

# @The Cygnet Journal

*Improving lives together*

Issue no.

01



Artwork created by service users at Cygnet Services



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# Introduction

## The First Edition

The initial concept for The Cygnet Journal was to provide a platform for showcasing some of the collaborative work which takes place within Cygnet and to ensure that this is accessible to carers, stakeholders and anyone else who shares an interest in our practices.

As a peer reviewed journal, its aim is to share research, quality improvement and developments that are professionally relevant, in addition to welcoming discussion and special interest pieces from people affiliated with the company.

As this first edition has taken a lot of work in establishing some of the logistics and processes needed to set up a journal it spans a longer time frame than we envisage will be covered in future publications.

There was a great deal of valuable work which was completed during the COVID-19 pandemic and whilst this period of health care history is now hopefully behind us, we wanted to recognise this work and the lessons learned from it.

We would like to thank our authors for their patience and everyone who has supported us in putting together this first publication.

We would also like to acknowledge and thank Dr. Naresh Rasquinha who was the initial instigator of The Cygnet Journal and who was a key member of the Journal Team before moving onto another post.

## The Cygnet Journal Editorial Team



### Dr Lorraine Bobbie Turnbull

Bobbie is a Consultant Clinical Psychologist working at Cygnet St William's, which is one of Cygnet Health Care's Neurological Rehabilitation hospitals. She is also the Cygnet lead for Research and Development, as well as being a member of the Greater Manchester Research Ethics Committee, and a reviewer for one of the UK Psychology peer review journals.



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Sarah is a Forensic Psychologist working within Cygnet Health Care's Neuropsychiatric service line. She has a passion for clinical research, with over 30 publications including academic articles, book chapters, manuals, and academic posters. She is regularly invited to act as a peer reviewer for academic journals and presents her work at national and international conferences.



### Raf Hamaizia

Raf's role as an Expert by Experience sees him using his perspective as a former service user in a variety of organisations within the public and independent sector. This has included the development of policy and guidance with NICE (National Institute of Health and Care Excellence), the Royal College of Psychiatrists and the NHS.

He is currently the Expert by Experience Lead at Cygnet, leading on the organisation's engagement and involvement initiatives.

## Writing for The Cygnet journal

If you would like to write an article for the journal, we welcome any of the following:

- > Research / QI / Audit projects
- > Opinion pieces
- > Service user / carer perspectives
- > Reviews
- > Articles around innovation
- > Book or training reviews

Submissions should be emailed to the editorial board at [TheCygnetJournal@cygnethealth.co.uk](mailto:TheCygnetJournal@cygnethealth.co.uk)

# Foreword

It gives me great pleasure to introduce the first edition of The Cygnet Journal, a series of articles by our clinicians and wider company experts, which provide sector-leading innovations and expert insights into the provision of high quality care.

This new publication showcases our innovative work and highlights the exceptional knowledge and skills of the individuals we have here at Cygnet.

Cygnet staff are the very best in their field and this journal showcases the pioneering work they are delivering in their practices, to ensure our service users and residents have the very best experience with us. We hope this Journal is the first of many, which will provide an opportunity for our staff to demonstrate, and evidence, the exceptional work they do.

Contributors to these articles are staff with specialist knowledge, across different disciplines of the organisation. Amongst others, topics discussed in this edition include Eye Movement Desensitisation and Reprocessing (EMDR) therapy, positive behaviour support plans and the COVID-19 pandemic and its impact on both staff and those we support.

The response of our clinicians and frontline staff at such a challenging time is a testament to why they work in a caring profession.

Over recent years we have seen Cygnet enhance the role of research and development within our organisation. This is critically important in ensuring we provide high quality care based on best available evidence. A culture of learning is fully embedded across Cygnet and we are an organisation that cares for its colleagues as much as its service users. That is why we are proud to invest so heavily in our teams.

Our research has made a significant impact on clinical practice across the organisation. These studies evidence the great work achieved in the company and our constant drive for quality improvement and clinical excellence.

Congratulations to all involved in producing the first edition and I look forward to seeing the research team grow and develop further.



**Dr Tony Romero, CEO, Cygnet**

# Support Workers', Experiences of Compassion Fatigue and Coping During COVID-19 Pandemic

## About the Authors



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## Abstract

### Background

Compassion fatigue is the feeling of exhaustion experienced by people caring for individuals in emotional distress. As the COVID-19 pandemic and lockdown impacted the mental health of the public, staff working in mental health care may have experienced compassion fatigue. This may have been mediated by the staff's coping ability. This study aimed to explore the experiences of support workers caring for people with mental health difficulties during COVID-19.

### Methods

This study followed a qualitative design. Semi-structured interviews explored participants' experiences of supporting people with mental health difficulties during the pandemic. Interviews were analysed using Interpretative Phenomenological Analysis.

### Results

It was found that job enjoyment was related to a person's identity, relationships and witnessing improvement in patient wellbeing, which were negatively impacted by the pandemic. People who were unable to use their established coping skills seemed to be more impacted by the pandemic.

### Conclusions

This study contributes to the understanding of staff wellbeing during the COVID-19 pandemic and highlights the importance of staff wellbeing services.

## Introduction

Compassion fatigue is emotional exhaustion resulting from caring for people experiencing emotional distress. Through learning about the trauma of others, individuals may experience symptoms of Post-Traumatic-Stress-Disorder (PTSD) themselves<sup>1</sup>. Compassion fatigue has been associated with reduced empathy towards patients, increased depression and anxiety, inadequate self-care, and unhealthy coping mechanisms<sup>2</sup>. Compassion fatigue may have affected mental healthcare staff during the COVID-19 pandemic, when long-term fear and restrictions appear to have impacted public mental health<sup>3,4</sup> and previous pandemics have been associated with depression and PTSD<sup>5</sup>.

### Methods

#### Design

This study followed a qualitative design to allow for a comprehensive understanding of participants' experiences. This study employed qualitative semi-structured interviews to allow participants' to explore their unique experiences.

### Materials

The semi-structured interview schedule (Appendix) covered; reasons participants chose to work in and enjoy their role, the impact of COVID-19, and how participants coped with difficult emotions before and during COVID-19.

### Recruitment

An email was sent to Cygnet Health Care Hospital wards which cared for adults with mental health difficulties. Eleven hospital managers agreed to participate and distributed an invitation email to their staff. All staff working with patients experiencing mental health difficulties were eligible to participate. All participants had worked as support workers during the COVID-19 pandemic.

### Data Collection

Interviews were conducted over the phone from a private room in the researcher's home, recorded on a dictaphone and deleted once they were transcribed.

### Data Analysis

Qualitative analysis aimed to explore the experiences of participants using Interpretative Phenomenological Analysis (IPA) and followed Pietkiewicz & Smith's guide<sup>10</sup> to understand the lived experiences of individuals<sup>11</sup>. Interview transcripts were read multiple times with codes generated, then categorised and sorted into themes. Similar themes were grouped together and overarching themes identified. Themes with a weak evidential base were discarded.

### Reflexivity

The researcher has worked with patients experiencing COVID-19 isolation protocols. To support quality of data analysis and reduce potential bias, the researcher regularly met with the supervisor to discuss themes and how these relate to participants' experiences.

### Ethics

It was acknowledged that interviews may be emotional. Informed consent was obtained and participants were reminded of their right to withdraw before the interview. Participants were asked if they would like to continue with the interview if they showed signs of distress. Participants were debriefed following the interview, informed of sources of support, and sent a debrief sheet to reiterate this information.

## Results

### Why I Enjoy the Job

#### Identity

Across all participants, identity and self-perception were significant reasons for working in support work;

"I feel like I can do this. Like, I'm talkative, I'm caring without trying to sound, like, quite generic." – P2

"I obviously find myself a very sociable person and I think that's one thing that they do, that the patients really, that they liked about me. I was always talking and engaging with them, so [...] that's something that I really like." – P4

Personal history was particularly important for P3.

"My dad, um, is mentally unwell. He's got [illness]. [...] I didn't really know what other job would ever suit me." – P3

#### Relationships

The relationships formed were seen as central to the enjoyment of support work, whether these were with staff or patients;

"I think it's the people I work with you know. Like staff and patients." – P2

"It feels nice to sort of connect with service users." – P3

#### I Make a Difference

Participants gained a sense of pride from their work particularly when seeing patients progress.

"For me it's seeing people take all the little steps in life, like sort of achieving towards their goals. That could be little things like [...] improving on their personal care, uh, improving on their sort of relationships with others, sort of opening up to being actively talking about sort of their issues and such. Um and I find all those little steps really rewarding cause I mean I've been through stuff myself. I know how difficult it can be." – P1

P2 described their own difficulties with mental health and seemed to take reassurance that things can improve;

"Seeing patients get discharged and stuff, and getting better, like, it's, this will sound silly but it's like proof that can happen." – P2

### Impact of COVID-19 on Patients

#### Life Disruption

Lockdown restrictions caused disruption to patients' routines;

"Their daily routine is just ruined, this individual would go to the shops every morning, and had that kind of routine of go to the shops, have a cigarette, do their bits, um, and just over time, and because of that, yeah, it definitely affected them, and definitely a bit of a relapse." – P1

"I always do sometimes feel sorry for some of the service users who want to go out on leave and I sort of imagine their point of view. They don't have anything to look forward to in the day, they want to go outside, off the ward, for like 15 minutes, it's probably the highlight of their life." – P3

Being able to go out on Section 17 leave, a leave of absence granted by a doctor while a patient is detained under the Mental Health Act, was seen as an important part of recovery and a significant milestone of hospital admission.

Patients experienced changes in their lives due to lockdown restrictions;

"You couldn't even go to the shop really unless you absolutely had to, like, even that concept like going out to get snacks like we would have to plan that, and stuff like that you know, so I imagine, everyone was kind of in the same boat really." – P2

"Men who lost contact with people, and stuff like that before they had been admitted and then Covid happened and they can't get back in touch with people, they can't see people. Um and that's quite sad." – P3

### Impact on the Admission Process

COVID-19 impacted patients' experience of hospital, from the point of admission through to discharge.

