren 2009; Department of Health and Human Services 2011; Commonwealth of Australia 2013)

The *National Standards for Mental Health Services* highlights that delivery of care should take an overall recovery-oriented approach and include the involvement of consumers in development, delivery and evaluation of services. Practices



and principles for specialist mental health services have been further defined by the Department of Health in the *Framework for recovery-oriented practice*, identifying the importance of incorporating recovery values and a peer support workforce.

In this context, St Vincent's Hospital, in inner city Melbourne, set about implementing recovery-oriented practice from 2004 onwards and development of a peer workforce from 2014. In 2013 preparations were made in the acute inpatient hospital context to reduce seclusion rates utilising a pilot study, looking at admission data and seclusion rates. This paper sets out to discuss this intervention: *Reducing restrictive interventions using the Pre-Admission Liaison (PAL) program*, using a peer worker role as central to the innovation.

A descriptive study was undertaken to explore data relating to circumstances surrounding restrictive interventions within one in-patient service in Melbourne (Chavulak & Petrakis 2017). Focusing on the link between the ED and restrictive interventions, it was found that half of the number of people who were admitted via the ED were first time admissions and half of those people experienced seclusion. For many people their seclusion episode occurred within the first four hours of admission.

Providing support, information & 'familiar faces'

Peer worker roles within the mental health system are newly emerging in Australia.

Worldwide people with lived experience are being increasingly employed in paid peer worker roles. This work is achieving positive consumer outcomes (Campbell 2005; Chinman, Young, Hassel, Davidson 2006; Gray 2014). Research has found that a peer worker can offer a sense of hope to those experiencing a 'patient role' and can supplement care in a different way than traditional clinical systems can (Austin, Ramakrishnan & Hopper 2014).

Informed by this evidence, the Pre Admission Liaison (PAL) Team was developed at St Vincent's to support people who had been assessed within the ED as requiring an in-patient admission. The team was led by a peer worker, accompanied by a nurse from the Acute In-Patient Service (AIS), and tasked with visiting people in the ED following assessment, to:

- explain the process of transferring to the AIS
- provide an introduction so the person would have familiar faces in the unit
- offer sensory modulation to make them more comfortable and more connected to reality
- have a conversation to help the person feel safe and supported.

It was suggested that by the time the person did come to the ward they would be less agitated and hopefully would not require seclusion.

These visits aimed to facilitate information sharing of processes and create a space whereby the person could voice any concerns or queries they had regarding their experience and the process; with a key focus on utilising the lived experience of the peer worker. Once on the ward, the person would have follow-up access to the peer worker alongside their nursing care and prior introduction was aimed to develop early rapport.

It was hoped this intervention would alleviate some concerns early on, with the goal of reducing agitation levels during and post transfer process, so that restrictive interventions methods would not be used as often.

The views of those who experienced this intervention were regarded to be of critical importance to understand the impact of such changes.

Research Question

What is the feedback from consumers regarding the Pre-Admission Liaison team and support received during transfer from the Emergency Department to the Acute Inpatient Service (AIS) at a Melbourne hospital?

Method

Research design

This project utilised a peer worker part-time to be available to liaise with consumers waiting in the ED for admission to the AIS during the hours of 12pm-4pm Monday-Thursday. It was a one year project. This was based on funding availability and the times allocated had the highest rates for admissions to AIS. Following a six month establishment phase in the project, a mixed-methods research design was added to allow for both quantitative and qualitative data to be collected; being a descriptive study of who the service was able to engage with PAL visits, and their opinions and feedback.

Data collection

A survey tool comprising of both measurement (Likert scale) and text responses was designed to collect detailed data from consumers regarding their access (or lack of access) to the PAL Team. This also collected demographics of participants. Admission records were accessed to compare demographics of those who were surveyed to the general cohort who were admitted to the AIS via the ED.

The survey was designed to be completed either online via SurveyMonkey or on paper, to increase the accessibility for consumers on the ward. Where possible the peer worker member of the PAL team assisted consumers to complete the survey. This approach was in line with that used successfully in the National Consumer Experience of Care survey, and was intended to increase consumer confidence regarding providing feedback. In a few instances a PAL team clinician provided this facilitation.

