Applying Values-based Practice for People Experiencing Psychosis:

A training pack for inpatient settings

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Welcome and introduction

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Aim of the course

To provide:

- Multidisciplinary education applicable to all staff working in inpatient units.
- Specific focus on values-based practice (VBP) and people experiencing psychosis.
- General focus on the broad application of VBP in clinical decision making.
- Overall education objective is to provide the skills and theory to provide practice that is values-based.

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Shared rules

Ground rules: The physical space

- Breaks, emergency exit, food, toilets.

Group rules: The psychological space

- Respect the values of all the group members.
- Respect the shared space.
- Respect confidentiality of discussion.
- Use language that is appropriate.
- Be tolerant of different perspectives, types and levels of experience.

Anything else to add?

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Group introductions

Introductions:

- Name.
- Reasons for being here today.
- What you want to get out of the course.

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Overview of the course

- Section 1: Introduction to values-based practice.
- Section 2: Reason to include all values.
- Section 3: Creating a space to understand psychosis.
- Section 4: Practice analysis – using skills in practice.

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Section 1: Introduction to VBP learning outcomes

Learning points:

- Point 1: What are values?
- Point 2: What is VBP?
- Point 3: Key principles of VBP.
- Point 4: How will the key principles be taught?

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Point 1: What are values?

- Group brainstorm on values
- Differentiate between moral values, ethical values and preferences.

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Point 2: What is VBP?

- Fulford defines VBP as:

  '*The theory and skills base for effective healthcare decision making where different (and hence potentially conflicting) values are in play*.'

  (Fulford, 2004).

- The aim is to reduce conflict in situations where there are different values.

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What does VBP do?

Generally it provides the theory and skills to:

- Make clinical decisions inclusive of different values.
- Apply clinical decisions that are informed by all the parties involved at the time.
- Provide care that is patient/person/user-centred.

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Point 3: 10 key principles of VBP

- There are 10 key principles that provide the overarching framework for VBP.
- VBP works by applying the principles in specific situations.

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10 key principles of VBP (1)

Practice skills

1. AWARENESS: of the values present in a given situation. Careful attention to language is one way of raising awareness of values.
2. REASONING: using a clear reasoning process to explore the values present when making decisions.
3. KNOWLEDGE: of the values and facts relevant to the specific situation.
4. COMMUNICATION: combined with the previous three skills, this is central to the resolution of conflicts and the decision-making process.

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10 key principles of VBP (2)

Models of service delivery

5. USER-CENTRED: the first source of information on values in any situation is the perspective of the service user concerned.
6. MULTIDISCIPLINARY: conflicts of values are not resolved in VBP by applying a ‘pre-prescribed rule’, but by working towards a balance of different perspectives e.g. a multidisciplinary team working together.

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10 key principles of VBP (3)

Values-based practice and evidence-based practice

7. THE 'TWO FEET' PRINCIPLE: all decisions are based on facts and values (values-base and evidence-base work together).
8. THE 'SQUEAKY WHEEL' PRINCIPLE: we only notice values when there is a problem.
9. SCIENCE AND VALUES: increasing scientific knowledge creates choice in healthcare, which introduces wide differences in values.

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10 key principles of VBP (4)

Partnership

10. PARTNERSHIP: in VBP decisions are taken by service users and the providers of care working in partnership.

(Woodbridge et al, 2004)

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Point 4: How will the key principles be taught?

- Values are all around but we cannot touch feel or see them.
- This training will attempt to bring values into focus through exercises, prompts and guides that enable you to reflect on experiences.
- The reflective template guides your application of VBP in a particular situation.

Reflective Template (Woodbridge *et al*, 2004)

	Comments
Awareness	
Reasoning	
Communication	
Knowledge	
User–centred	
Multidisciplinary	
The ‘Two Feet’ Principle	
The ‘Squeaky Wheel’ principle	
Science and values	
Partnership	

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Section 2: Reasons to include all values

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Learning outcomes

- To increase awareness of the importance of values and to consider clinical practice in light of this.
- To consider historical and contemporary reasons for practice change.
- To challenge institutional practice through language analysis and preconceptions.

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Section 2: Modules

- Module 1: VBP within contemporary health care.
- Module 2: A clinical approach that includes both understanding and explanation.
- Module 3: Validating a person's experience.
- Module 4: Supporting person-centred decision making.

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Module 1: VBP within contemporary healthcare

Learning points:

- Point 1: Individual values (clinician).
- Point 2: Changing values of healthcare.
- Point 3: VBP provides a balanced approach.
- Point 4: Individual values (patient).
- Point 5: When patient values are ignored.

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Point 1: Individual values (clinician)

- Handout 2.1: Personal and professional values

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Point 2: Changing values of health care

Reasons for a values-based approach:

- Historically, healthcare decisions were made by the medical team on behalf of the person. The person was seen as the totality of their diagnosis, for example '*a schizophrenic*' rather than a person living with schizophrenia.
- The consequence was people were not included in their care and were passive recipients rather than active partners of care.