A common problem described was disruption to the discharge process;

"Transport would have to be quite highly planned and stuff would fall through because of Covid on the ward or on the ward they were going to, um negative like inconclusive Covid tests like slowing things down." – P2

"For some of them it's just a bit frustrating but for some of them it's completely set them right back to square one and ruined their discharge." – P5

Outbreaks on the ward caused distress for both staff and patients;

"We had Covid on the ward and we had to go into lockdown, it was a completely different like change in them. Complete opposite person. They were being quite verbally hostile, um threatened staff, um it was quite, quite a shock to see the change in them." – P5

### Personal Experience of COVID-19

#### Changes to Own Life

What made mental health support work particularly difficult is the shared experience of a mass trauma. Participants described difficult changes to their lives;

"It kind of changed my life. In a sense. Uh I was living in [area], uh the workplace I was working at closed down because of, cause of Covid, ended up having to move back to [area]. [...] That was probably the darkest time of my life, definitely." – P1

Participants struggled to get basic essentials;

"I don't really like appreciate just the small things that I had, like being able to go to [shop] without feeling like you're breaking the law. You know, to get some chocolate and stuff like that, just small bits like that.

Or even being able to just jump on a plane whenever you want, and stuff like that. It's like I'm just trying to live [...] you couldn't even get toilet roll, like it's such a small necessity and you're actually thinking like, trying to survive on that, it's just, it's kind of crazy you know." – P2

Participants were unable to partake in social activities due to restrictions;

"I haven't seen anyone. Apart from last weekend which was the first time I saw a friend from uni but apart from that I haven't seen anyone. So it threw that plan off completely." – P3

### Feelings at Work

#### Increased Demand

COVID-19 appeared to increase the stress of the job;

"I do like my job and I definitely do, and I handle stress quite well, there is an element of like, when Covid happened, it was, it was more stressful." – P3

For some patients, it was difficult to understand the reasons for restrictions;

"I worked with [redacted] patients last year um and whatever ward I was in the service users just couldn't get out of the ward, cause of the restrictions. Um a lot of them had difficulty understanding that." – P3

"They were sort of not understanding why they couldn't go out. It was like they think oh it's not as bad as you lot say it is." – P5

### Burnout

Increased demand led to feelings of exhaustion. Some participants reported burnout;

"I started to feel more like a number as opposed to an individual, which, that's obviously not what I signed up for. And I think that that's kind of why it burnt me out a bit, like because it started to matter less to me what I was doing, like I was clocking in and clocking out, and again that's not what I signed up to do." – P2

"I just started working in care work and that became my life really, I wasn't seeing any friends outside of work, which is really lonely, but that that's what happened." – P3

Increased stress made it difficult to empathise with patients;

"I try to put myself in their shoes and imagine what it would be like. If I'm having a stressful day at work, and to be really honest, if, a really stressful day on the ward does take away from empathising just slightly. You might not have the time or the space that day in your head just to like think about how they feel." – P3

### Fear

Participants described fear related to COVID-19;

"It makes you a bit paranoid as well because you see the virus is entirely invisible and um you know it you can't obviously like and it [...] can be potentially to anyone a killer." – P4

Fear of loved ones contracting the virus, particularly fearing spreading the virus themselves;

"Am I going to come back with it and kill my mum?" – P4

"I was more worried for like my elderly relatives that have health problems, I was worried for them." – P5

### Coping

#### Seeing the Positives

For some participants, part of coping with the pandemic was noticing the positive impacts, such as improvements in technological communication;

"With the technology nowadays staying connected is quite easy. [...] being able to have full on conferences with other services around the UK that's crazy." – P1

It was noted that patient care may have been improved due to longer periods of admission;

"While I felt bad for them and stuff like that I thought well let's just give them the best care that we can, in the sense that let's work on a lot of the skills that we wouldn't normally be able to touch on because they weren't here as long as, we would hope, as long as they were here now. There's always more we can do because we have more time." – P1

#### Coping Skills During COVID-19

Participants described a range of different coping mechanisms;

"I do quite a bit of mindfulness, meditation, um I mean I smoke, that's one of the big things, but that's more habitual. Um music, music helps, um video games, I mean I've done that since I was, I've been playing video games since I was very young. Um so it's kind of more of a safe space for me. – P1

"I've learned a lot of coping skills through being a client um I've had different types of counsellors, different stages, I've had DBT, I've had like an interpretive counsellor and I've got a psychodynamic counsellor now, we do like art therapy." – P3

When helpful coping methods were used but no longer worked, participants turned to maladaptive coping mechanisms;

"Um I've always done mindfulness as like since I was in school. I've done that, I did that throughout the pandemic. Um I think there was a time where like even that wasn't helping, so I ended up, I was just like, going to work, coming home, drinking, and that was it, that was all I did. That's obviously not very healthy." – P5

Restrictions to face-to-face contact meant that some coping methods were unable to continue;

"I couldn't really spend a lot of time outside work with my colleagues, uh cause of to do with the restrictions and stuff. And also there'd be times where we would just spend (usually) time after [...] work but during the height of the pandemic that wasn't even allowed." – P1

"My actual counselling sessions, they got changed, they carried on throughout Covid but they got changed to Zoom sessions and I know for a fact that doesn't work for everyone." – P3

Participant 2 described improved wellbeing over the pandemic due to an improved social support system;

"I didn't have the people I have around me now but I feel like if I did it would probably have been a lot easier, for real." – P2

Participants that were able to continue with their established coping skills seemed more able to manage their wellbeing over the course of the pandemic.

### Discussion

The aim of this study was to explore the experiences of support workers caring for people with mental health difficulties during the pandemic.

Participants described relationships with patients and staff as central to their enjoyment of their role, enhancing feelings of making a difference and satisfaction. This reflects previous findings around the importance of relationships in job satisfaction<sup>12</sup> and managing compassion fatigue<sup>13</sup>. These relationships were disrupted by lockdown. While restrictions were necessary, they came with long term impacts on mental health, as social connectedness is important in maintaining wellbeing<sup>5</sup> and mediating emotional exhaustion<sup>14</sup>.

The findings indicate patients and staff faced disruption due to COVID-19. Participants described feelings of fear and increased stress. This is consistent with literature on the impact of COVID-19 on health care<sup>18</sup> and contributes to knowledge of how mental health care has been impacted specifically. It was important for participants to witness progress in patients' recovery, however participants described isolation on admission, delayed discharges, and disruption to Section 17 leave. It is understandable that this may cause increased stress in staff.

The interviews suggest that the increased stress of the job contributed to periods of decreased empathy, mirroring previous findings around burnout negatively impacting empathy<sup>15</sup>. This could be detrimental to staff wellbeing, and consequently, patient care<sup>16</sup>. Many people have experienced trauma as a result of the pandemic, witnessed death or isolation during death<sup>17</sup>, or experienced traumatic COVID-19 illness<sup>18</sup>.



One participant expressed fear of infecting his mother resulting in her death, reflecting previous findings around fear of transmitting COVID-19. The prevalence of long COVID could increase anxiety levels<sup>20</sup>, impacting public mental health long after the pandemic is over. Symptoms of PTSD and depression have been acknowledged in health care workers<sup>21</sup>, and there appears to have been a deterioration in public mental health<sup>3,4,5</sup>.

Mental health services need to be prepared for an increase in people experiencing mental distress, and an important part of this is ensuring their staff are well supported. Participants that were unable to continue their usual coping mechanisms seemed to struggle to maintain their wellbeing, turning to maladaptive methods of coping. Employers may be able to support staff who are unable to continue their usual coping methods by providing alternate coping mechanisms through supervision, staff wellbeing services, or sessions facilitated by staff.

This study benefits from an in-depth analysis of qualitative data exploring the experiences of support workers caring for individuals experiencing mental distress during the COVID-19 pandemic, however there are several limitations. Qualitative data cannot be generalised to the population and as the interviews were conducted over the phone, non-verbal communication was limited, which may impact interpretations found using IPA.

The interviews provided important findings around the COVID-19 pandemic significantly impacting people's coping skills and consequently their wellbeing. This is important to understand in order to maintain staff wellbeing and positively impact patient care, particularly in future pandemics or disasters where access to social interaction or activities is prevented.

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## Appendix: Semi-Structured Interview Schedule

- 1. Can you tell me why you chose this work?**
  - > What do you enjoy about it?
- 2. Has COVID-19 affected this in any way?**
  - > Can you tell me more about it?
  - > What is different?
  - > (Probe) Can you tell me more about that?
- 3. Without going into detail about specific individuals, can you tell me how COVID-19 has affected patients?**
  - > Any changes to life before admission?
  - > What about during admission?
  - > Discharge?
  - > Have you noticed patients reacting to COVID-19 in any way?
- 4. Are you aware of any COVID-19 outbreaks having occurred at your workplace?**
  - > Without going into detail about specific individuals, can you tell me how this affected patients on the ward?
  - > (Probe) What was your involvement in that situation?
- 5. How do you feel when you think about how patients are affected?**
  - > How do their reactions affect you?
  - > How is your work affecting life at home?
  - > (Probe) How do you feel about that?
- 6. How do you feel about the pandemic yourself?**
- 7. Can you tell me how you coped with difficult emotions before the pandemic?**
  - > Has this changed as a result of COVID-19?
  - > How do you feel you are managing now?
- 8. Is there anything you feel is important that you would like to add?**

# My Time at Cygnet Wallace Hospital

## About the Author



**Sophie Marriott**

**Final Year Medical Student, University of Dundee**

This piece was written to reflect on a placement I undertook during my earlier years of Medical School. The clinical placement was based within the specialty Psychiatry of Intellectual Disabilities at Cygnet Wallace Hospital.

Psychiatry of Intellectual Disability is an area of medicine which I was particularly intrigued by, so when I had the opportunity to choose it as my top choice for my third-year student selected component I knew I would want to explore it. Having worked with my peers in secondary school who had additional support needs, and often intellectual disabilities or other difficulties meaning they required extra support with education, I felt I had a secure grounding to take on the challenges which this placement could present. However, an area of the placement which I had not anticipated was the strong connection and deep sadness I would feel when leaving after just four weeks.

The hospital which I was placed in was Cygnet Wallace Hospital, a 10-bed inpatient clinical environment which provided long term care for people with an Intellectual Disability and a range of conditions including Personality Disorder, Schizophrenia and Autism.