Data analysis

The quantitative survey responses were analysed descriptively and the qualitative responses were analysed thematically.

Ethical considerations

The hospital Human Research Ethics Committee deemed this research a quality assurance activity and it was approved under the 'Recovery-Oriented Practice and Peer Workforce Development' project. A second ethics process was undertaken and approval was gained from the university Human Research Ethics Committee to involve academic and student researchers.

As this research occurred within an inpatient setting, effort was made to ensure that participants were asked at appropriate times and participants could give informed consent to participate. All participants were given the options to have assistance or to complete the survey confidentially.

Recruitment

Although the project was funded for one year, it took some months to establish a peer worker in the AIS setting. Once that was achieved, data was then collected and surveys conducted. During this time there were 194 people admitted to the in-patient unit, with 40 of those receiving a PAL visit (20 per cent or 1 in 5 people). The PAL surveys were conducted for approximately six months of this year. There were also four extra PAL visits completed, however these people were discharged from the ED.

There were 35 surveys collected, however five people specifically stated they did not want their results reported on, and three more did not give their consent, therefore this report only includes those who did consent. The purpose of this survey was to engage and report feedback from people who came via the ED; two of the remaining 27 respondents were not admitted via the ED, therefore this report will only focus on the 25 who did come via the ED.

Results

Demographics

With regard to gender, nine (36 per cent) identified as female, 15 (60 per cent) as male and 1 as neither. For the general cohort during the time of data collection, 52 per cent identified as male and 48 per cent as female, so there are fewer female voices represented by the surveys than the general cohort. The same person who did not specify their gender did not specify their age, however of the remaining 24: four were 18-25 years old, four were 26-35, eight were 36-45, four were 46-55 and four were 56-65 years old.

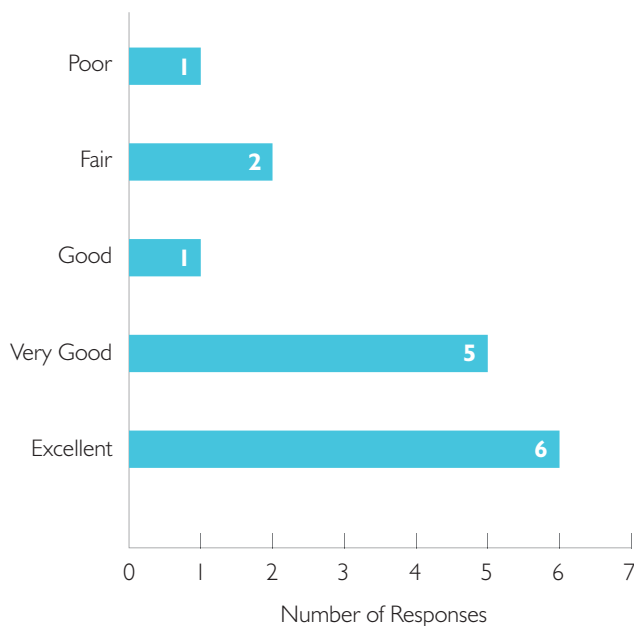
This is a very even spread across all ages and was reflective of ages of people within the in-patient unit at the time. Data from patient records during the time period of this survey indicates a similar curve in ages. The mean, median and mode age group was between 36 and 45.

Only three participants stated their preferred language was not English, the rest identified English as their preferred language. Fourteen people – over half – had the assistance of the peer worker from the PAL team fill the survey out; seven people (less than a third) opted to fill the survey out on their own.

Experience with PAL Team in ED

Overall 15 out of 25 people surveyed (60 per cent) reported seeing the PAL team in the ED. See Figure 1 below for their ratings of the intervention.

Figure 1: Responses to PAL team interventions



One comment of note in this section was from someone who did not have access to the PAL team. They stated they only saw:

"Just the other staff, security, nurses. No one could tell me why [I was going to go to the AIS], or say 'you are going through an episode'. I was intense, but no one told me my rights. [The] police laughed at me [in the] divvie van".