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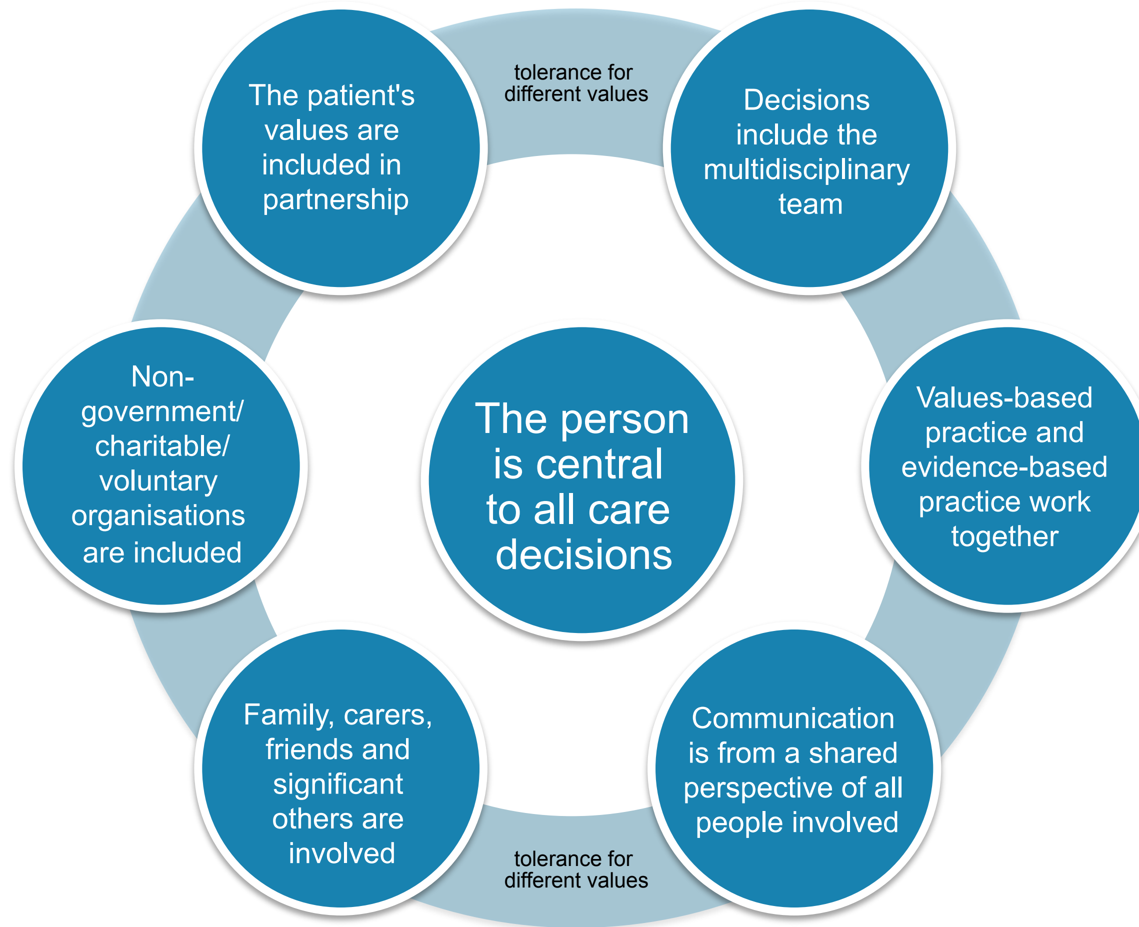
PowerPoint slide 2.7

21st century mental healthcare



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Point 3: VBP provides a balanced approach

- All knowledge is considered in equal ways.
- Provides a wider view to enable the complexities of health to be considered.
- A democratic rather than autocratic approach that allows all relevant areas to be explored.

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Balanced decisions

- Balanced decisions are inclusive of science and values.
- VBP provides subjective information derived from personal experience.
- EBP provides objective information derived from research.
- VBP + EBP = healthcare decisions.

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Balanced approach = informed approach

Information is gained by using:

- **Skills** to derive knowledge of values and facts relevant to the situation.
- **Model of service delivery** that considers the patient's perspective first so it isn't lost to professional knowledge.
- **Multidisciplinary** knowledge that incorporates all the different perspectives.
- **Partnership** with other agents outside of immediate health providers.

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Point 4: Individual values (patient)

- What would be one example of person-centred care?
- Consider the example on the next slide.

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Generalised care

Decisions of care

- You are working on a medical ward nursing an 86 year old lady called Janice. She was admitted two weeks ago having taken an overdose of her morphine medication which had been prescribed for chronic back pain. The lady is in the early stages of dementia. All investigations are within normal limits. She has been on the ward for two weeks and is currently awaiting placement in a residential care home.
- It is a morning shift and you are looking after Janice, what sort of general routines would be put in place for Janice?