During my time at Cygnet Wallace Hospital, I grew to love working with both the multidisciplinary team (MDT) and the patients. Although only a 10-bed unit, Cygnet Wallace Hospital provided a safe space for this small number of patients with complex needs to get the specialised treatment they require.

Cygnet Wallace Hospital was the epitome of teamwork. Psychiatry, Nursing, Psychology, Occupational Therapy (OT), Speech and Language Therapy and Support workers working together to provide the best care for their patients. It became clear to me within a few days in the hospital how much each profession valued each other's input and respected their roles. This was particularly obvious during the MDT meetings – each discussing five patients every second week. Having observed MDT meetings within a physical health ward, I thought I would have a good understanding of how these sessions would take place, but these meetings were much more in depth than I had previously seen.

Each profession was given time to explain each patient's progress within their area of expertise and there was discussion at length about the future care and treatment plans for the individual patient. Near the end of the session the patient would be invited to provide their feedback on the care they were receiving. Reflecting on this section of the MDT meeting, I was struck by the inclusivity of the patients within the session.

I feel that often the perception of psychiatric hospitals, where the patients are often detained, is that the patients' treatment is imposed on them, and they do not have a great level of input into their care plans. But at Cygnet Wallace Hospital, the patients were consulted on the decisions about their care and often compromises would be made to ensure the patients were happy with the future plans.

As part of the MDT meetings, the patients' families, and external support (guardians, Social Workers, Mental Health Officers) were all encouraged to attend and receive a monthly update on the progress of the patient they were involved with the care of. This was especially important with the patients at Cygnet Wallace Hospital as many of them are "out of area", meaning they have been moved from their home council area to Dundee to receive treatment. I found this aspect of the placement particularly interesting. The staff within the hospital placed a large emphasis on ensuring that the patients had a connection with their home area, and it became clear that the patients enjoyed this contact.

An allied health profession which I had little knowledge of prior to the placement was OT. During my time in physical health care hospitals, OT teams were often discussed but I never had the opportunity to spend any time with them. I was fortunate during this placement to gain a great insight into this important profession. My understanding of OT grew over the four weeks, and I came to realise that their role in this environment was to equip the patients with the skills they would need to progress on from the hospital and live in the community.

Working closely with the activity co-ordinator – they worked on skills such as handling money and travelling using public transport as well as cooking and interpersonal relationships - for the patients, working with the OT provided them with the opportunity to engage in therapeutic outings – often of their choosing. The patients would often frequent restaurants, cinemas and the local wildlife park depending on their personal interests. The emphasis on the patients having autonomy over how they spend their time was heartening and not only provided enjoyment but also key learning opportunities. Over time, I observed the patients beginning to take more ownership over their care and showing great delight when they had chosen to participate in meaningful therapeutic activities benefiting them in gaining skills which would help them progress to lower levels of care.

As part of their occupational therapy, patients were encouraged to attend a weekly community meeting. This meeting, which was facilitated by staff, provided an open and friendly space for the patients to give feedback on the unit. An agenda was in place to ensure the meetings were productive, items included Meals, Cleanliness, Activities, Sign of the Week and getting along together. All available staff attended the meeting and were involved in the discussion.

The meeting allowed the patients to voice their views about their care, but by also including the staff, it provided them with a learning opportunity. The patients could learn from the staff interactions how to have meaningful and constructive discussion helping them to develop their interpersonal skills – key to life in the community.

Over my time at Cygnet Wallace Hospital, I observed the patients becoming more engaged in the meeting and using it as a positive space. It was clear that the patients enjoyed sharing their progress and were encouraging others to do the same. From my perspective, the community meeting highlighted that care at Cygnet Wallace Hospital was not only about improving the patients' psychiatric conditions but also there was an emphasis on teaching life skills which would be key to life in the community.

“Holistic Care” This is a phrase which I feel encapsulates the care at Cygnet Wallace Hospital. Throughout my placement I was continually struck by the psychiatrist's involvement in every aspect of the patients' lives and the consideration that they took to discuss how changes to a patient's care would impact their lives as a whole, rather than just their condition. Whether that be in relation to medication changes or the use of mobile phones and other devices, the doctors at Cygnet Wallace Hospital always took time to discuss their thoughts and decisions with the MDT. On reflection, this idea of holistic care was in keeping with the culture of honesty and openness which exists within the hospital.

During my time at Cygnet Wallace Hospital, I was always encouraged to ask questions and challenge the team to create discussion around why and how certain decisions were made. I found this extremely comforting and unusual that as a medical student the team were so keen to hear my input and made me feel that I was a member of the team.

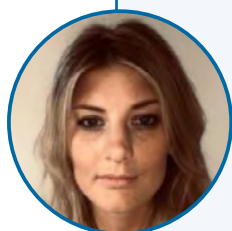
I thoroughly enjoyed my time on placement and am thankful for the opportunity to better understand the care in psychiatric hospitals for those with an Intellectual Disability. As I previously mentioned, it feels strange and sad to no longer be involved with the daily workings of Cygnet Wallace Hospital, but I hope to be able to take more opportunities to spend time in this environment and learn more about the specialist treatment they provide, as I know that I have only scratched the surface of the learning opportunities which are available within this speciality.

# Evaluating the Use of Positive Behaviour Support Plans in a High Support Rehabilitation Unit for Adult Males

## About the Authors

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Caroline is a Consultant Forensic Psychologist who joined the team at Cygnet Hospital Bierley as Head of Psychology in June 2020. She has worked in a Psychological setting since 2008 and has experience of working with adults with a range of different needs including complex personality disorder, mental health issues, autism and learning disabilities. Caroline has attended training in working in complex trauma and different therapeutic approaches (including CBT, EMDR, CAT and Schema Therapy). She enjoys working with individuals to develop a collaborative treatment plan that will meet their needs. Caroline is keen to put individuals at the centre of the care, and enjoys being creative and trying different ways to help people to improve their quality of life and progress in their recovery journey.

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## Abstract

The use of Positive Behaviour Support (PBS) plans within healthcare settings has been seen to increase in recent years<sup>1</sup>. Their validity in educational settings is well-established, however there has been less research specific to its use for adult males with a diagnosis of Mental Illness. Less still is known about the appropriateness and effectiveness of PBS for individuals with a personality disorder. The following research evaluated the implementation of PBS plans in a High Dependency Rehabilitation unit for 16 adult males with diagnoses including Mental Illness, Personality Disorder, and / or Autism Spectrum disorder.

A Wilcoxon Signed Rank Test revealed no significant difference in incidences of violence and aggression between pre and post PBS intervention. Due to the limited sample size and data obtained, there were a number of study limitations that affected the data analysis and limited the ability to support or reject the proposed hypotheses. Recommendations for further research are made.

**Keywords:** Positive Behaviour Support (PBS), Personality Disorder (PD) Autism Spectrum Disorder (ASD).

## Introduction

Incidents of verbal and physical aggression remain prevalent within mental health inpatient settings<sup>2</sup>. An inverse relationship between aggression and well-being for the individual displaying the behaviour is well established in available literature<sup>3</sup>.

Challenging behaviour is also associated with placement breakdowns<sup>4</sup> and sometimes the removal of individuals to more restrictive, out-of-area settings<sup>5</sup>. Alongside this, dealing with challenging behaviour is associated with increased symptoms of burnout in caring professionals<sup>2</sup>. Interventions that can effectively reduce aggression are therefore considered a priority in the healthcare sector.

Positive behaviour support (PBS) is an evidence-based framework used in a range of educational and healthcare settings<sup>6</sup>. It is used to support and better understand individuals who display behaviours that are challenging to others, by better understanding the context and motivating factors of the behaviour that is occurring<sup>7</sup>. PBS therefore involves the application of an appropriate functional analysis or other formulatory framework. It is then pro-active in identifying a range of ways to promote an individual's well-being and therefore reducing the need for the behaviours that concern.

PBS encourages a holistic stance when considering what promotes an individual's well-being, and a range of professionals, including Psychologists and Nursing staff, may be involved in the development of a PBS plan<sup>8</sup>. PBS is also skills based, and identifies potential areas of deficit where the individual would benefit from learning more adaptive ways to communicate their needs or manage challenging situations.

PBS was initially devised by Carr<sup>9</sup> within the field of developmental disability. In the present day the PBS plan is individualised, person-centred, and informs decision-making and care plan formulation. A holistic, organisational approach to PBS is recommended<sup>6</sup>. It is predominantly used in the support of individuals who have Learning Disability (LD), and / or Autism Spectrum Disorder (ASD), but has also been used for those with a mental health condition<sup>10</sup>.

To date the PBS literature has predominantly focused on the effectiveness and implementation of PBS within school settings<sup>11,12</sup> and in addressing challenging behaviours in children and teenagers<sup>13,14</sup>. These studies lend support to PBS in terms of their effectiveness for individuals with behavioural issues and ranging abilities and needs across different settings (including preschool, primary school and youth detention and care settings). McGill et al<sup>8</sup> assessed the effectiveness of PBS for adults with LD in supported accommodation settings and found that ratings of behaviours that concern reduced significantly in the experimental group.

There are few other (accessible) research papers that specifically explore PBS implemented with adult service users, particularly in psychiatric inpatient services, indicating that there is scope for extending current knowledge in this area.

In 2012, La Vigna and Willis<sup>15</sup> investigated the efficacy of PBS for individuals presenting with severe and high-rate behaviours that concern. A review of 12 studies, comprising a total of 423 participants, concluded that PBS is cost-effective, is effective in community and institutional settings, can reduce severe and high-rate behaviours that concern, and is easy for training and dissemination purposes. They also stated that PBS is consistent with the right to effective treatment and least restrictive practice policies, lending strong support to PBS theory in terms of improving social care by increasing opportunities for choice.

In an evaluation of studies on PBS by Uslu & Baglama<sup>16</sup>, through a comprehensive literature review looking at trends between 1998 – 2019, fifty-three articles from thirty-five different journals were analysed for journal subject, research topic, sample and authors' study interests. It was found that there is a growing interest in PBS in the UK with 41.5% of articles coming from UK research, most of which were published 2011 – 2019. More than a quarter of all journals analysed were from LD publications and one fifth of articles focused on the research topic of schools / education.

