Activating Lived Experience Leadership

Emerging Participatory Research Design

Ellie Hodges & Mark Loughhead, September 2019
the Activating Lived Experience Leadership (ALEL) Project

• Purpose:
To examine and describe how lived experience (LE) advocacy and leadership embedded within the mental health ecosystem can be defined, recognised and utilised in South Australia

• Partnership:
SA Lived Experience Leadership and Advocacy Network (LELAN)
Mental Health and Suicide Prevention Research Group (MHSPRG – UniSA)
the start of the idea

- Collective voice
- Influencing ‘real’ change
- Sustainability
- Power
- LE leadership
- Systemic impact

[Hodges (2018)]
why this work is vitally important

- In SA the power for people with LE to be active, influential and collectively drive change is limited

- To take ‘no action’ is to continue the same inadequate governance structures that fail to invest in LE leadership and advocacy innovation

- Without decisive action LE roles risk being ad-hoc and/or co-opted without any clear narrative towards durable LE leadership solutions

- by, for and with
What is the impact of LE advocacy and representation on individual recovery from mental health issues, including active participation in broader areas of life?

What are the reasons why LE leadership and advocacy is not well recognised or acknowledged by the health system? What steps are needed to change this?

What do people with LE say is needed in the design of training resources and networks to guide and support LE advocacy, representation and leadership?

How do we ensure LE advocacy and leadership resources and thinking is embedded in communities and the SA health system?
• **Stage 1: Jul-Dec 2019**
Recruit project staff. Establish advisory group. Prepare and submit ethics applications. Literature review addressing the research questions

• **Stage 2: Jan-Jun 2020**
Recruit LE participants and conduct focus groups (country and metropolitan travel). Recruit and conduct interviews (online and face-to-face). Use online platform for participant engagement. Interviews also with service leaders. Thematic analysis of data and generate themes. Support the development of place-based networks and/or communities of practice

• **Stage 3: Jul-Jun 2020/21**
Review themes and co-create training resources as online or printed. Review and evaluate training resources. Evaluation of training resources

• **Stage 4: Jan-Jun 2021**
Limited distribution of training and resources. On-going evaluation. Reporting and publications including recommendations for state-wide planning towards translational research
research methodology: participatory action research (PAR)

• PAR joins three important ideas: research, action, and participation

• It generally involves participants as active in producing research knowledge which is practical and leads to action or change in the social settings important to participants

• Research participant involvement in:
  • project design
  • choice of methods
  • recruitment
  • data collection and analysis
  • reporting
  • translating into change
PAR cycle
our interests in the research

- **Background knowledge**: Defining LE leadership? Scope of roles? How to influence? Common issues and challenges?

- **Planning for change**: With services? In the sector?

- **Putting into action**: Building networks? Trying new leadership skills and approaches?

- **Reflecting**: What works and has influence? How to share with others and support leadership?
Co-researchers often need preparation and training methods, depending on role they do.

Research participants often meet on multiple occasions over the research cycle and are involved in analysis and commentary.

Knowledge generated often involves definition of issue or problem, how issue can be addressed, how change occurs, how local conditions impact on knowledge.

PAR often involves ethical challenges in terms of maintaining privacy, confidentiality, anonymity, but also achieving participation, action and change.

[Lawson (2015)]
Emerging project design:

- Community development activities:
  - round table summit with sector leaders
  - building networks
  - workshops on LE engagement with research
  - project communications

- Complemented by formal research activities:
  - recruitment of diverse LE participant groups and service leaders
  - literature reviews
  - multiple focus groups with same group of LE participants
  - interviews with service leaders
  - national survey of LE and service leaders
  - evaluation of training resources
The PAG provides guidance and helps with recruitment strategies and broad level analysis, and translation.

All research focused activities will be governed by the UniSA Human Research Ethics Committee.
In wisdom we would see that the anatomical heart, which we have given our students to study [to know], is nobody’s heart. It is a heart that could belong to anybody and therefore it belongs to nobody. **Wisdom would have us understand that there is another heart.**

... the heart that can break; the heart that grows weary; the hardened heart; the heartless one; the cold heart; the heart that aches; the heart that stands still; the heart that leaps with joy; and the one who has lost heart. Wisdom demands that we teach students of the human sciences about the essence of this heart. The human heart. **Not the pump that beats in any body but the one that lives in my body and in your body**

[Deegan (1996), p.91]
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references


• Lawson, H 2015, Participatory Action Research Oxford University Press Inc.

Good afternoon, my name is David Moseley, I am a Senior Clinical Project Officer with the Barossa Hills Fleurieu Local Health Network, AND I am the coordinator of the Artist in Residence Program.

I will give you brief outline of the project, THEN Nicholas with talk to you more deeply about the research accompanying the residencies, BEFORE finally artists Joe Felber and Ashton Boyd will share their experiences and their broader thoughts about the role of arts in health.

The Artist in Residency Program has been running since 2017. (Ashton and Joe are the 6th and 7th participating artists)

The program is co-funded by the BHF LHN and the University of South Australia.

The program brings visual artists into the Rural and Remote Acute Psychiatric Inpatient Unit at Glenside, to make art WITH and ALONGSIDE consumers, AS WELL AS to produce a body of work for exhibition in the SALA festival.

Participating Artists receive $1000 at the commencement of the residency AND THEN a further $1000 when their works are exhibited in the SALA Festival.

Typically the residency occurs in the 3 months prior to SALA.