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Individualised care

What do you think the patient priorities may be?

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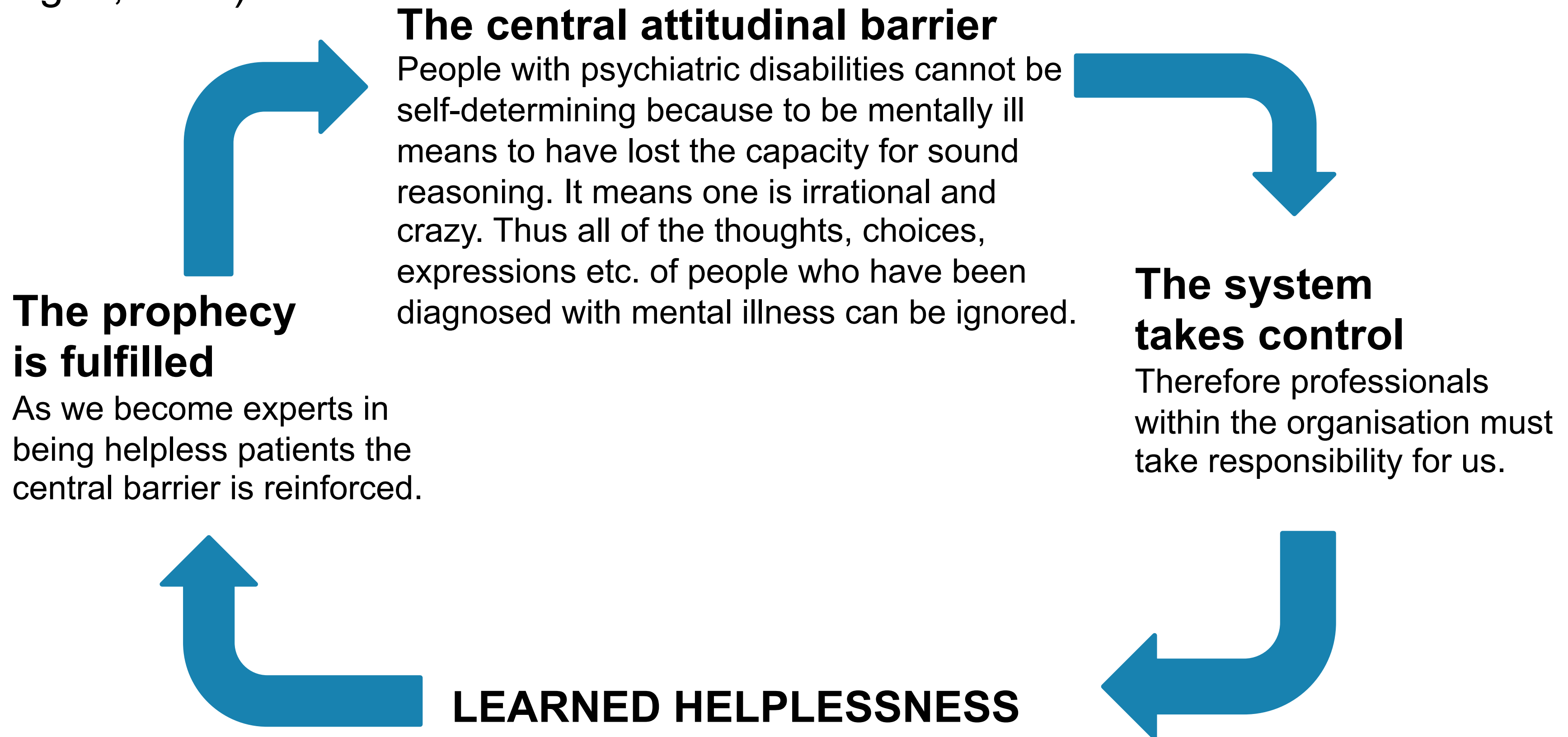
PowerPoint slide 2.14

Point 5 :The cycle of disempowerment and despair

(Deegan, 1992)



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Discussion of the cycle of disempowerment and despair

- VBP and evidence-based practice (EBP): which is the dominant practice?
- How can balance be restored?
- Can you think of any other consequences of not including the patient's values?

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Clinical consequences of being unaware of patient's values

Can lead to:

- Biases.
- Neglect.
- Blocking the person's recovery.
- Passive recipients of care rather then active participants.