This review gives an idea of current trends in PBS research and the scope for expanding knowledge by extending research into the lesser explored fields and disciplines such as forensic and mental health services.

Cygnets Oaks has a multi-disciplinary team which consists of a Psychiatrist, Specialty Doctor, Psychologist, Occupational Therapist, Management Staff, and Qualified Nurses. All individuals who have a diagnosis of Learning Disability and / or Autism Spectrum Disorder are identified by the Psychology department as requiring a Positive Behaviour Support plan upon admission (in line with NICE guidelines).

Alongside this, individuals are allocated for a PBS plan to be developed if they are requested by Nursing or Support Worker staff, if there are a high frequency of incident logs being received in the daily morning meetings, or if difficult or unhelpful dynamics are observed between staff and the service users. The Psychologist, with support of the assistant and trainee psychologists in role, leads on creating and developing the PBS plans. Information from a range of sources including case formulations, incident forms (which include an ABC method of behavioural analysis), historical and current risk assessments, and staff feedback are referred to during the development phase.

Service user input is encouraged and promoted wherever possible and at times service user family members have been able to support the process. The PBS is reviewed by members of the MDT before being implemented and is reviewed on at least a four monthly basis.

The primary purpose of this research was to compare incidents of aggression, pre and post implementing a PBS plan with a small sample of adult males who reside at Cygnet Oaks. Preliminary exploration of the data was aimed at identifying if there is a significant difference between pre and post PBS MOAS scores (The Modified Overt Aggression Scale; see below for further information). Subsequent analysis explored possible differences in MOAS score (incidences) by number of diagnoses (one or more than one diagnosis) and age to determine if there was a relationship. Based on the findings of previous literature and logical reasoning it was hypothesised that MOAS score would decrease following PBS intervention and that there would be a significant difference in scores between 'Pre' and 'Post' conditions.

## Method

Ethical approval was granted by Cygnet Health Care's Research and Development Group prior to the research commencing.

### The Modified Overt Aggression Scale (MOAS)

The Overt Aggression Scale was originally developed by Yudofsky and Silver<sup>17</sup>. The OAS ratings were found to have high levels of inter-rater reliability in a study by Yudofsky, Silver, Jackson, Endicott and Williams<sup>17</sup>. The MOAS was developed to overcome some of the practical limitations highlighted by users of the OAS, such as being unable to record the time an incident started and finished on each occurrence. The MOAS is a four-part behaviour rating scale used to evaluate and document the "frequency and severity" of aggressive episodes. The rating scale is made up of four categories; verbal aggression, aggression against objects, aggression against self, and aggression against others. For each subscale, the rater can score 0, 1, 2, 3, or 4. These numbers correspond to no aggression (0), mild (1), moderate (2), severe (3), or profound aggression (4). The MOAS has been used in a range of different institutions and is suggested to be a valid measure for indicating the presence and severity of aggression<sup>18,19</sup>.

## Data and Variables

In line with Cygnet Health Care Policy, incident logs are completed if there are behaviours of concern observed, including aggression towards self or others. All staff at Cygnet Oaks receive some training in the completion of incident logs and are encouraged to complete these as required. This process is overseen by a designated Qualified Nurse (appointed Nurse in Charge for that shift) every day. These records are then reviewed by a member of the Psychology team and uploaded to a database on a daily basis. This process also provides an additional safeguard to ensuring incident logs are required based on the verbal handover given by a member of the Nursing team or observations on the ward.

The current research used the Psychology database and online incident record system for the purposes of identifying incidents of aggression. Coding was performed by a Voluntary Research Assistant using the Modified Overt Aggression Scale. Some of the coding completed was double scored by the Lead Researcher to promote accuracy.

## Sampling

The sample comprised of 16 adult male service users who reside in a High Dependency Rehabilitation unit (psychiatric rehabilitation facility) at Cygnet Oaks Hospital in Barnsley. A priori-calculations of the minimum sample size required to test hypothesis 1 and hypothesis 2 were conducted using G\* Power version 3.1.9.4.<sup>23</sup> For hypothesis 1 it was indicated that to achieve 80% power to detect a medium effect the required sample size was N=12. For hypothesis 2, in order to detect a large effect ( $r=0.5$ ), the required sample size was N=23. The implications of these analysis in comparison to the actual number of participants of the study is discussed further within the limitations section below.

## Participants

All participants who had a PBS plan in place and remained within the service for at least six months after the PBS had been implemented were included in the current sample. All participants were adult males. The majority (81.25% n=13) of patients were detained under Section 3 of the Mental Health Act (1983) and the remaining 3 were under Section 37/41 of the Mental Health Act (1983).

Participants' ages ranged from 23 - 61. Fifteen out of the sixteen participants identified as White British, and one participant identified as Black British. Table 1 provides the primary and secondary diagnoses for the participants.

**Table 1: Primary and Secondary diagnoses (including ICD-10 reference code) for all participants:**

Participant Number	Primary Diagnosis	Secondary Diagnosis
1	Emotionally Unstable Personality Disorder (F60.03)	Obsessive Compulsive Disorder (F42)
2	Paranoid Schizophrenia (F20.0)	
3	Paranoid Schizophrenia (F20.0)	Antisocial Personality Disorder (F60.2)
4	Paranoid Schizophrenia (F20.0)	Autism Spectrum Disorder (F84.0)
5	Autism Spectrum Disorder (F84.0)	
6	Mixed Personality Disorder (F61)	Drug Induced Psychosis (F19.150)
7	Autism Spectrum Disorder (F84.0)	
8	Bi-polar Affective Disorder (F31.0)	
9	Bi-polar Affective Disorder (F31.0)	
10	Paranoid Schizophrenia (F20.0)	
11	Antisocial Personality Disorder (F60.2)	Mild Learning Disability (F70)
12	Paranoid Schizophrenia (F20.0)	
13	Autism Spectrum Disorder (F84.0)	
14	Paranoid Schizophrenia (F20.0)	
15	Autism Spectrum Disorder (F84.0)	Mixed Personality Disorder (F61)
16	Paranoid Schizophrenia (F20.0)	

## Hypotheses

The following hypotheses were stated:

- Incidents of aggression will reduce in the six month period after a PBS plan has been implemented as measured by the MOAS.
- An exploratory hypothesis to compare whether the effectiveness of PBS was affected by the individual's primary diagnosis (when other variables are controlled for), number of diagnoses, or age, was also stated.

## Results

### Statistical Techniques

Means and standard deviations for 'Pre PBS' and 'Post PBS' measures of aggression can be seen below in 'Table 2'. Preliminary exploration of the dataset using skewness and kurtosis values identified violation of normality for both levels of the independent variable ('Pre PBS' Skewness .840, Kurtosis -.280, 'Post PBS' Skewness 1.97, Kurtosis 3.32). Examination of boxplots and histograms showed extreme outliers in the data set. Kolmogorov-Smirnov statistic demonstrated moderate normality for 'Pre PBS' (>.05) but was not normal for 'Post PBS' (<.05). Due to these preliminary findings and based on the small sample size, data was transformed using SQRT ('Pre') and LOG10 ('Post'). Data transformation failed to bring the skewness and kurtosis values to within a normal range therefore the non-parametric Wilcoxon Signed Rank Test was selected to further explore the data.



**Table 2: Means and Standard Deviations for Pre and Post PBS scores:**

	N	Minimum	Maximum	Mean	Std.	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Standard Error	Statistic	Standard Error
<b>Incidents 6 months Before</b>	16	.00	78.00	27.8750	25.11805	.840	.564	-.280	1.091
<b>Incidents 6 months After</b>	16	.00	118.00	28.6250	34.69462	1.969	.564	3.321	1.091
<b>Valid N (listwise)</b>	16								

## Hypothesis one

A Wilcoxon Signed Rank Test revealed no significant difference in incidences of violence and aggression between pre and post PBS intervention,  $z = -.052$ ,  $p > .005$ , with a very small effect size ( $r = .009$ ).

## Hypothesis two

A Non-Parametric Partial Correlation was used to explore the relationship between difference in incidences of violence and aggression (as measured by the MOAS) and number of diagnoses, while controlling for age. Due to the data not meeting assumptions of normality, a non-parametric correlation syntax code was used to recode the data and enable Pearson's Partial Correlation to be executed. There was weak positive correlation between subjects incidences and number of diagnoses, when controlling for age ( $r(13) = 0.405$ ,  $p = 0.134$ ) therefore suggesting the relationship was not significant. Further analysis when controlling for diagnosis looked at the relationship between subject's age and incidents of violence and aggression. There was no association between age and number of incidents when controlling for diagnosis ( $r(0) = 0.096$ ,  $p = 0.733$ ).

Due to the limitations of the sample size and data distribution, this hypothesis could not be fully explored. Further research is recommended.

## Discussion

This report investigated levels of violence and aggression pre and post PBS implementation in a small sample of adult males who reside at a High Dependency Psychiatric Rehabilitation Hospital. Due to an abundance of support for the positive effects of PBS in previous research, it was expected that MOAS<sup>17</sup> incidence scores would decrease after PBS implementation for this sample. This was not the case and no significant reduction was observed on this occasion. It is possible that the results could be affected by the very small sample size and skewed data.

The current research also aimed to explore the effectiveness of positive behaviour support plans for individuals with a primary diagnosis of Mental Illness or Personality Disorder, as there is very limited available literature exploring this. Due to the small sample size and data sample provided, it was not possible to conduct data analysis to explore this hypothesis. Similarly, data to consider whether age was a relevant variable impacting on PBS effectiveness could not be extrapolated.

PBS theory proposes that learning about the function of challenging behaviours is key to supporting service users to gain the skills to learn new behaviours that serve the same function / outcome.

In the case of this research it is not known if PBS intervention was systematically employed when the incidents arose.

Anecdotally, there were issues with staff reporting that they had not been allocated time to read the PBS plans and could therefore not be confident they were acting in line with the recommended principles. PBS involves service users and multidisciplinary staff and therefore future investigation may benefit from a holistic approach that involves more stakeholder perspectives or perhaps employs alternative and more rigorous methods of data analysis.