So, How did it come about? The Russian novelist and poet Vladimir Nabokov said
“There is no science without fancy and no art without fact”

Vladimir Nabokov

This is very much the spirit in which I approached Nicholas when proposing the residency project.

I knew the power of human connection possible through art marking, and I wanted the consumers of our service to have the opportunity experience it.

However, I also knew, that unlike other health services in the United Kingdom and Canada, Arts in Health in Australia, was NOT YET part of standard practice

There is a question of LEGITAMACY that hangs over it.

The university’s partnership AND research would be a legitimising force and pave a future for the program.

So reflecting back on Nabokov, art provided the fancy and the university the fact, each is equally dependant on the other.
The residency is designed to bring about a **meaningful connection** between **artist and consumer** that **empowers** both.

The artist is **WITH** the consumer, present in an **equal partnership**. Any art making outcome is **subordinate** to the development of a human connection.

The artist is **privileged to spend time in a setting** that they would not normally have access to, and have THAT experience **shape their creative character and open new avenues in their work**. And;

The consumer is **introduced to art practice**, and its **POWER to modulate mood, address boredom, provide purpose and build connections**.
IN ADDITION to the research findings that Nicholas will present shortly,

the residency gave US (the health service) access to the artists skills of perception.

The Artists, expressed observations in their work, that WE CAN USE to better understand the experience of the consumer.

This preparatory drawing from artist Henry Stentiford shows the importance of the ward telephone to the person AS A CONNECTION to the world outside their admission.
The residency did have CHALLENGES and DIFFICULTIES

• Younger artists were sometimes intimidated by the environment

• Not all artists engaged as we would have liked, but we have got better at selecting them.

• Not all Nursing and Medical staff were supportive, BUT we recognise we can do more to engage them.

AND, most significantly, The high patient turn over of the inpatient setting is a barrier to developing consistent relationships between artist and consumers.

However, most of these challenges can be overcome AND New exciting opportunities DO exist for the program,

This could include;

expanding the residencies into the community setting,

creating artist lead initiatives that connect community MH consumers WITH local creative communities, to build PROTECTIVE SOCIAL CONNECTEDNESS
THANKYOU, I’ll now pass you onto Nicholas to talk about the research findings.
The Rural and Remote Inpatient Mental Health Unit Artist-in-Residence Program and Research Project

A collaboration between the University of South Australia (Dr Amy Baker & Professor Nicholas Procter), Country Health SA (David Moseley), the SALA Festival and the artists-in-residence (Josef Felber and Donovan Christie (2019), Ashton Boyd & Thomas Readett (2018), Jade Harland and Henry Stentiford (2017))

Presentation adapted from a paper delivered at the International Conference on the Arts in Society in 2018, Vancouver, Canada
Rural and Remote Inpatient Unit (Country Health SA) Glenside Health Services

Artists-in-residence project at Rural and Remote Unit – typical timeline

EOI for selecting artists (February – March)

Artists selected; undertake induction (April - June)

Artists at R & R Unit (June – Aug / October)

Artwork exhibited (August)
Research Aims and Approach

Aims:

• To understand the impact of the artist-in-residence program for consumers and artists
• To evaluate the artist-in-residence program from the perspectives of consumers and artists

Approach:

• Qualitative design
• Semi-structured interviews with consumers and artists
• Thematic analysis
Would you say the artist-in-residence program has impacted on you as a person?

“definitely given me an option for somewhere else to hang out aside from going outside… the art room materials aren’t available a lot of the time… (Participant 1, 2017)

‘I’ve really enjoyed doing something because… I get so bored in here and I really enjoyed that extra couple of hours doing something, you know, painting and expressing myself in a way. It’s a pity they don’t have a lot more things like that or it wasn’t a bit longer… it kills the boredom… it sort of gives you something to do in that time. And it’s something you really enjoy doing. (Participant 5, 2018)
Would you say the artist-in-residence program has impacted on you as a person?

‘Huge. Absolutely huge. Wish I had have had it in hospital any other time I’ve been to hospital… Something to look forward to here is hard to come by so that was very helpful. It’s the most comforting thing I’ve ever done in hospital. (Participant 2, 2017)

‘It's impacted in a way that there is more out there than just sport that can stop my mind and drugs… sitting there and doing… art, even though mine wasn’t the best… even though I was just sitting there painting it brown it didn’t matter… it stopped my brain from going at a million miles an hour.’ (Participant 4, 2018)
Henry Stentiford,
2017
Do you think that having an artist-in-residence program relates to recovery in mental health?

‘Big time. Huge. It’s just so nice to see a happy face and someone so welcoming and happy to do a drawing for you…. They’re very special drawings – it’s like a letter without words. … It’s like getting friendship, unconditional friendship and it’s all in a picture, it’s like a photo but it’s not but it’s even more personal because he did it himself.’ (Participant 2, 2017)

‘hanging out with [the artist] yesterday made me feel like less of a monster and more of a human.’