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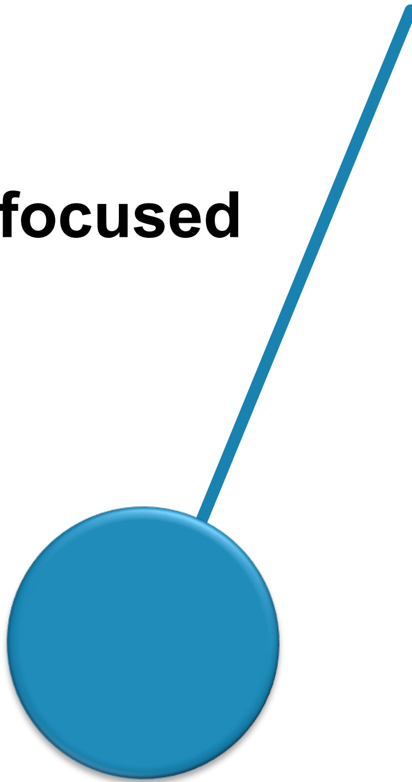
Evidence-based practice and values-based practice

Illness focused

Patient focused



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Which way is the pendulum swinging?

In the ward

1. Patients spend time in their beds not involved in the ward activities. The clinician sees this as their choice; part of their self-determination and recovery.
2. Patients spend time in their beds not involved in ward activities. The clinician sees this as part of their pathology; that they are isolated and withdrawn.

Patient is seen as

……………………………….

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Including patient values in clinical decisions

- Consider patient values in decision making.

BUT

- Needs to be considered in line with medical perspective.

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Individual care with the person experiencing psychosis

- What are the complexities that living with psychosis brings?
- How do we provide user-centred care to the person whose sense of reality is different?

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Maybe we need to look in a different spot

A policeman sees a drunk searching for something under a street light and asks what the drunk has lost. He says he lost his keys and they both look under the streetlight together. After a few minutes the policeman asks if he is sure he lost them here, and the drunk replies, ‘*no*’, and that he lost them in the park. The policeman asks why he is searching here, and he replies, ‘*this is where the light is*.’

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Maybe we need to change familiar language

- Consider new narratives and meanings to express the person’s situation.
- Consider the tensions between familiar and new language.
- Reflect on the tensions of working in new ways that brings in different knowledge.

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Module 2: A clinical approach that includes both understanding and explanation

Learning points:

- Point 1: Awareness of impact of values from a patient's perspective.
- Point 2: Awareness of impact of values from a social perspective.
- Point 3: Awareness of impact of values on a medical perspective.

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Point 1: Awareness of the impact of values from a patient's perspective

Handout 2.2: Experience of hospitalisation.

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Reflecting on experiences of hospitalisation

Handout 2.2 Questions:

How do the readings make you feel?

- What is Pat Deegan experiencing?
- How does that make her feel?
- How do her experiences relate to values?

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Point 2: Awareness of the impact of values from a social perspective

Handout 2.3: Social perspectives that devalue people with mental illness

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Point 3: Awareness of the impact of values on a medical perspective

The following slide demonstrates the influence of experience on a medical perspective. How and to what degree this relates appears to be influenced by individual experience.

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Influence of experience on psychosis

- The following table summarises particular views discussed in a document about psychosis and schizophrenia titled *Understanding Psychosis* (British Psychological Society, 2000; 2014)

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Analysis table: Influence of experience on psychosis (Adapted from BPS, 2014)

Medical/causative	Overlap	Individual understanding
Whilst drugs that reduce dopamine can help with psychotic experiences, it doesn't mean that dopamine abnormalities cause psychosis.	Abuse and trauma may affect brain chemistry.	Childhood exposure to trauma may lead to a stress vulnerability.
Diagnosis based on causation explained through generalised symptoms across populations.	Cause and effect variable across populations according to individual experience.	Individual responses are based on reasons and experience, rather than medical causation.
Medical model based on the identification of problems and deficits.	The experience may have a positive meaning for the person.	Individual responses to the phenomena vary.
Diagnosis based on descriptions that vary according to individual interpretation or culture.	Need to balance experiential and descriptive knowledge.	Individual knowledge unique for the person experiencing psychosis.
Psychotic symptoms based on idea of abnormality.	Accepting of difference according to personal choice.	Understand human traits; it's how a person is, not necessarily an 'illness'.
Research examined possible abnormalities in brain structure.	Findings complex and contradictory. Modest difference between people with or without a history of psychosis.	Brain scans of London taxi-drivers show enlargement of certain brain structures.

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Perspectives expressed in a multidisciplinary team meeting

- Research examined how person-centred a community team was by analysing types and frequency of topics discussed.
- It provided a challenge to the idea that VBP was already being done.