Clark et al<sup>1</sup> discovered that PBS plans were often not implemented consistently, and that a lot of confusion about their purpose and implementation existed amongst nursing staff. Training on Positive Behaviour Support plans was delivered by the Psychology team at Cygnet Oaks to approximately 70% of staff (n=44) in July and August 2017, which was during the implementation of some of the Positive Behaviour Support plans that were evaluated as part of the study. It would be helpful to repeat the current study in the same environment to help evaluate whether attendance to training in Positive Behaviour Support had a significant impact on the effectiveness of PBS plans.

Clark et al<sup>1</sup> also found that staff and patients' relatives identified the potential benefits of PBS plans, and commented favourably about the plans potential for facilitating individualised care. It also falls in line with Reducing Restrictive Practice principles of reducing the need for restriction, medication and restraint in psychiatric settings<sup>20</sup> which have been shown to be effective in reducing challenging behaviour and improving service user and staff relationships<sup>21</sup>.

### Study Limitations and Recommendations for Future Research

The present study was conducted on a small sample (n=16) within one of Cygnet Health Care's High Dependency Rehabilitation Units. Due to the effectiveness of PBS identified across the available literature (1,6,8,9,10,11,12,13,15) it was anticipated that a moderate to large effect would be detected in the sample, therefore requiring fewer participants and enabling the study to be conducted at one site. The effect may exist in the population, but the study may not have detected it due to the available sample size, and more in depth analysis has not been possible. It is also noted that the sample used was predominantly White British participants and consisted of all adult males. For these reasons, the results cannot be confidently generalised to the greater population. Further repetition of this research in other high dependency rehabilitation units is recommended to consider the usefulness of PBS plans for adult males accessing these services. Gathering data from more units could also increase statistical power of future research.

The Lead Researcher is the Psychologist on the unit who was also involved in the development of the PBS plans that were evaluated. A potential for bias in data interpretation was highlighted which could increase the likelihood of false positives. A voluntary research assistant was appointed to support with the data collection and analysis to reduce this effect. However, it is relevant to note that the research assistant was also employed as a Support Worker on the unit and was working under the supervision of the Lead Researcher. The recruitment of researchers who work remotely or are external to the service could reduce bias in this type of study if it were to be repeated.

McGill et al's<sup>8</sup> research found support for the use of PBS plans in adults with Learning Disability in supported accommodation settings. It is noted that in this research, as well as others that have been cited to support the effectiveness of PBS plans, an external specialist was recruited to develop the PBS plans. Further consideration as to whether this is a more effective process than the use of in house specialists would be of benefit.

The research could be replicated in similar High Dependency Rehabilitation units. Exploration of whether the PBS plans effect is impacted by the environment (which would be expected given our understanding of how a range of factors, including environmental, influence well-being;<sup>22</sup> could be considered by replicating the research in other settings such as Low and Medium secure units, supported accommodations, and Prisons. The research aim to consider whether PBS plans are more effective for individuals with a diagnosis of Autism or Learning Disability (compared to other Mental Illness or Personality Disorder) should be explored further by recruiting an increased number of participants across different service lines.

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# Psychology Staff Support During the COVID-19 Pandemic

## About the Authors



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Shaun has a long and distinguished career as Director for Psychology Services North and is a Chartered Consultant Clinical Psychologist. Shaun has dedicated his time and talents to developing psychology services for Cambian and Cygnet Health and Social Care.

## Abstract

The Cygnet psychology service responded to the need for staff support at the start of the COVID-19 pandemic. This article explores how Cygnet came to develop their response strategy to offer the 'COVID-19 psychology staff support programme' to their frontline staff. Data collection methodology is explained and results from a one year period is reported on. Qualitative findings are discussed including how this work led to the current 'How are you today campaign', which continues to support staff well-being and resilience. The article is concluded by giving tribute to the hard work and dedication of the Cygnet Psychology team.

## Introduction

At the beginning of the pandemic we saw the outbreak of the COVID-19 global pandemic affecting our services across the organisation. We responded quickly to follow the national guidelines as set out by the government.

Our Chief Executive Officer called a national teleconference and reassured all our staff members that Cygnet would take the necessary action to face this crisis. Our Cygnet Operations teams responded speedily by launching daily meetings where topics such as Personal Protective Equipment (PPE) and infection control became the agenda for the day. The prevalent question amongst the worry and uncertainty we experienced was: how do we deal with this pandemic and ensure the safety and wellbeing of our patients and staff?

As a response to this question and the challenges of COVID-19, the psychology service implemented an additional level of staff support. The psychology drop in sessions were initiated across all service lines and geographical regions of Cygnet Health Care and Social Care. The British Psychological Society distributed their "Guidance for psychological professionals during the COVID-19 pandemic"<sup>1</sup> five days later and the Cygnet directors incorporated these guidelines for the implementation of their response strategy. As the response strategy was implemented it was reviewed at regular intervals and updated as new information was released.

The staff support sessions were intended to compliment the ad hoc support for clinical and operational staff, as well as daily COVID-19 communications. They were also intended to complement the other staff support structures offered by Cygnet Health Care. The following protocol was communicated to all qualified psychologists in the organisation and was implemented the following week.

- The Psychology department will offer an informal drop in session between 15.00 and 16.00 twice a week (this will ensure that different shift patterns of frontline staff had access to this support).
- A designated psychology representative / representatives will be identified in each hospital to facilitate these drop in sessions.
- Additional support and guidance will continue to be provided on a day to day basis in every service (on either an ad hoc basis, through reflective practice or debrief sessions etc).

## Method

A poster (see Fig. 1 on page 22) for staff, together with useful resources and attendance logs, were distributed and were completed on a weekly basis at sites. This was helpful in assisting with the monitoring of these sessions, identifying the staff uptake of these sessions and identifying any sites which required additional support. Data recording was initiated and was carried out over a one year period.

# Cygnet Hospital Wolverhampton and Cygnet Hospital Oldbury

## NEW PICU & Acute Hospitals for Men and Women in West Midlands

Cygnet Hospital Wolverhampton for men and Cygnet Hospital Oldbury for women are both new state-of-the-art PICU & Acute hospitals in the West Midlands.

Both hospitals feature two wards a PICU and an Acute. A full Multi-Disciplinary Team (MDT) supports the acute needs of adults requiring rapid access to mental health services, including those who may need an intensive care environment.



Cygnet Hospital Wolverhampton



Cygnet Hospital Oldbury



0808 164 4450



chcl.referrals@nhs.net

Fig. 1 Example of the poster for psychology staff support sessions.

## Staff Psychology Drop-in Sessions

### INSERT day & time

We recognise that the Coronavirus pandemic is presenting us all with unique challenges. We are in unprecedented times and the Corona virus crisis can affect us in many different ways (emotionally, psychologically, socially, economically, and physically).

Worries and anxieties are a normal and natural response to any challenging situation where there is uncertainty.

During this time we would like to offer all staff additional support to manage any anxieties or worries they may have.

Contact person: **INSERT name**

### Useful Resources:

**Mind** have released some information to help if you have symptoms and things you can do if you find yourself in self-isolation.

<https://www.mind.org.uk/information-support/coronavirus-and-your-wellbeing/>

If you do have to self-isolate, try to keep as much routine as you can and remain connected to those around you (electronically!).

**Keep fit!** We can't currently go to the gym but there are numerous exercises that can be done in the comfort of your own home. Exercise can improve your mood and has been shown to reduce feelings of depression, anxiety and stress. See below for some home exercises that you can do:

<https://www.verywellfit.com/best-ways-to-exercise-at-home-1231142>

<https://www.self.com/gallery/bodyweight-exercises-you-can-do-at-home>

### Take Some Time to Relax

**Headspace** mobile app (<https://www.headspace.com/>): most of the basic exercises are free and they include breathing exercises and mindfulness.

Calm is another mobile app (<https://www.calm.com/>) which is handy if you struggle with sleep, but bear in mind that some of these exercises only take around 10 minutes so they are useful if you are feeling anxious during the day and can take 10 minutes for a timeout.

If you do find yourself struggling, in any area of your life, the **Employee Assistance Programme** is a good place to turn to discuss a variety of subjects including: financial difficulty, relationship advice, counselling and medical advice. Helpful, if you feel unable to turn to those close to you and prefer to speak to someone independent. They too have a mobile app called **Health e-Hub**. Login using 72111 for both the username and password.

<https://mycygnet.cygnethealth.co.uk/departments/hr-recruitment/employee-assistance-programme/>

### Cygnets Staff Portal:

Be mindful to continue checking your emails for any updates and check the staff portal where there is a dedicated page for Coronavirus, including the COVID-19 policy and further advice/guidance. This is being updated on a regular basis. Ensure that you talk to your line managers and each other for support and reassurance.

**Positive Psychology** have developed a document for clients, but it is relevant to us all and contains five of the most relevant, science-based tools to help you and for you to help others navigate turbulence and uncertainty. It is free to download here:

<https://positivepsychology.com/the-crisis-kit/>

**FACE COVID:** Is a set of practical steps for responding effectively to the Corona Crisis using principles of acceptance and commitment therapy (ACT). This guidance has now been updated.

The information was provided for the psychology staff to offer support for the drop-in sessions and a log of attendance was completed by all staff who attended the sessions each week. These templates were sent out to all sites in all regions in Cygnet (London & South, Midlands & Wales, North & Scotland). Furthermore, weekly communications were sent to all staff via the Communications department and a COVID-19 support web page was developed for staff<sup>2</sup>.

### Data collection

From the initiation of the support sessions weekly data was collected on site to determine the uptake of these sessions and monthly data was collected from each site and each region and shared with the Cygnet Executive Board in a monthly report. These monthly reports were made available on MyCygnet, our company intranet. The results section will provide a summary for the data for a one year period for all regions and all sites in Cygnet.

### Results

Over a one year period a total number of 2,870 support sessions were offered by the Psychology team and 3,233 staff members attended these support sessions (Fig.2).

Fig. 2 Psychology staff support and attendance.