(Participant 1, 2017)
Do you think that having an artist-in-residence program relates to recovery in mental health? (cont)

‘It’s inspired me to want to learn to do artwork which I never thought I was capable of. It inspired me to want to try harder, and have a job and be able to comfort somebody else like that would be awesome. It makes me want to help other people because he helped me….’ (Participant 2, 2017)

‘I feel like I’ve got the trees in my room [referring to drawing] so I don’t need to go outside for a smoke. I can just sit in my room and pretend I’m outside without all the people going ‘have you got a smoke? Have you got a smoke?’ … It’s so comforting. Feels like you’ve got your friend sitting with you but they don’t talk.’ (Participant 2, 2017)
Do you think that having an artist-in-residence program relates to recovery in mental health? (cont)

Yeah it gives me relaxation and peace in the heart you know, and all the worries are just gone, you’re… not holding onto the worry any more you know, just letting it go, doing something else, something good, holding onto something light instead of holding onto something heavy… something hard to carry, that's all the worries and stuff that's a big thing to carry in life cos we're holding onto it but when we look up to the painting, we’re dropping that big heavy load, worry, and picking up this good, light… something that makes you feel relaxed, happy… (Participant 7, 2019)
Does the artwork that you’ve done relate to recovery in any way for you?

…I reckon if I sat there and with a paintbrush and that like for a day, I could get a lot better real quick. My problem is… my underlying thing is anxiety and depression. Yeh so I’ve always had that… but it stops my anxiety when I’m painting. (Participant 4, 2018)
‘To be able to draw whatever you like and get it off your chest without telling anybody because maybe it’s too personal you just write it as you think it but no-one else knows what it means, so you can just get it all out.

I got so much off my chest on there but without disturbing anyone.’

( Participant 2, 2017)
‘Saltwater (Tears)’
Ashton Boyd, 2018
Research study:
Next steps

Interviews with the artists (2019-2020)

Thematic analysis

Dissemination – journal paper
Thanks to the consumers and staff at the Rural and Remote Inpatient Unit at Glenside (Country Health SA), Heather Eaton (Research Assistant at UniSA) as well as the SALA Festival for their support throughout this project.

For more information about the artists:

Henry Stentiford: http://www.henrystentiford.com/
Jade Harland: http://jadeharland.com/
Ashton Boyd: https://www.baytheartist.com/

Thomas Readett: https://www.trvisualarts.com/
Donovan Christie: https://www.donovanchristie.com/
Josef Felber: http://www.joefelber.com/

For more information about the research project or overall artist-in-residence program, please contact:

Dr Amy Baker: amy.baker@unisa.edu.au / David Moseley: David.Moseley@sa.gov.au
Joe Felber
Residency for SA Health 2019
Psychology and art is an interdisciplinary field that reflects historically like Art brut where perception and cognition are characteristics of an art production.
Art Brut founder Jean Dubuffet describes art created outside the boundaries of official culture.
Why is art essential in public health and mental health?
Wiru Kata Ngayulu Piña

Hope

Anxiety

Wati Palya Ngayulu

Tjunyaji

$tjupitjin$

I was feeling insecure

Smile, happy
Consumers exploring art
Pioneer figures like Swiss Curator changed extended peoples art perception with research and showing every aspect in contemporary art historically including Adolf Woelfli obsession with drawing on paper and objects.
Martin Disler

Martin was a friend Swiss Artist who became known with the 1980-ties movement *Neue Wilden* and his work resembles Egon Schiele and *Art Brut*. 
Adolph Wolfli 1864 – 1930 was a Swedish orphan and worked as a farm laborer. He was arrested and later diagnosed with schizophrenia and spent most of his adult life institutionalized. He created many great adventures with scraps of paper and pencils given to him by staff. At Christmas he received a box of colored pencils that might last a month.
A continues interest in the work of Adolf Woelfli collected in museums and art institutions.

Art Collections like this reveals an interest in mental health over time in history.
Louis Soutter  Swiss 1871 – 1942
Black and White
Atmospheric pressure...
Hard on
Landscape for tomorrow
Spills
Orgasm
Sea rising
Since 9/11
Fleurieu
Landscape in drought

Bees Disappearing
Linear illusion
Linear illusion
Nations collapsing
Modernity
Dog run Dog
Migration
Flowers
Illumination
Wars Repeating
Code language

Vapour
Apocalyptic landscape
Colours over time
LandEscape, Patrick White
Global change
Accident
The men who drinks petrol
The planet earth
White Froth
Add remove Time

Modernity left over
New York Soho
Assume...
At the Beginning
A Monologue
The Fate of Self-Taught Art

By conceiving the notion of *art brut* in a Europe devastated by the Second World War, French artist Jean Dubuffet questioned the underlying pretense behind the processes of artistic legitimization, dispossessing those authorities empowered to legislate in the art world. He also insisted on the flexible nature of definitions, maintaining that *art brut* could incessantly evolve depending on the context of its emergence, knowing that the norm and the margins are perpetually reassessed.
Proposal
Art Container
Mobile or
In place
How can we improve?

Experiencing art can build confidence!

Process drawing painting will release energy build up hate, anger!

Trust with consumers is only gained over time by staffs that believes in building companionship.

Gaining self-belief through drawing scribble, writing text or painting abstracts.

Can consistent art making reduce drug intake?

Through art learning autonomy.
‘Please Talk to Me. Please Include Me. I Want Nurses to Understand’.

Carer Perspectives on Emergency Department Nursing Practices for a Person with Borderline Personality Disorder

Kristy Acres | PhD Candidate, Mental Health and Suicide Prevention Research Group UniSA
Judy Burke | Founder, Sanctuary BPD Carers Support Group
Overview

• Borderline personality disorder (BPD) is a mental illness where a person experiences negative self-image, chronic feelings of emptiness, challenges with interpersonal relationships and presents with a high prevalence of self-harm and/or suicide attempts.