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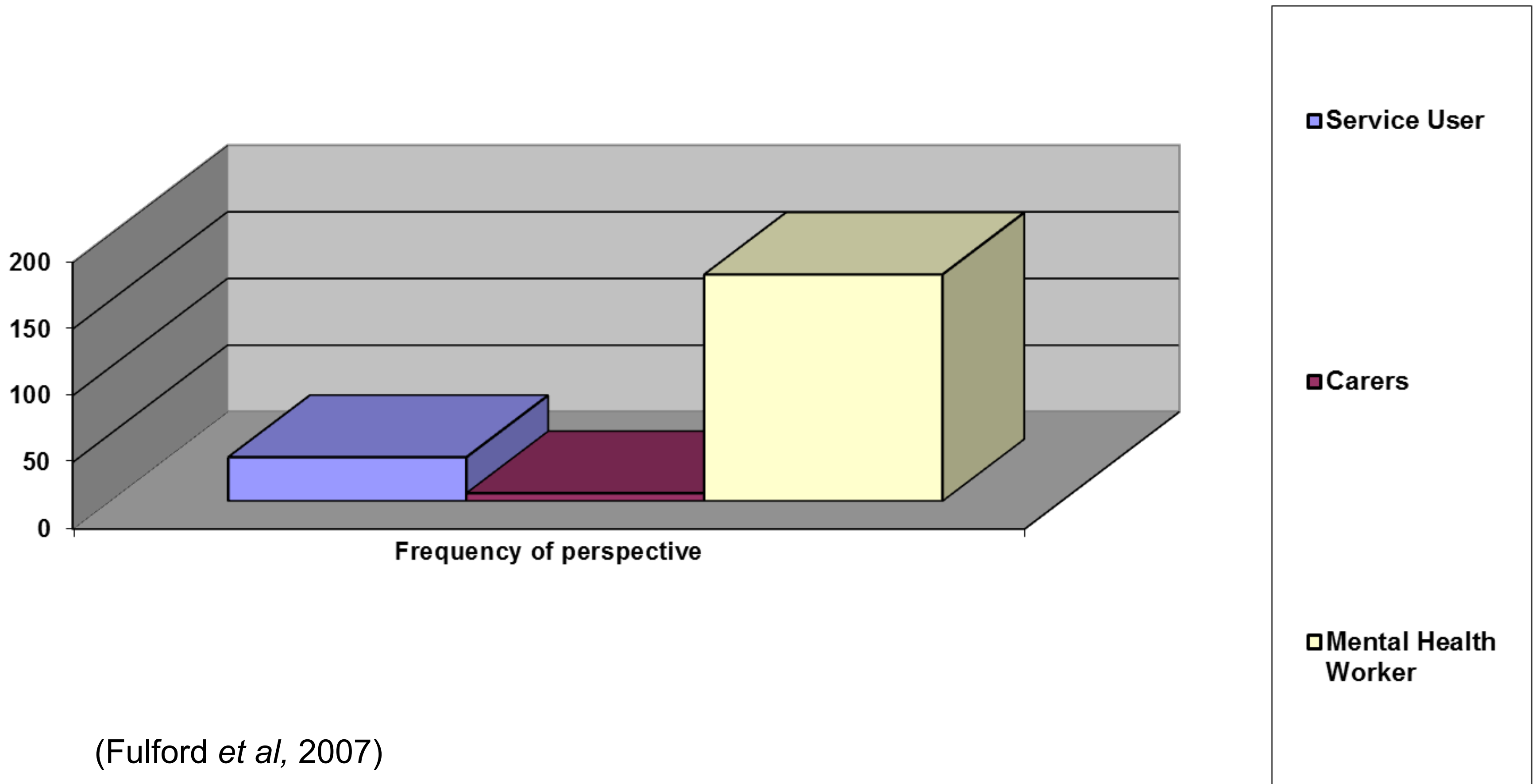
Frequency of perspective



(Fulford *et al,* 2007)

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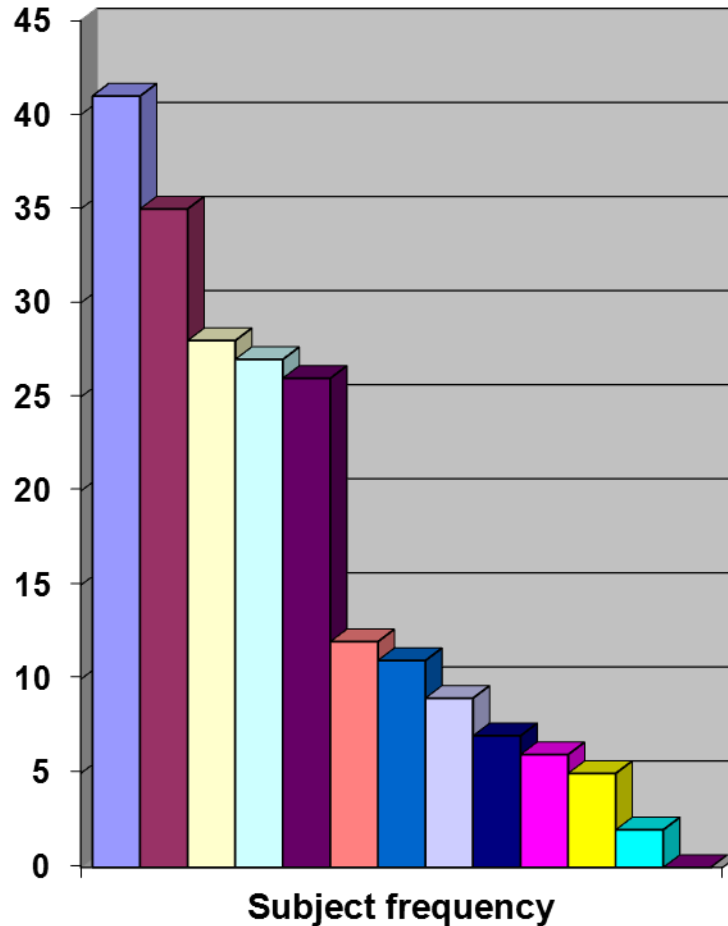
Subject frequency