This experience will be explored further in the discussion.

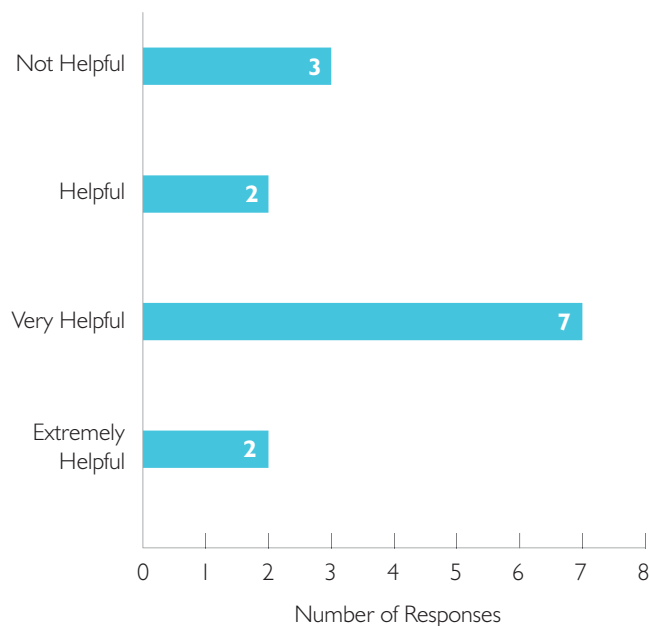


Overall 7 out of the 15 who had access to PAL elected to provide comment, and all were positive. One comment in particular raises questions as to where the PAL team could be improved, in saying “Friendly enough but didn’t really have anything specific that I personally found to be of use.” This too will be explored in the discussion. The remaining comments involved respondents’ feelings of being calmed and relaxed before their transfer, and being generally happy with the interaction.

Experience with peer worker (specifically) in ED

There were 14 people who also explicitly remembered meeting the peer worker (who is present on every PAL visit). One person, who stated they had seen the PAL team, said they had not seen the peer worker. Participants were asked how helpful they found the peer worker’s intervention during the PAL visit. Below are the results (Figure 2).

Figure 2: Peer worker rating



One participant who did not have access to the PAL team intervention stated they would have liked to have met such a person during their ED stay.

One of the ‘not helpful’ responses explains: “I wanted a mental health advocate.”

The other two ‘not helpful’ responses did not comment.

Four responses were relevant to the peer worker role, with statements such as that it was:

“Good to talk to someone with shared experience.”

“Nice to have a welcoming committee.”

In the AIS: Post Contact with Peer Worker

Overall 16 people (64 per cent) reported interacting with the peer worker once they were in the AIS. One stated he was unhelpful, 6 stated he was helpful, 6 stated he was very helpful and three stated he was extremely helpful. Not many people gave additional feedback (6 people who had access and 2 who did not have access to peer worker), but all feedback given was positive.

One suggested they would like the peer worker to take on more of an advocate role. The participants who did not meet with the peer worker in the AIS said that would have been good, and one stated they had asked for one but the request had not been met (possibly this was outside the hours of the pilot role). Other feedback included that it was useful to have someone to explain things for them, and overall being “helpful”.

Discussion

Achievements

Although there were a few missed opportunities and limitations regarding the times where people are admitted to the AIS, one in five people were able to have access to a PAL visit. This is commendable for a new program with restricted hours due to being a pilot with a limited budget, in a busy environment, with diverse staff input, whereby the program required inter-disciplinary communication across different services.

The age demographic of the sample collected was reflective of the population studied, however males were overrepresented in the gender of participants.

Overall most of the feedback was positive and reflected that participants valued being informed, having contact with people who have shared experience, and creating safe and positive links in the ward.

The qualitative component of this study allowed for consumers to voice their experiences in their own words. This allowed the service to gain insight into the experiences of participants in relation to the PAL Team interventions but also their experience more broadly.