• The estimated prevalence of BPD is estimated between 1-4% of the population, in South Australia this equates to an estimate of between 17,000 to 68,000 people living with BPD.

(National Health and Medical Research Council (NHMRC) 2012, SA Health 2019, World Health Organisation 2003)
Overview

• Suicide is a leading cause of death worldwide.

• People with BPD are at an increased risk of suicide.

• It is estimated that 10% of people with BPD will die by suicide.

• In addition a further 60-75% will attempt suicide.

Sanctuary

About Us

- Founded in 2012 by Bob and Judy Burke
- In 2012 there were 3 members, today there are over 250 members
The need for support

- Sanctuary is a safe place for loved ones and carers to find support and information.
- It provides compassion and understanding.
- Provide advocacy about discrimination and stigmatizing practices.
How Sanctuary partnered with UniSA

- Historically carers have been overlooked as a partner in recovery and in research settings.

- By partnering with UniSA, carers had the opportunity to collaborate with the research team to generate new insights and knowledge which will hopefully translate into clinical practice.
The Study

• We set out to explore the deeper meaning of the phenomenon of carers accessing support and care in a crisis.

• We partnered with carers to hear their voices.
Part 1: Scoping review

Literature review

Carer perspectives of people diagnosed with borderline personality disorder: A scoping review of emergency care responses

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ABSTRACT

Background: Caring for a person with borderline personality disorder remains largely stigmatised and misunderstood. When a crisis arises, carers often seek help with the person they care for in emergency care settings such as the emergency department. The aim of this review was to explore, locate and compile the literature regarding the perspectives of family carers for a person with borderline personality disorder in an emergency care setting with a focus on nursing practices. This review advances understandings of carer perspectives in emergency care settings.

Methods: The Joanna Briggs Institute (2015) [1], methodology for scoping reviews guided this review. A search of Emcare, Medline and Ovid Nursing was performed during April 2018, to identify literature where carer views and perspectives on engaging with emergency care services were reported. A grey literature search was also conducted. A total of ten articles and reports were included in this review. Consultation with a carer support group precipitated this review, which assisted in the formulation of the research questions.
Findings

• A lack of communication between health professionals and carers is a significant barrier in treatment management (Dune and Rogers 2013).

• Carers often experience stigma and medical discrimination as a result of the self-harming behaviour associated with BPD, resulting in limited access or refusal of medical treatment.

• When practices of stigma occur the therapeutic relationship can be damaged (Ng et al 2016).

• Health professionals were reluctant to engage with carers resulting in a lack of knowledge and information for the continued support and management of their loved one (Giffin 2008).
**Part 2: Focus Group Interviews**

**Characteristics of study sample (N=13)**

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Key Findings

• ED is the gateway into crisis support
• Talk to us don’t judge us
• A different level of care
• What I want you to know
How this translates to clinical practice

• The main reason carers present to the ED with their loved one is the treat of death by suicide or self-harm.

• Carers are a significant resource in recovery planning and contribute to positive outcomes. Information on what the disorder is and how to manage high risk situations does not question confidentiality.

• Many carers are living with significant stress and trauma, they require kindness and compassion just like any other medical condition.
Questions????

People don’t always need advice. Sometimes all they really need is a hand to hold, an ear to listen and a heart to understand them. (Anonymous)
The Tale of Two Communities of Practice: Mental Health in the Royal Adelaide Hospital Emergency Department/Short Stay and the South Australian Trauma Informed Practice Committee

Nicholas Procter, Chair: Mental Health Nursing and Leader, Mental Health and Suicide Prevention Research Group, University of South Australia

Del Thomson, Clinical Risk Manager, Office of the Chief Psychiatrist SA Department for Health and Wellbeing

Julie-Anne Reilly, Nurse Unit Manager, RAH Mental Health Team, Consultation Liaison and Mental Health Short Stay Unit, Royal Adelaide Hospital, Central Adelaide Local Health Network
What is a Community of Practice?

Communities of Practice (CoP) are groups of people who share a common concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.

CoP often involve people that don’t necessarily work together every day.

However, they come together because they find value and meaning in their interactions.

Wenger, E McDermott, E Snyder, W 2002 *Cultivating Communities of Practice* Boston: Harvard Business School
What happens in a Community of Practice?

As they spend time together, they typically share information, insight, and advice. They willingly help each other solve problems; discuss their situations, their aspirations, their needs; Ponder common issues, explore ideas, and act as a sounding board.

They may create tools, standards, resources and other documents – or they may simply develop a tacit understanding that they share with each other.
What is the key to success in a Community of Practice?

CoP must develop their own ways of operating, connecting people from different clinical and service areas as well as across independent specialised units.

In the process, they remain open to how they knit the whole system together around core knowledge requirements relevant to what they are doing. Over time, such knowledge becomes cumulative and embedded in overall ways of working.
A democracy of ideas where knowledge is social as well as individual

Through a process of communal involvement, including all the controversies, that a body of knowledge is developed.

It is by participating in these communities – even when going against the mainstream that members produce new knowledge.

The best communities welcome strong personalities and encourage disagreements and debates. Controversy is part of what makes a community vital, effective, and productive.
So now you know what a community of practice is –
• a forum for information exchange and building capacity.
• a central share-point for teaching and learning resources and experiences.
• The creation of an opportunity for personal and professional development and
• A process that facilitates communication of best practice principles

The CoP that I have been involved with is an ‘off shoot’ of the SA Trauma Informed Practice Committee’. That committee started life as the Restraint and seclusion Minimisation working party, became the Minimising Restrictive Practices Working Group and then in 2016 the CP invited some US based trainers in TIC from the Substance Abuse and Mental Health Services Administration to SA to provide train the trainer training, the working group then became the TIPWG.