## COVID-19 Psychology staff support sessions - April 2020 to April 2021

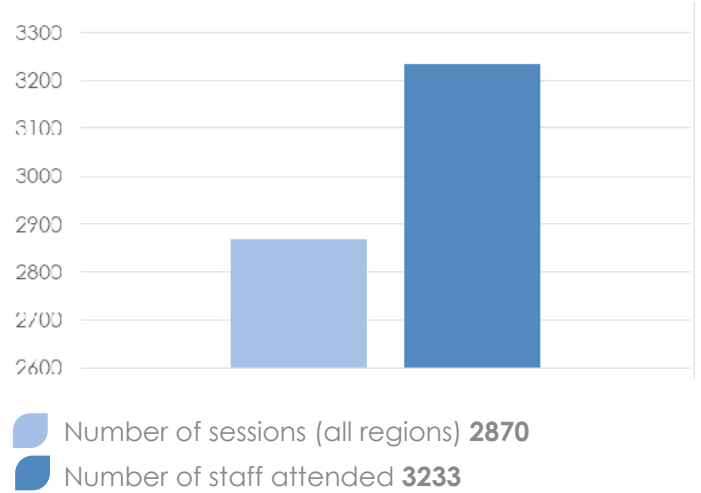
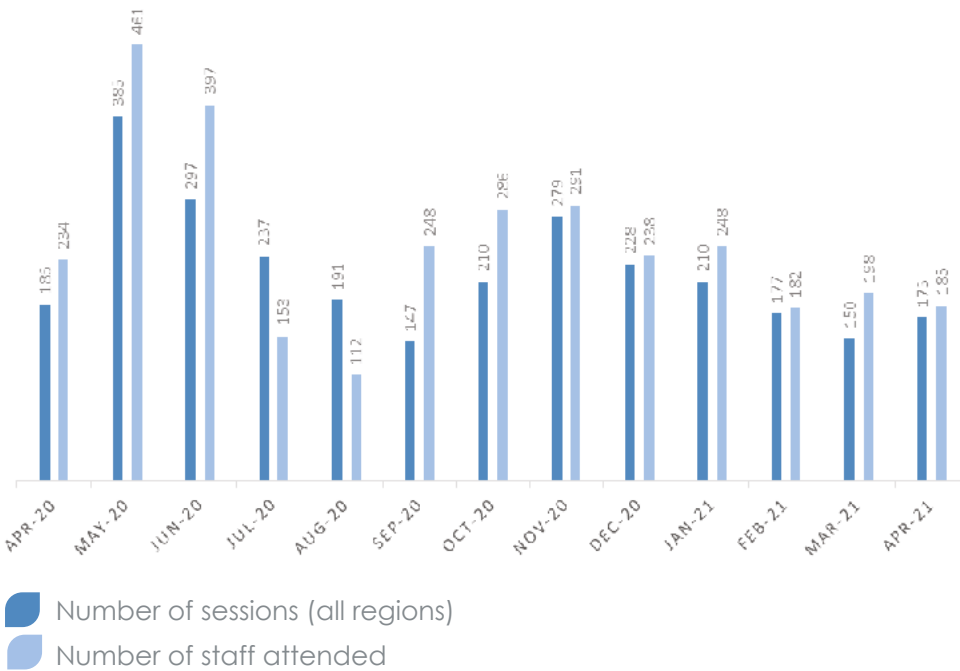


Fig. 3 Psychology Staff Support During COVID-19.

## Psychology Staff Support During COVID-19



The graph in Figure 3 below indicated the monthly staff support sessions and the number of staff that attended these sessions. The higher numbers of staff attending is visible during the months of national lockdown in the COVID-19 pandemic March to June 2020, November to December 2020 and January to March 2021; with numbers decreasing as the need for the support sessions reduced.

Note: Adaptations were made to the delivery of psychology provision to accommodate the staff support programme.

## Discussion

Qualitative feedback collected from regional and clinical leads, heads and leads of services and communication to the psychology directors indicated that at some sites staff preferred the group drop-in while at other sites staff requested more of a one to one support structure. These differences were accommodated based on the needs of the staff at the various Cygnet sites. The national lockdown was gradually lifted across all regions and vaccines were rolled out for all keyworkers from February 2021 and then to members of the public via vaccination centres throughout the UK.

At that time psychology teams were reporting that less frequent support was requested from staff on sites and this information did correlate to the overall reduction of infection numbers. It could be postulated that this reduction was correlated to the decrease in national deaths due to COVID-19, as the national vaccination programme gained momentum.

Psychology teams reported that the themes of the support sessions were becoming less about COVID-19 in content and more general in theme (centred around general themes that would be addressed in reflective practice). The staff support programme was reviewed in line with the national trend and brought to conclusion on 30 April 2021. The Cygnet Wellbeing Campaign “How are you today?” continues to support staff well-being and resilience, by means of peer support and referrals to the Employee Assistance Programme when needed. Cygnet also developed the Trauma Risk Incident Management and Staff Resilience and Well-Being programmes (TriM & StRaW)(3).

The following protocol (Fig. 4) was communicated to all qualified psychologists in the organisation on Friday 30 April 2021 when the staff support sessions were ended. The communication thanked the team for going above and beyond in offering this support to all staff during the global pandemic.

Fig. 4 Final communication & EAP.

**\*Sent on behalf of our Psychology Department\***

Dear colleague,

Throughout the pandemic, our Psychology teams have been providing regular COVID-19 support sessions for all our staff. This support has been extraordinarily well received and has provided much needed benefit to colleagues during this difficult period.

In recent weeks we have seen a reduction in demand for the sessions and feel this is the right time to bring them to a close. Therefore, the sessions will finish **from Friday 30<sup>th</sup> April**.

**For anyone feeling like they need some advice and support, we have lots of free resources available to all staff on MyCygnet. All Cygnet employees have access to MyWellbeing, our Employee Assistance Programme, which provides confidential and free access to a 27/4 counselling service for you and your family. The helpline number is 0800 975 3356.**



## Conclusion

The psychology staff support sessions that were offered by the Cygnet psychology teams were well received and attended by many staff members in our services. The psychology team pulled together across all regions during this time of crisis to offer much needed support to our staff members.

Some interesting preliminary data from the annual staff surveys 2021 also concluded that “On health and wellbeing, there has been a real improvement. Coming out of the pandemic, staff are reporting they are much less likely to experience work related stress than in previous years (down 6% to 30%).”<sup>4</sup> Further research regarding the correlation of staff support and well-being could be explored.

Finally we conclude with the communication from Dr Jon van Niekerk (Cygnet Group Clinical Director) who said: “I want to take this opportunity to thank you for going above and beyond in your roles to support our staff during the pandemic. I am so grateful and proud of you all for working tirelessly on the front line and caring for our staff whilst still looking after those in our care. I am inspired by your personal commitment to making a difference in these most challenging and unprecedented times. Thank you for the example you have set and embodying our values<sup>5</sup>.”

## Acknowledgements

We would like to extend our gratitude to all our psychology teams in Cygnet who provided the COVID-19 staff support sessions during the global pandemic.

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# “My Rights Project” A Service Evaluation of Individual Understanding of Legal Rights at Cygnet Brunel

## About the Authors

### Clare Crew-Gee

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Previously lead Speech and Language Therapist at Cygnet Brunel in Bristol, Claire has practised clinically as an SLT for over 30 years, specialising in neuro rehabilitation for adults with communication, speech and swallowing difficulties. She works primarily with brain injured adults, and is committed to maximising a person's communication success in everyday life. She currently has an independent practice in Bristol.

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Former assistant psychologist Yaz works as an applied research practitioner in Hywel Dda University Health Board, NHS Wales with an interest in bridging the gap between mental health and specialist neuro rehabilitation services. They are passionate about the role of lived experience within research, interventions and local community.

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## Abstract

In this service evaluation, we examine how individuals with Brain Injury and mental health diagnoses understand the legal framework that applies to their admission to a rehabilitative neuropsychiatric hospital. The authors identified areas of improvement for the accessibility and delivery of information which were then implemented. Descriptive statistics explored patterns in quantitative response, and thematic analysis identified five themes: control; dependency; treatment; information; and communication across two data collections pre and post improvements. We discuss the results and recommend further improvements to empower individuals in our hospitals to understand, express and uphold their rights.

## Introduction

Traumatic or acquired brain injury (TBI / ABI) can lead to acute and long term emotional, cognitive, physical and behavioural changes. In turn this can have a significant impact on the individual and their wider psychosocial<sup>1</sup>. Factors such as premorbid illness, age, sex or psychosocial factors increase risk of experiencing a brain injury<sup>3</sup>. Common neurological sequelae following brain injury include impairments in memory and attention, information processing success and speed, and language impairment<sup>4</sup>. These individuals may be offered rehabilitation in Neuropsychiatric (NP) settings<sup>2</sup>.

In contrast to the breadth of research literature within TBI / ABI services, research within NP settings is limited<sup>5</sup>. Contributory factors for this may be the higher risk or barriers in engagement with research, the complex nature of multiple diagnoses and the lower number of services available that offer a neuropsychiatric service.

Studies exploring the experience of individuals within brain injury and mental health rehabilitation services, identify the positive experiential impact of effective, appropriate and timely communication about detainment, duration, and future plans of care<sup>6,7</sup>. With effective communication in place, negative experiences of individuals in rehabilitation settings were reduced and individuals were empowered by clear, individualised and accessible information. This is crucial considering that effective communication is a primary concern for individuals and their families, and is associated with improved safety and clinical effectiveness, increased medication adherence, reduced hospitalisation and length of stay<sup>7,8,9,10,11</sup>.

A common factor influencing communication in NP populations is language impairment known as aphasia<sup>12,13</sup>. Aphasia is an acquired impairment of language function resulting from brain injury to the language dominant hemisphere that affects the person's communicative and social functioning. Aphasia can be present across all language modalities (understanding, expression, reading, and writing). The impact of aphasia will directly affect an individual's understanding of information. Other significant and relevant cognitive consequences of a brain injury include slowed processing speed, impaired attention span and difficulties with short-term memory encoding and consolidation<sup>4</sup>. These difficulties can significantly impact an individual's processing and consolidation of information.

Between 2022-2023 there were 51,312 new detentions under the MHA in the UK, with a number of these individuals living within NP settings. Fourteen Individuals living within NP settings also include those detained under Deprivation of Liberty Standards (DoLS) or who are considered voluntary or 'informal'. Legal frameworks are in place to protect the rights of an individual and keep them and those around them safe. Restrictions within NP settings can significantly impact individuals' everyday lives including treatment consent, access to their community and what decisions they or those around them can make about their care<sup>7</sup>.