medication
symptoms
discharge
engagement
family
physical health
occupation
interventions other than medication
referral
accommodation

(Fulford *et al*, 2007)

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Values blindness

- It found ‘values blindness’; where a lack of awareness of the different values is present in a situation.

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Research findings

'Despite the team's commitment to person-centred practice, a large majority of the comments reflected their own priorities rather than those of their patients. Thus it has been known since the pioneering survey work of the sociologist Anne Rogers, David Pilgrim and Richard Lacey in the 1990s that what matters to people with long-term mental disorders are issues like housing, employment and a social friendship group.'

(Rogers *et al*,1993)

'*But the care review meeting was almost entirely taken up with clinician priorities such as medication and risk management. The team's surprise at the extent of the disjunction between their person-centred intentions and their person-centred practice provided a strong basis for the training that followed*.'

(Fulford *et al*, 2012).

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Reflecting on learning

There is something very individual about healthcare that scientific generalisations may miss, therefore there is a:

- need for EBP and VBP
- need to consider the person's experience outside of a medical framework
- need to be user-centred.

Anything else you would like to add?

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Module 3: Validating a person's experience – communicating in a way that is meaningful for the person

Learning points:

- Point 1: Comparing two accounts of mental distress: personal narrative and professional interpretation.
- Point 2: Challenging the limits of scientific integrity.
- Point 3: Hearing the person's perspective by changing clinical communication.
- Point 4: Validating the person's story (narrative).

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Point 1: Comparing two accounts of mental distress – personal narrative and professional interpretation

Handout 2.4: Two accounts of mental distress

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Reflecting on two accounts of mental distress

Questions about Handout 2.4

- What do you notice about the two notes?
- What information is the medical writing giving about Mary?
- If you were a relative or a friend of Mary would you be able to understand it?
- What information is Mary's diary telling you?
- How are you able to understand it?
- Can you consider how Mary's diary information may be included in the chart without losing its character?

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Point 2: Challenging the limits of scientific integrity

- Handout 2.5: An experiment in social interpretation

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Reflecting on an experiment in social interpretation

Questions about Handout 2.5

1. What is influencing the diagnosis?
2. What are the limits to a scientific view?
3. How could being curious provide a broader view?

Group discussion

- Discuss interpretation as a way of understanding.
- What are the challenges of this within an inpatient unit?

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Point 3: Hearing the person's perspective by changing clinical communication

- Handout 2.6: A reason to connect

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Reason for tolerance

'Admonishing the person for his/her inappropriate or unacceptable behaviour is likely to exacerbate the situation by demonstrating that we do not understand or empathise with his/her distress. The behaviour may be self-destructive or unacceptable but it is understandable. We must demonstrate our understanding if we are to help people to find ways of living with what has happened to them.'
(Repper & Perkins, 2003).

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Understanding the person from their own frame of reference

- If you are finding it difficult to engage with a patient, why is this? Maybe try reflecting in the moment on the situation.
- Be mindful of your values being a potential barrier to engagement. Maybe you need to leave them aside for a moment.
- Consider if and how you are listening.
- How clear are you about the patient's perspective?
- Do you know their values?
- Do you need to ask further questions?
- What are your priorities?
- Is there an opportunity for a shared understanding?
- How can you negotiate around the difference?

(Adapted from Egan, 1994)

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Point 4: Validating the person's story (narrative)

- Handout 2.7: Validating the person – Helen's narrative

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Reflecting on validating the person's story

Questions about Handout 2.7

- What is happening for Helen?
- What values are important for Helen?
- How would you explain any conflict between Helen's values and the nurse's?
- Consider the language of the script. Can you identify anything that may not be a shared perspective between Helen and the nurse?
- Why do you think she is disengaged?
- How are we linking in with her around this?

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Module 4: Navigating person-centred decision making when there are different values in play

Learning points

- Point 1: Values in clinical decision making.
- Point 2: Reflecting in/on practice.

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Point 1: Values in clinical decision making

- Handout 2.9 : Values conflict between clinicians

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Reflecting on values conflict between clinicians

Questions about Handout 2.9

- Are all parties concerned with the best for Paul?
- What do you think is driving Kate's decision?
- What do you think is driving the doctor's decision?
- What do you think is driving Lucy's decision?