Having a group of TIC trainers who could support each other was the impetus then for the TIC CoP.

But why trauma informed care?
What is trauma -

> ….trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

If we look at the definition of trauma –

Everyone is different in what they might find traumatizing, and the younger trauma occurs potentially, the more damaging, long term effects might result.

In 2015, the Dept. of Health in Victoria considered the importance of trauma in mental health care and had commenced TIC training for staff based on the prevalence of trauma experienced by mental health consumers.

This includes acknowledging that:

• young people are affected by trauma more than older people,
• people who experience repeated episodes of trauma are affected more greatly than those who experience an isolated event; and
• the severity or the type of trauma can makes a difference.

And in mental health we have -

• over-representation of groups of people being at greater risk of trauma due to sustained discrimination and abuse such as refugees, Aboriginal and Torres Strait Islander people as well as lesbian, gay, bisexual, transgender and intersex people.
• There is trauma associated with war, torture and natural disasters
• Trauma related to the impact of family violence and/or childhood sexual assault and we know that experiencing or witnessing domestic violence is particularly damaging because it is premeditated, planned and perpetrated in a relationship of care.
And the ABS data tells us that - one in three women and one in six men will be sexually abused before the age of 16 and one in five women and one in 20 men report having experienced sexual violence from the age of 15.

Another report into a study conducted in Victoria in 2012 titled ZERO TOLERANCE FOR SEXUAL ASSAULT: A safe admission for women by the Victorian Mental Illness Awareness Council stated that:

Data analysis demonstrated that 85% of females felt unsafe during hospitalisation,

That is what our system can do to a person who is most likely to have already experienced some form of trauma.
So what is trauma informed care?

There isn’t (as far as I am aware) a really well defined, internationally agreed definition but it is described as the slide says this way by the US Substance Abuse and Mental Health Services Administration.

- Trauma-informed approaches reflect a fundamental shift in the culture of an entire organization.
- These four R’s highlight basic aspects of culture change that an organization will demonstrate as it becomes trauma-informed.
- The Four R’s reflect that it is not enough to simply know about trauma.
- To be trauma-informed, people must be able to identify trauma when they see it, and they must know how to respond in a way that doesn’t unintentionally re-traumatise people.
- Trauma-Informed approaches can be implemented anywhere, by anyone. Everyone in the organisation has a role to play in becoming trauma-informed.

It is a complete culture shift and requires education and training, a change in language, a review of policies and procedures, an acknowledgement of how the environment can ‘trigger’ a person as well as everyday institutional practices......
And some basic things we do that could be ‘triggering’ and or ‘re-triggering’ include:

- When we have someone on a mental health legal order we have absolute power/control over them – just like a sexual abuser may have done to them in the past
- We might see the persons behaviour as intentionally provocative & volitional and respond to that without considering the implications - I remember a person who I had felt there was a degree of purposeful uselessness in their behaviour and when they looked yet again like they would not make it to the toilet and wet their pants
- The use of labelling language, especially with ‘the borderlines’ of being manipulative, needy, “attention seeking” etc
- Our observation practices are often just a checks to locate the person and not seen as an opportunity to engage with the person – for the person does this feel like they are being watched / aren’t trusted instead of feeling like I really want to know how they are and if they are ok?
- The physical layout of nurses stations – as a closed off barrier creating an environment of ‘us and them’
- Use of guards – they aren’t clinicians, they wear uniforms - this is potentially promoting a sense of a prison not a therapeutic environment
To start impacting on this and with Nicholas’s support we started a community of practice. It included members of the committee but also other people who were actively (or at least trying to) providing trauma informed care training and had an interest in the practical application of trauma informed care in clinical settings.

We wanted to start that change towards a trauma informed service with education and as a group to share ideas on the use of trauma informed language and how individuals TIC training was progressing.

We were then asked by the TIPWG to review the ‘debriefing’ tool from the Minimising Restrictive Practice Tool Kit. This felt like a really practical way to use our skills to impact on bringing trauma informed care and practice into all mental health services.

We wanted to make sure we used a trauma informed approach to co-designing and developing a trauma informed product.

When we started looking at it, members commented on the positive aspects of the tool and the areas that we thought required improvement. There was a strong focus on ensuring that questions utilised Trauma Informed language (hence the change from ‘debriefing tool’ to ‘post incident conversation’) and a person-centred approach. It was noted that Trauma Informed Care works from the fundamental principles of trauma awareness. That is, to avoid re-traumatisation by empowering consumers and staff in decision making, safety, trustworthiness, choice and collaboration as well as building
strengths and skills. Members workshopped and assessed the purpose of the Tool through this lens and provided thorough feedback on what could be modified or improved.

I think we came up with a tool that could then be used within the training provided by CoP members as well as used by any staff member or consumer or carer consultant, following any type of incident to help prevent another incident but also to help reduce the impact that event may have had on the person.

So, a community of practice can serve a number of purposes and for me, this one can help make a fundamental change to services, because if we don’t provide an environment that is therapeutic, if we don’t engage in a trauma informed way with consumers and carers, we’ll continue to have an environment and a service in which our consumers don’t feel safe, where they’ll continue to engage in practices that are harmful to themselves or others and a workforce that feels more and more disheartened.
“CL and ED is busy but MHSSU is only 6 beds?”
Where am I and what is going on here?