Organisations that provide NHS or Adult Social Care must follow the Accessible Information Standard, which states it is a legal obligation for all NHS care providers to ensure information is as accessible as possible for an individual<sup>15,16</sup>. For individuals detained under the MHA, the legislation states “everything possible should be done to overcome barriers to effective communication”<sup>17</sup>. Aphasia friendly formatting i.e. simplified vocabulary and syntax, large print, increased white space, and accompanying pictures / photographs, has been shown to result in increased comprehension compared to control paragraphs<sup>13</sup>. Within learning principles, whilst multiple exposures and contextualisation of information are recommended, the pattern of exposure is similarly important.

11,23 Distributed learning i.e. spacing out information over time, has been shown to support memory consolidation and association over long periods<sup>22</sup>.

MHA guidance states that all individuals are entitled to have their rights reviewed with them or a “reading of rights” (ROR) at minimum three-month intervals of a person's stay, or when triggered by a number of events such as admission, discharge, individual request, or a significant change in treatment.

## The Neuropsychiatric setting

Cygnet Brunel is a 32-bed neuropsychiatric rehabilitation centre for men based in Bristol, UK. The hospital provides a person-centred rehabilitation pathway focusing on skill and strategy acquisition following a brain injury and supporting recovery from psychiatric disorders to regain abilities as close as possible to premorbid levels. The hospital is staffed by a multidisciplinary team including Psychiatrists, Psychologists, Nurses, Support Workers, Occupational Therapists, Speech and Language Therapists, and Physiotherapists.

Individuals at Brunel are admitted under the most appropriate, least restrictive legal framework, including MHA or DoLS legislation or as an 'informal' patient. Cygnet Policy states that individuals should have their rights read to them by appropriately trained staff. Initial evaluation of the service by the authors identified that staff had access to online training and guidance on the MHA, DoLS and Informal rights legislation. There was no provision of training on practical delivery of this information to service users. Nurses and Senior Support workers were accepted as the most suitable staff members to deliver rights sessions due to their consistent presence on the ward, familiarity and rapport with individuals, and their knowledge of communication needs. Re-attempts of sessions were not always found on record when individuals had declined previous sessions. The records reflected that few of the individuals were able to understand, retain and express information about their legal status. Additionally, the documentation used to support ROR sessions at Brunel was sourced from the Learning Disability (LD) literature rather than being specific to people with brain injury or neurodegenerative conditions. LD literature uses symbols that are usually familiar to the LD group through educational experience and accessible information. This familiarity was not the case for most individuals at Cygnet Brunel, who would not be familiar with symbol support for literacy.

The authors' aim was to improve the delivery and accessibility of the information about individuals' legal rights at Cygnet Brunel through the provision of accessible documentation, delivered in a way that allowed for increased retention of information. In addition we offered specific training sessions for the staff team. The authors then evaluated the impact of these improvements.

## Method

### Setting and Participants

The service evaluation involved all 30 individuals staying at Brunel over a six month period. Individuals involved in this evaluation were aged between 18 and 80. All had a mental health diagnosis and / or acquired brain injury including Schizophrenia, Huntington's disease, Organic Personality Disorder, Stroke, Alcohol Related Brain Injury, Dementia. In addition, many men had physical health challenges such as diabetes, dysphagia, mobility issues. In instances where an individual's first language was not English, an interpreter was used to support delivery of rights information and the pre and post questionnaire. Note that many individuals were admitted or discharged during the service evaluation period of six months, impacting on sample size.

### Materials

Each ward was provided with Reading of Rights pack which included:

- Accessible, aphasia friendly documentation personalised for each service user (Fig 1). The documentation included their name, their legal status, what that means for them. Also included was the name of their family member (responsible person or next of kin), responsible clinician and advocate who they could talk to for support. All relevant sections of MHA, DoLS legislation was adapted for the neurologically impaired individual in line with Accessible Information standards. Non personalised documents were reviewed and approved by an Expert by Experience and Director of SLT.
- Guidance for delivering reading rights sessions. This included advice on how to deliver the information in short chunks, with a focus on key words and use of distributed learning. The familiar staff member was advised to ensure a low stimulus setting, usually a quiet, distraction free environment, away from TV or music and peers on the ward. This meant that the information may be delivered on more than one occasion and over a period of a few days.
- Photos (A5) of the multidisciplinary team to use as reference during ROR sessions e.g. which consultant to talk to about medication, which therapist was working with them.

The staff team also had access to individual communication profile sheets and Positive Behaviour Support Plans within the ward files.

## ROR Training sessions

All nurses and support workers involved in ROR were offered a training session and discussion facilitated by the authors.

This included a revision of legislation, education about the cognitive and communication impairments frequently experienced by NP individuals, and training on how to deliver and maximise understanding and memory. These sessions allowed a supported, reflective space to discuss the legislation, the team shared their expertise and conducted role play for ROR sessions.



Fig 1. Accessible individualised documentation

## Measures

To assess individuals' subjective confidence in their knowledge of their rights, the authors developed a 12-point questionnaire covering key information highlighted in MHA rights reviews. The authors utilised a 5-point Likert-type scale including statements to measure subjective confidence in their own knowledge. A Likert scale was chosen to take into consideration individual ease of use and is considered appropriate for gathering relevant information with reduced cognitive load. 19,20 to optimise the scale for the varying ability within a cognitively impaired population, symbolic faces, numbers and words were provided and questions were reduced to key concepts. This scale was approved by the expert by experience prior to evaluation taking place (Fig 2).



Fig 2.

To gather qualitative data, individuals were invited to expand on their Likert scale response with neutral prompts e.g. tell me more, and these responses were recorded verbatim. Completion of questionnaires and data collection occurred at the beginning (data 1) and end (data 2) of the six-month service evaluation.

### Analysis

Quantitative data was explored using descriptive and frequency statistics on Microsoft Excel, in order to identify the patterns of confidence in individual questions across both data collections.

Qualitative data was analysed using latent thematic analysis<sup>21</sup>. Authors used an iterative process to collate and code the free text information, categorise these codes and discuss the themes identified.

### Results

Of the 30 possible participants at each data collection point, 60% of the individuals were excluded from analysis: those who did not answer any of the questions; those unavailable due to COVID restrictions; those exhibiting risk behaviour or unavailable due to other commitments; those who refused interview on two occasions; and those who were discharged. Data was included even if individuals responded to only one question to ensure their voice was heard, and for analytical purposes their unanswered questions were scored at 0. There were 20 remaining respondents for data 1 collection and 14 respondents for data 2 collection.

Two statements (I make big/small decisions in my life) were removed from data analysis as they were considered inappropriate to quantify as they relied on subjective interpretation of the question.

### Mean Response Scores for Per Question

The mean score per question was calculated for both data collections to demonstrate patterns in confidence in knowledge. Blank responses were scored at 0.

Fig. 3 Mean responses per question.



Note. Q7 and Q8 were removed from final analysis

Average scores for the second data collection demonstrated higher confidence in knowledge on 7 out of 10 questions. I know who to talk to demonstrated the highest difference in mean (M = 3.36, SD 1.91). Higher scores demonstrated an increased understanding of knowledge.

## Thematic Analysis

The following themes were identified in an iterative thematic analysis of verbal responses to the questionnaires <sup>21</sup>.

### Control

Individuals widely referenced a lack of control over their situation, daily events, decisions and choices. The control theme was most prevalent when talking about going out on leave or making decisions in their life.

“I have to have someone going out with me, to do with being in hospital. I haven't got the same freedoms as I have at home.”

Some individuals showed awareness that the hospital setting may limit or impact their choices, others appeared to believe that decisions were under the control of another person or group, from whom they needed to ask permission.

“It's usually arranged for me. I haven't been able to choose where to live as I've been in hospital the last few years. My mother's in control of my bank account.”

Extracts from data 2 suggested that participants had some increased awareness of their rights, for example their leave entitlement.

“This place is sectioned. You can only do certain things. I'm no trouble.”

### Dependency

Individuals' expressed awareness of their choices being dependant on other people, with specific mention of factors such as time and availability of staff.

“Morning or afternoon. I ask to go out if someone's available. Depends - I can go out, if someone is available or not.”

“Depends on staff levels, depends on what staff can take me. When the paperwork is done. Depends on capacity, we choose our day trips out”.

### Treatment

Individuals perceived treatment as medical in nature in contrast to treatment being a combination of medicine and therapies.

“I only have medication to sort my headaches. That's all I get.”

“You follow the doctor's orders. You've done everything right.”

Several individuals expressed no awareness or knowledge of their treatment. Data 2 analysis identified some references to treatment involving both medication and therapies.

“It's not always explained very clearly what treatment I am having. Medication and therapy. Learning to manage and relax.”

### Information

In data 1 analysis individuals described written information about their care as being too complex.

“Not sure of legal framework, there's so much framework. The paperwork is too complex to understand.”

“My knowledge of the whole thing is that it is complicated treatment.”

In data 2 analysis there were continued themes of information being unclear or absent, although participants made no reference to complexity.

“It's not explained very clearly what treatment I am having.”

“I got two medications for depression and a heart condition. I take what I'm given. I'd like it explained to me, because it's my body. “

### Communication

Both data collections reflected that individuals understood who they could communicate with and that communication was consistently taking place between individuals and their teams. Some individuals felt there was no one they could communicate with.

“I can talk to anyone. Staff, doctors. It depends what I want to talk about.”

“I don't know. I would ask yourself. Because I know you well enough, I would ask a member of staff I know, and I can trust.”

A wide range of professions across the MDT were referenced as people that participants can talk to for different reasons and depending on the relationship.

“Yes, I can ask you and (support worker). I told you how it is. Tell me the truth. I lose hope and lose trust if people don't ask me or be honest.”

“A member of staff. I sort of know, you (AP), OT's, seniors. I like to ask someone familiar.”

### Conclusions

This service evaluation explored the knowledge and understanding an individual has of their rights under legislative frameworks whilst under the care of a Neuropsychiatric hospital. The literature and clinical practice supports the view that the complex nature of neuropsychiatric (NP) conditions, premorbid factors and post-injury sequelae require an approach that is specific and accessible to this population.