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Point 2: Reflecting in/on practice

Ways to reflect in/on practice:

- Reflecting in practice means bringing decisions to conscious awareness during the moment.
- Reflecting on practice means bringing decisions to conscious awareness through reflection on a past event.

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Thinking about difficult decisions

- What influences clinical decisions?
- Think of a time when you had to make a difficult decision. What were some of the factors that influenced your decision?

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Section 3: Creating space to understand psychosis

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Learning outcomes

- Understand static influences on practice.
- Understand the dynamic aspects of disorder.
- Consider different perspectives on understanding.
- Provide meaningful practice.

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Section 3 modules

- Module 1: Exploring a biomedical perspective of schizophrenia – a professional view.
- Module 2: Understanding the person living with schizophrenia – an individual view.
- Module 3: Communicating meaningfully.

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Module 1: Exploring a biomedical perspective of schizophrenia – a professional view

Learning points:

- Point 1: Schizophrenia as a static condition – predictable outcomes and downwards trajectory.
- Point 2: Schizophrenia as a dynamic condition – fluctuating outcomes and unpredictable trajectory.
- Point 3: Challenging static terms – insight.

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Point 1: Schizophrenia as a static condition

- In 1904 Emile Kraepelin termed what is now known as schizophrenia as dementia praecox, that is, premature dementia.
- It was seen as:
  - a chronic disease that was unremitting, leading to progressive deterioration and early death
  - a purely organic disorder that left neurological degeneration and irreversible brain damage
  - having predictable outcomes and downwards trajectory.

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Static view of schizophrenia

Davidson described the following consequences of a static perspective.

'*Schizophrenia was viewed akin to a death sentence condemning the person to a life of increasing incoherence, emptiness and isolation and in this he would inevitably withdraw into his or her own world cutting off all ties to family friends and constructive membership in society until death would come to put the tortured soul to rest*.'

(Davidson, 2003).

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Point 2: Post-institutional view

During the 1970s researchers started to question the static nature of schizophrenia proposing that:

- It was a fluctuating condition.
- Effects were a matter of degrees.
- It involved fluctuating outcomes and unpredictable trajectory.

(Strauss & Carpenter 1974; 1977)

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Schizophrenia as a dynamic condition

Davidson described the following dynamic perspective.

'*In other words some people have hallucinations who do not have schizophrenia, some people have schizophrenia without having hallucinations and some people with schizophrenia go from having hallucinations to not having hallucinations and back again (or not) over time.*'

(Davidson, 2003, p11)

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Contemporary knowledge of dynamic factors

- Phenomenology (Stanghellini, 2004).
- Poverty (Read *et al,* 2005; Brown *et al,* 2000).
- Urban living (van Os *et al,* 2001).
- Bullying (Campbell & Morrison, 2007).
- Post-traumatic stress disorder (Geekie & Read, 2009).
- Stress vulnerability (Zubin & Spring, 1977).
- Trauma (Read *et al,* 2005).
- Accepting voices (Romme & Escher, 1993).

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Point 3: Challenging static terms – insight

Handout 3.1: Insight

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Module 2: Understanding the person living with schizophrenia – an individual view

Learning points

- Point 1: The dynamic person – interacting with the world.
- Point 2 : A dynamic state of possibility.

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Point 1: The dynamic person – interacting with the world

Handouts 3.2, 3.3 and 3.4: Intersubjective nature of experience.

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Point 2: A dynamic state of possibility

Reading: Hope

- '*When I hope it will rain I do not necessarily believe it "will" or "may" rain. Hope is a different thing, liberated from actuality and probability because hope is a unique modalisation of belief carried out in the mode of possibility. I am not suggesting that possibility only arises with hope, but that when I hope, a unique possibility structure is in play*.'

(Steinbock, 2003).

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Hope: a feeling of expectation and desire for a particular thing to happen

Questions:

- Why do you think the consumer movement has identified hope as a fundamental aspect of well-being?
- How do you practise hope?
- How do you maintain your hope?

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Module 3: Communicating meaningfully

Learning points

- Understanding a meaningful care approach.
- Challenging reductionist views.
- Identifying value terms.
- Being aware of imbalance of values.
- Documenting information inclusive of consumer perception and experience.

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Point 1: Communication

Handout 3.5: Meaningful communication

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Reflecting on meaningful communication

Questions about Handout 3.5:

- What values are apparent throughout the extract?
- What are the value judgements?
- What is seen as desired, important, a priority?
- Are there any values missing?
- How would you document a balanced view? What could you include?
- What changes would reflect a meaningful communication?
- What plan of care could result from these changes?
- Complete the group exercise finding a space to understand the person.

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Section 4: Scenario analysis – using skills in practice

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Learning outcomes

Use the skills of:

- Awareness of values.
- Knowledge of values and facts to inform decisions.
- Reasoning on values.
- Communicating to resolve conflict.