Consumer group
- Complex individuals ... biopsychosocial assessment
- Medical comorbidities / unpredictability
- Complex personality structures
- High suicidality and self-harming behaviour
- High turnover ... multiple admissions and discharges a day

Staff affected by:
- Navigating new relationships and building a rapport with the wider hospital community i.e AMU “Psychiatric Prejudice”
- Staff functioning with high anxiety levels “think on your feet”
- Constant media attention... demand and PIC not opening
- A unit interfacing with the ED pressure daily, in fact State MH bed pressure
- Daily pressure to admit individuals not appropriate to the short stay length of stay and or environment... “just because there is a bed”
Help needed!

“As a team and as a Manager...struggling to advocate for our consumers and struggling to assert our worth as a function within the Mental Health Unit”

**Imperative for Consumers and urgent for staff**

- Safety and Quality
- Clinical outcomes
- Morale and Milieu............*lost meaning*

“deep dive”
Communities of Practice

From April 2019...

- 1st RAH Mental Health Short Stay Communities of Practice Meeting - Being therapeutic in a mental health short stay environment

- 2nd RAH Mental Health Short Stay Communities of Practice Meeting - Therapeutic relationships and self-care in a mental health short stay environment

- 3rd RAH Mental Health Short Stay Communities of Practice Meeting - Identifying and describing clinical practice in mental health short stay

- 4th RAH Mental Health Short Stay Communities of Practice Meeting - Trust, Validation and Leadership in Mental Health Short Stay Environment
“You were all incredibly caring and I felt safe from the moment I walked in the unit despite it all being foreign”

“Please pass on my thanks to the team for helping me turn a corner”

“I’m a bit tired today but I’m using the skills you guys gave me, who would have thought an old bugger like me would learn some new tricks”
“Warmth and the Wall of Thank you”
12th Shared Learning in Clinical Practice Symposium: “Showcasing Engagement in Mental Health and Suicide Prevention”
University of South Australia

Jennifer Hurley, Chief Nurse and Midwifery Officer
24 September 2019
SA HEALTH

NURSING AND MIDWIFERY STRATEGIC DIRECTIONS

2019 – 2022

To find out more visit sahealth.sa.gov.au/nursingandmidwifery
NURSING AND MIDWIFERY STRATEGIC DIRECTIONS 2019 –2022

Nurses and Midwives will lead the design and provision of quality sustainable health care services to improve the wellbeing of all South Australians.

OUR VALUES
- Generosity
- Empathy
- Integrity

KEY PRIORITIES
- Enabling Professionalism
- Connecting Care
- Workforce Agility
- Research and Innovation

STRATEGIC OBJECTIVES
- Inspiring South Australia
- Influencing Nationally
- Leading Globally

SA HEALTH
Nurses and Midwives:

> Will be leaders and drivers of change across the health care system
> Influence, shape and design health services through effective policy and decision making
> Recognise and celebrate our professional identities
> Value their contribution to the health and wellbeing of South Australians
> Will continue to work collaboratively to extend their full scope of practice
> Commit to caring for themselves and each other
Nurses and Midwives:

> Provide compassionate, reliable person centred care that is timely, appropriate and supports wellbeing
> Bring a unique body of knowledge essential to the development of successful models of care
> Are at the forefront of clinical governance
> Recognise and enable a person’s right to self-determination for wellbeing
> Recognise and welcome diversity in the community
Nurses and Midwives:

> Will promote and build a sustainable, resilient, contemporary and adaptive workforce to meet the needs of the community
> Will foster strong authentic leaders at all points across the care continuum
> Recognise the value of life long learning opportunities
> Embrace a culture of respect and create continual opportunities for growth and professional development
Nurses and Midwives:

> Recognise research is essential in driving innovation and translating evidence into practice
> Are early adopters of technology into care
> Will utilise data and information to innovate, create and support decision making
> Use evidence to predict and plan future health care directions
> Value innovation through collaboration and partnerships
SA Health Nursing and Midwifery Office and University of South Australia

Mental Health Nursing Workforce Strategy

Creating a new and healthy narrative mental health nursing in South Australian Context
Mental health nurses will be compassionate resilient, adaptive, contemporary and highly skilled, with a genuinely empathic and recovery orientated approach to health care. We will be drivers for effective and safe care delivery and we will work to reduce stigma and strengthen the wellbeing of South Australians.
Side-by-side is central in this diagram as it encompasses two core themes.

First, as nurses we are side-by-side with consumers and their loved ones; providing supportive nurturance and facilitating strengths based recovery with dignity.

Second, as nurse leaders at all levels we are working side-by-side with new entrants into the profession as well as existing staff to advance individual careers, career progression and career support, while simultaneously ensuring evidence based person-centered nursing.

Taken in combination with each other this constructs a narrative towards excellence in clinical and organisational effectiveness.
Mental Health Nursing Workforce Model
– SA Health

- Lead, influence and shape policy
- Lead, inform and co-design mental health services
- Shared governance and decision making
- Embrace change, innovation and research
  - Promote a positive and constructive workplace culture

LEADERSHIP

PERSON CENTRED

COMPASSIONATE LEARNING

CARING

COMMITTED WORKFORCE

EDUCATION

CAPABLE

MODEL OF CARE

SUPPORT STRUCTURES

SIDE BY SIDE
NURSING AND MIDWIFERY STRATEGIC DIRECTIONS 2019 –2022

Nurses and Midwives will lead the design and provision of quality sustainable health care services to improve the wellbeing of all South Australians.