The findings of this study are specific to this population and suggest an increase of individual's understanding of their rights following the service improvements. The authors consider and discuss to what extent the changes themselves may relate to an individual's knowledge and understanding, and the association of this with improved clinical care.

The Accessible Information Standard highlights the requirement for health providers to offer information that is as accessible as possible for individuals. Following an evaluation of current practices at Cygnet Brunel, the authors set out to increase accessibility based on easy read principles rather than using existing borrowed LD documentation. The authors identified a need for information to be delivered with acknowledgment of the cognitive changes following brain injury as well as the emotional impact of their situation. Suggested improvements included applying distributed learning principles, and making communication and environmental alterations when reading rights. Additional training, support and discussion opportunities were offered for the staff members most commonly offering ROR sessions.

Following service improvements, the theme of communication revealed individuals could often identify a reason that they were in hospital and who they could talk to about their care. This had been directly addressed within the ROR pack through the use of clear photos of the staff team and indicates a positive level of communication at Cygnet Brunel.

The theme of information reflected that information was often too complex to understand and suggested previous ROR sessions were not meeting the cognitive needs of the service users. Notably, in the second data collection the authors found no specific use of the word “complexity”, instead the comments implied a lack of clarity e.g. “It's not explained very clearly”. This suggests the improvements had made some headway in simplification, but that further improvements were needed to clearly share information. Ideas include further personalisation of ROR information, with the use of photos and objects to maximise accessibility of information. When individuals were asked about their legal status (e.g. MHA Section 3) some were able to name the framework, though many could not, and neutral prompts revealed little understanding of the meaning of this title. The authors highlight the importance of communicating physical and mental health information along with their legal framework across meetings, ward round and therapy sessions<sup>4</sup>. As described in previous literature, this awareness may conceivably empower individuals to make sense of, recall and talk about their hospital stay, particularly as key moments such as admission can be emotionally and cognitively overwhelming<sup>7</sup>.

Treatment as a theme produced varying levels of awareness and perceived knowledge. The theme of treatment highlighted the dominance of the medical model in individuals' awareness of diagnosis and Doctor's involvement in care<sup>7</sup>. Psychological or behavioural difficulties as reasons for being in hospital had limited mention across both data collections, despite being common post-injury sequelae and a significant factor in detention under the MHA. This may be a consequence of the dominance of medical input within the MHA legislation and the provision of information previously provided at Cygnet Brunel. Following service improvements, the second data collection included references to both medication and therapeutic input, although the analysis indicates the principal understanding of individuals is that treatment at Cygnet Brunel is primarily medical in nature.

Consistent with findings from previous literature; our analysis led to two linked but distinct themes of having reduced control, and the awareness of dependency on others<sup>6,7</sup>. References to systemic factors such as dependence on staff availability provides helpful feedback on changes that may support an individual's independence. As demonstrated in previous research, feelings of captivity and lack of control can disempower an individual, and are distinct from environmental restrictions they experience.

The lowest mean score of confidence in knowledge related to Advocacy. Since independent advocacy is a core legislative right and provides opportunity to promote and protect an individual's wishes, this reveals a notable area for service improvement. Ideas to mitigate this include offering increased opportunity for co-production i.e. individuals' involvement in hospital meetings, projects and quality improvement. This could be in the planning and facilitation of therapeutic and diversional activities, or having a voice in larger decisions made about the hospital environment and staffing decisions.

Feedback gained within the training and focus sessions prior to service evaluation, showed nursing staff and senior support workers were sometimes unable to offer clear information when asked specific questions by the individual about their rights. Following the service improvements Brunel staff gave positive comments about the ease in which rights could be accessed, shared with individuals, and monitored. The provision of an easy to find, up to date ROR file within each ward was viewed positively by the focus group, and nurses now report they are confident in taking responsibility for creating personalised documents for ROR sessions.

Although training sessions were held with staff, the authors were unable to objectively report the direct impact of these in this study.

The relatively small number of participants and the change of population due to hospital admission and discharges was a significant limitation for the exploration of data. Two wards within the hospital had periods of COVID related lockdown whilst conducting the second data collection, which reduced the data set. Within this study, family and carer networks were not consulted on the information provision and understanding regarding their individual's legal rights. Christie and colleagues highlight that family involvement in rehabilitation is predictive of long-term positive outcomes and quality of life, thus the authors recommend consideration is given to increased collaboration between hospital teams and families in further service improvements<sup>6</sup>.

It was not within the scope of this evaluation to measure individuals' wellbeing or satisfaction. Previous research supports increased satisfaction in services with appropriate, accessible and individualised information. The authors suggest that making these improvements was likely to have an impact on individuals' feelings of empowerment and confidence. It is hoped service improvements made at Cygnet Brunel will be mirrored across other Cygnet services. The impact of improved information provision on an individual's experience, satisfaction, rehabilitation and recovery whilst staying at Cygnet Neuro psychiatric hospitals could then be more widely examined.

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# The Use of Eye Movement Desensitisation and Reprocessing (EMDR) Therapy Within Cygnet Services

## About the Author



**Dr Lorraine Bobbie Turnbull**  
Consultant Clinical Psychologist

Dr Lorraine Bobbie Turnbull is accredited in EMDR. She is currently working in a neuro rehabilitation unit but has also extensively worked in mental health acute and rehabilitation services and set up the Cygnet EMDR special interest group.

Eye Movement Desensitisation and Reprocessing, or EMDR, is a therapy that was initially introduced by Shapiro in 1987 for military personnel who had developed Post-traumatic stress disorder (PTSD) following service<sup>1</sup>. Since its early conception, Shapiro has written extensively on the topic and developed the practice of EMDR further<sup>2,3</sup>. The therapy has also undergone numerous research studies and is now used to support people experiencing many challenges including traumas, pain, phobias, and anxiety disorders.

I first became interested in EMDR when I was doing my undergraduate degree and was asked to participate in a research project using the method. I encountered it again as a Psychology trainee when a somewhat charismatic practitioner of the therapy came to speak to our cohort and demonstrated its use.

Whilst working in a mental health rehabilitation unit I observed that many of the men, I was working with, had experienced multiple traumas, were suffering from phobias, and also found it difficult to engage in therapy. One of the reasons that they gave, was that they had long-term involvement with mental health services, and throughout this had experienced numerous therapeutic approaches. The prospect of further longer-term therapy was a clear barrier. EMDR is unlike many other therapies in that it is a briefer therapy, "typically delivered one to two times per week for a total of 6-12 sessions, although some people benefit from fewer sessions"<sup>4</sup>.

I am very integrative in my approach, drawing on elements from different theories and therapies that seem appropriate to the individual or the issue we are working on, rather than focusing on any one particular approach.

As I felt that EMDR might add to what I could already offer, and there was not at that point anyone else trained in it, I decided to complete the training.

The training took a total of seven days which was divided into two training blocks. There was some background and theory, however on the whole it was very practical with us practicing techniques and then having to work with patients between the two blocks of learning. The therapy itself involves 'processing the memory' or the traumatic event by using 'bilateral stimulation' of the brain. The most common technique for doing this is by the therapist moving their fingers back and forth in front of the patient and asking them to follow the fingers with their eyes. There are other techniques of bilateral stimulation. For example tappers (paddles that the person holds in their hands that buzz alternately), butterfly taps (where the person places their hands on opposite upper arms and alternately taps their hands onto their arms), and light bars (an electronic strip with a moving coloured light).

Within my unit, I began work with several patients and the results were fascinating. I worked with people who had experienced car crashes, sexual abuse, phobias, social anxieties, and many other things and was amazed to see how quickly things could change for the people I was working with. Some people chose only to do the preparatory aspects of the therapy, which involve establishing coping skills and building resources that the person can use when needed. Examples of this include body scans, and establishing a safe place image using an imagined image and enhancing it with the senses. Other relaxation and grounding exercises are used together with other exercises where imagination is employed to generate supportive figures or images.

The therapy itself additionally uses aspects that are similar to other therapies such as rating scales, noticing where discomfort is located in the body, and recognising negative thought patterns.

Often during the processing stage of the therapy, images or memories can change for the person revealing other forgotten aspects. One man I worked with described a traumatic situation that had happened to him twenty years previously which had left him with a feeling of being alone. When he recalled the situation during the therapy he realised that there were other people present at the time of the event supporting him. The realisation of this helped to soothe the negative cognition of being alone. This fit with my own experience of EMDR during my training. I had experienced a car crash several years before and when I recalled it, I was aware of experiencing a memory of sitting in the driver's seat after the crash with the cracked window in front of me and feeling fearful that it might fall in. During the processing of this, my image changed to a bird's-eye view, and the anxiety that I associated with the event diminished. Now if I recall the accident that is what I see.

Whilst working towards becoming accredited in EMDR (a recognition that is achieved by working over a few years with a set number of patients and receiving supervision from a consultant) I worked with patients in other units as well as my own. It was a different dynamic as I did not have a pre-existing relationship with the individual and was meeting them solely to offer EMDR. We worked jointly with the psychologist in the unit. I would offer a session, and then we would meet with their psychologist to give some feedback and ensure that the person had the support that they needed between our sessions.

Initially, I did this by visiting the other units, however, with the COVID-19 pandemic, I had to introduce remote working, using video conferencing. This worked surprisingly well despite my initial reservations. I was able to email resources, and some of the patients seemed to respond more openly when I was on a screen. I have wondered if, for some, this is less intimidating than a face-to-face session, my being on a small tablet that they can carry and place where they feel comfortable in the room. The bilateral stimulation was more challenging as I could not use traditional eye movements, however other approaches, such as butterfly taps and light bars, proved more effective when working remotely.

In the last few years, I have become accredited in EMDR and have also set up a Cygnet EMDR Special Interest Group (SIG). We are a growing number of staff members, who are either trained and practicing, or interested in training in EMDR. The SIG provides an opportunity to share resources and offer support and ideas to one another.

Additionally, it offers a network across the company as a whole, so that should an individual in a service want to access the therapy, we can hopefully put them in touch with a practitioner, either in their own area or who can offer the work remotely.

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