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Section 4 modules

- Module 1: Awareness of judgements – pre-admission.
- Module 2: Staying curious during conflict and congruence – admission to the ward.
- Module 3: Analysis of knowledge influencing practice – inpatient dining room.
- Module 4: Bringing VBP together.

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Module 1: Awareness of judgements – pre-admission

Learning points

- Point 1: Reflect in practice on VBP principles
- Point 2: Aware of pre-determined assumptions: influence of personal, professional and past values on decisions
- Point 3: Reason around values
- Point 4: Negotiate, communicate and empathise

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Point 1: Reflect in practice on VBP principles

Handout 4.1 Reflective template

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Use of the reflective template

- A framework to support values-based clinical decisions.
- Highlights what is happening in the situation and areas for further consideration and clarification.
- Use as a VBP check to reflect **in** practice.
- Use as VBP check to reflect **on** practice (during clinical supervision).

Handout 4.2 Values-based practice principles

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Point 2: Aware of pre-determined assumptions – influence of personal, professional and past values on decisions

Handout 4.3 Pre-admission scenario

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Point 3:
Reasoning around values

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Scenario analysis

Comments: Reflecting on areas that need further investigation	
Awareness Finding out about John's values :	What are John's values. What is important for him?
Reasoning Reflecting on the decision and the reasoning behind this.	What was the reasoning behind the case managers decision to call the police? What other options could there have been? What reasoning sits behind these other options?
Communication Communicating to transfer information	Consider the communication between John and the case manager. What other communication options could there have been?
Knowledge Information and values relevant to the situation at the time	Who else has been in touch with John during this period? Contact the peer support worker and the case manager for further information to help with your decision.
User–centred An approach that considers John's values central to decisions	Is the decision being led by Johns values?
Multidisciplinary	Are there options to involve the multidisciplinary team?
The 'Two Feet' Principle A decision that considers John's values as well as the facts about paranoid schizophrenia	Is the decision balanced? What are the facts and values in this situation?
The 'Squeaky Wheel' principle	What does the case manager know abut the values that are important for John ?
Science and Values	The evidence tell us there is a relationship between psychotic symptoms and stress. Are there any stressor that we need to know about?
Partnership	How is the case manager working in partnership with John? What would need to happen for him to do this?

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Point 4: Negotiate, communicate and empathise

Handout 4.4 John's perspective

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Recommendations for effective communication

- Communicate in a way that attempts to meet where the person is at.
- Slow down.
- Avoid pre-judgments.
- Attempt to understand.
- Gather information from other sources – there may be other people who can shed light on the picture.
- Be mindful of only working from one perspective.

(Adapted from Egan, 1994)

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Module 2: Staying curious during conflict – admission to the ward

Learning points

Point 1: Using a VBP approach.

Point 2: Embracing a shared approach.

Point 3: Provide a choice of clinician wherever possible.

Point 4: Meaningful documentation.

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Point 1: Using a VBP approach

Handout 4.5: John's admission

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Point 2: Embracing a shared approach

Three keys to a shared approach:

1. Active participation with key people, including service providers and carers.
2. Provide different perspectives within a multidisciplinary team.
3. Use a person-centred perspective, building on strengths, resilience and aspirations, as well as needs and challenges.

(National Institute for Mental Health in England, 2008)

How can David connect with where John is coming from?

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Point 3: Provide a choice of clinician wherever possible

- Most people select as confidants people who share their own values, beliefs and experiences (Fehr, 1996).
- The relationship between a young, white graduate nurse, and an older mother of three who migrated to Australia from Malaysia, is quite different from that existing between the same nurse and a young person who has just dropped out of university because of her mental health problems.

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Are you the best person for that patient?

- Sometimes contradictory and competing values can impair relationships between mental health workers and those who have mental health problems.
- It could be difficult for a mental health worker with religious beliefs that declare homosexuality a sin to work with a gay patient. They must be humble enough to question if they are really the best helpers for certain individuals.

(Repper & Perkins, 2007)

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Point 4: Meaningful documentation

- David writes down: '*Difficulty with engagement, angry, resistive, concerned that he will leave the unit, cannot agree on his safety to be nursed on a constant observation high risk of AWOL (absence without leave).*'

Group exercise

- Complete a reflective template. What is missing in this documentation?
- Write the script that is inclusive of a shared approach.

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Module 3: Analysis of knowledge influencing practice – inpatient dining room

Learning points

- Point 1: Considering the situation.
- Point 2: Analysing reasoning.
- Point 3: Finding a shared understanding or allowing difference.

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Point 1: Conflict of values

Handout 4.6: Dining Room

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Point 2: Analysing reasoning

Handout 4.7: Sue's perspective

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Point 3: Finding a shared understanding or allowing difference

Handout 4.8: Choosing not to take medication

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Module 4: Bringing VBP together

Learning point: To bring together the skills of VBP.

Handout 4.9: VBP – bringing it all together.

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