WE LEAD
WE INNOVATE
WE CARE

OUR VALUES
GENEROSITY
EMPATHY
INTEGRITY

KEY PRIORITIES

Enabling Professionalism
Connecting Care
Workforce Agility
Research and Innovation

https://youtu.be/5kShZNZ1-TA

SA Health
Thank you

Nursing and Midwifery Strategic Directions

Nurses and Midwives will lead the design and provision of quality sustainable health care services to improve the wellbeing of all South Australians.

OUR VALUES

GENEROSITY

EMPATHY

INTEGRITY

KEY PRIORITIES

Enabling Professionalism

Connecting Care

Strategic Objectives

Nurses and Midwives:

Will be leaders and drivers of change across the health care system

Influence, shape and design health services through effective policy and decision making

Recognise and celebrate our professional identities

Value their contribution to the health and wellbeing of South Australians

Will continue to work collaboratively to extend their full scope of practice

Commit to caring for themselves and each other

Nurses and Midwives:

Provide compassionate, reliable person-centred care that is timely, appropriate and supports wellbeing

Brings a unique body of knowledge essential to the development of successful models of care

Are at the forefront of clinical governance

Recognise and enable a patient's right to self-determination for wellbeing

Recognise and welcome in the community

SA Health
Mental Health and Suicide Prevention Research Group:

Lived Experience Engagement Strategy

Dr Mark Loughhead
Senior Research Fellow
School of Nursing and Midwifery, UniSA
Acknowledgements:

Matt Halpin and Nicholas Procter

HCASA – SAMHRI

SA Lived Experience Leadership and Advocacy Network

Members of the MHSPRG Shared Learning communities of practice

SoNM Research Executive
Our work so far

Purpose of LE engagement framework: guiding and strengthening practice and partnerships

Newsletter article
Consultations
Iterative development
Evidence from other states and international context
NHMRC context

- Ethics applications
- Grants
- Advisory roles of LE
- Partnerships across the research cycle
- Co-authorship
**Cultural principles**

- Lived experience complements and informs formalised professional knowledge.
- Consumer/carer engagement as standard practice for increasing knowledge of key issues.
- Consumer/carer perspectives are included across planning, implementation and translation of research activities.
- Consumer and carers partners set research priorities and ask research questions.
- MHSURG values shared authorship.
- MHSURG establishes a welcoming and supportive environment where consumers and carers feel a part of the research community.
- The boundaries of research projects are clear for everyone.
- Positive experience of engagement and relationships sets a benchmark for our success.

**Supports & Infrastructure**

- Appropriate reimbursement and employment processes for consumer and carer partner.
- Provide orientation and education sessions to consumer and carers on relevant research methods and processes.
- Provide information and support regarding questions about ethics, privacy and confidentiality.
- Provide learning sessions for researcher leaders on engagement practice.
- Consider adjunct status for lived experience researchers and leaders.
- Ensure office and educational infrastructure can be accessed for lived experience researchers and partners.

**Key practices**

- Consumer and Carer led.
- Partnerships and Collaboration.
- Consultation.
- Information.

**Levels of Engagement**

- Planning research – doing research – promoting research.
### Lived Experience Engagement Framework

#### Values and principles
- Lived experience (LE) expertise and skills complements and informs professional knowledge and learning.
- Consumers and carers bring diverse forms of learning and experience.
- Consumer/carer engagement is standard practice for increasing knowledge of key issues and research outcomes.
- Consumer/carer engagement occurs from the beginning, and informs research priorities, planning, implementation and evaluation activities.
- Use research and teaching methodologies which align with lived experience and co-production values.
- Lived experience educators offer essential learning opportunities for students of mental health.
- MHSPRG values shared authorship in curricula design and research.
- MHSPRG establishes a welcoming and supportive environment where LE partners feel a part of the research and teaching community.
- The scope of projects, roles and engagement processes is clear for everyone: be transparent.
- Authentic engagements and relationships are a benchmark of our success.

#### Supports and infrastructure
- Provide appropriate reimbursement and employment processes for LE partners.
- Find opportunities and roles for people with LE who want to contribute: ensure flexibility.
- Provide orientation and education sessions to LE partners on relevant research methods and processes.
- Provide information and support regarding questions about ethics, privacy and confidentiality in research and teaching.
- Provide learning sessions for research leaders on engagement practice and the value of lived experience.
- Consider adjunct status for LE researchers and educators.
- Prepare LE educators for understanding the learning needs of students and effective LE teaching approaches.
- Support LE educators to teach in safe ways, including the use of principles, consumer or carer perspectives, service standards, theory and effective storytelling.
- Prepare students, academics and classrooms for understanding the context of LE perspectives: ensure briefing and debriefing.
- Ensure safe teaching and learning opportunities for students and educators with lived experience.
- Ensure office and educational infrastructure/practical supports can be accessed for lived experience researchers, educators and partners.
- Encourage reflection, feedback and ongoing learning for all parties.