Worthy insight was gathered from a participant who did not have access to the PAL team in the ED. As shown in the results, they stated they would like to have access to the PAL team; that they had had a negative experience of being in the ward and their experience of being brought in by police had been quite distressing.

Consumers who have experienced restrictive interventions, such as seclusion, have reported feeling punished, abandoned, frightened and re-traumatised.

Another participant commented that they would have liked the peer worker to play more of an advocacy role, which highlights a possible area of service improvement to potentially provide greater access to mental health advocates during this process.

A key achievement of this project was the introduction of a peer worker within an acute inpatient service. Although the peer work role has been growing within the mental health community support sector, this was truly a pioneering project in a clinical setting.

Challenges

A key focus of this study was to capture the voices of people who are experiencing an acute episode, however this posed a variety of challenges for the study. There were some questions regarding the ability for participants to give genuine informed consent due to their mental state. During acute episodes or traumatic experiences cognitive functioning may be impaired, such as memory, which made it difficult for participants to remember the intervention of the PAL Team even if it was documented that it occurred. There were those who were too distressed to complete a survey during their stay; and with the aim of being least restrictive as possible in a time where people are vulnerable it was important for participants not to feel pressured or approached too many times to complete the survey. This contributed to the smaller than hoped for sample size of the study.

The peer worker role was integral to this intervention and was aimed to be utilised in a variety of different ways, including collecting the data. This helped develop the relationships between participants and the peer worker; however it also meant that participants were answering questioning pertaining to the evaluation of a person's intervention to the person. This may have had an impact in the responses collected.

The timing that the peer worker was available to carry out the PAL Team intervention was also limited due to funding for 16 hours of weekly peer work being provided for the project. In order to determine the times the peer worker would be available to intervene the times for admission to the AIS were explored; explaining the choice for afternoon shifts. During the project this rationale was questioned due to long wait times in the ED. Rather than being present at the times people were admitted, joining people in the mornings when most people were waiting in ED to be admitted into the AIS could have increased support to people during the time of the pilot on reflection. This could have also increased the sample size of the study.

As previously and importantly reflected as an achievement, the introduction of the role of a peer worker into an acute setting was not without its challenges. There was some difficulty initially in terms of maintaining someone in the role of peer worker, due to the complex nature of the role. Important changes were made, such as increased supervision and support, and employing someone who had a long history of working within the peer workforce and was already known within, and familiar with, the specific service setting.

The nursing staff in the AIS were often extremely busy and at times agency nursing staff were utilised, which had implications for the PAL team interventions, both practically and ideologically. It was difficult for nurses to find time to accompany the peer worker to the ED. This was identified early on and nursing staff were given information and a consistent message from management about the intervention which assisted with nurses becoming available. Agency nursing staff were not privy to this training and consistency of message so at times this message was lost.

Overall most of the feedback of this new program was positive and reflected that participants valued being informed, having contact with people who have lived experience, and creating safe and positive links in the ward.

The busy ED environment also was often not conducive to a therapeutic intervention, and many of the ED staff were not aware of the purpose of the intervention. Many efforts were made to inform and provide a consistent message to this area of the hospital; however this was very challenging due to the high paced environment; the sheer volume of staff and that the primary purpose of the ED was to assess emergency medical conditions rather than as a waiting area for people with acute mental health issues.

Conclusion

This report aimed to explore consumer perspectives utilising a survey within an acute in-patient service. The surveys collected to evaluate the Pre Admission Liaison Team's interventions showed to be overall positive. The aim of these interventions was to utilise a peer worker to provide information and support to people waiting for admission into the Acute In-Patient Service who were experiencing an acute episode. More broadly, this project aimed to broadly assist with hospital flow and reducing restrictive interventions. Although this was only a small sample,

it does raise and confirm themes which are important to consumers; such as being informed and working with people who have shared experiences. This pioneering intervention had its challenges however much was learned in regards to introducing peer work in an acute setting and ensuring the voices of consumers are heard within this space.

Acknowledgements

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