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#### Research

<table>
<thead>
<tr>
<th>LE partners generate a list of research priorities/questions that guide MHSPRG consideration of research grants, projects and student research topics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up flexible research partnership (steering) groups for research projects, enabling co-production of study information, recruitment process, consumer involvement, data collection tools and study Promotion.</td>
</tr>
<tr>
<td>Employ LE research assistants for individual research projects: engage in recruitment processes, data collection and analysis, reporting and promotion.</td>
</tr>
<tr>
<td>Enable joint authorship and contribution to publications, information or presentations in various ways. LE panel membership for post grad supervision.</td>
</tr>
</tbody>
</table>

#### Education

| LE educators lead a Recovery Learning Network, focused on promoting consumer, carer and clinician learning regarding recovery practice. |
| Partner with LE educators to co-produce curricula and develop learning activities and resources (podcasts, videos and virtual classrooms). |
| Employ LE academic staff to directly teach into programs and courses, providing knowledge and skills on recovery practice and person-centred care. LE academic staff can also provide guidance on courses taught by others. |
| Support leadership and learning regarding the peer workforce, consumer advocacy and recovery. |

#### Partnerships

<table>
<thead>
<tr>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
</tr>
</tbody>
</table>

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**Draft version 3.2**
For consultation purposes only 21 05 19

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Partnerships in mental health research and teaching
Values and Principles

- Complementary knowledge
- Diverse learning and knowledge
- Involved from beginning
- Informs research priorities
- Engagement across research cycle
- Shared authorship
- LE aligned research and teaching methodologies
- Clear roles, scope and boundaries
Support and Infrastructure

- Opportunities and defining roles
- Reimbursement/employment
- Planning and budget support
- Learning opportunities for LE leaders and partners
- Orientation and training for LE and non LE researchers
- Safe teaching practices and preparation
- Access to office and educational infrastructure
- Reflection, feedback and learning.
Research engagement actions

• LE list of research priorities
• Project partnerships – coproduction of aims, design, recruitment, data collection, analysis and translation
• LE research assistant roles
• Joint authorship
• LE on PHD supervision panels
• Build LE membership of research group members and email lists
• Enhance MHSPRG communications
Education engagement actions

- LE focused recovery learning CoP
- LE partnerships to develop curricula, learning activities and resources eg films and podcasts
- LE adjunct roles or educators roles to teach directly
- Support leadership and learning in wider LE community
- Consult on trends and issues – teaching priorities
- Enhance MHSPRG communications and information re teaching and learning
- Promote best practice via newsletters, symposia events and podcasts
Key references


Mental Health and Suicide Prevention Research Group:

Lived Experience Engagement Strategy

Dr Mark Loughhead
Senior Research Fellow
School of Nursing and Midwifery, UniSA
Contact: mark.loughhead@unisa.edu.au
Tel: 8302 1267
Collaboration in Older Person’s Mental Health:

UniSA & Northern Adelaide Local Health Network

A/Prof Terri Gibson: Project Lead
Mr Paul Brown: Advisory Committee
Ms Julie Brown: Project Manager
Why this project now?
Why this project?

A Lived Experience Perspective
Short course:
Professional Certificate in Older People’s Mental Health

• AQF level 8

• Multidisciplinary in focus & delivery

• 9 units of study over 18 weeks
Project Advisory Group

Clinical, academic, & management expertise from NALHN, UniSA & other relevant groups including people with lived experience perspectives

Role: Advise on content & oversee course development

Members:

Dr Terri Gibson, Assoc Head of School, Academic, SoNM, UniSA

Professor Nicholas Procter, Professor & Chair: Mental Health Nursing, SoNM, UniSA

Mr. Paul Brown, Consumer with lived experience

Ms Vicki Johns, Nurse Practitioner, SALHN

Adj. Ass Prof Vanessa Owen, Executive Director, Nursing & Midwifery & Clinical Governance, NALHN

Ms. Tara Crossman, Occupational Therapist, Older Persons Mental Health Services, NALHN

Dr Karleen Thornton, Acting Director: Organisational Development and Learning, NALHN

Ms Liz Owen, Registered Nurse, Advance Care Directives Educator, TQEHD, CALHN

Dr Duncan McKellar, Consultant Psychogeriatrician, Head of Unit, Older Persons’ Mental Health Service, NALHN

Dr Cheryl Lee, Consultant Psychiatrist, Older Persons Mental Health Services, NALHN

Ms. Janet Trotta, Nurse Educator, NALHN

Ms Julie Brown, UniSA Adjunct, Project Manager
Project Technical Group

Project Technical Group
Relevant curriculum/educational/ professional expertise

Role: course development

Members:
A/Prof Terri Gibson, Assoc Head of School Academic, SoNM UniSA
Prof Nicholas Procter, Professor and Chair: Mental Health Nursing, SoNM UniSA
Dr Kate Rhodes, Course Coordinator PG Mental Health
Ann Kempe, Tutor (online) & Project work (course writing)
Ms Julie Brown, UniSA Adjunct Industry Fellow, Project Manager
Course Development

Learning Design
• theoretically informed & practically oriented
• a blended learning approach of online facilitated & self-directed learning combined with 6 locally based masterclasses.

Content
• learning materials & associated learning activities provide evidence based/best practice information for health professionals to work more effectively to meet the mental health needs of older people
Course Aim & Objectives

The **aim** is to advance the knowledge, skills and attitudes of health professionals to achieve evidence based best practice in assessing and supporting older people’s mental health.

**Objectives:**

- Critically appraise and apply contemporary theories, principles and care frameworks to promote holistic, evidence-based mental health care of older people.
- Demonstrate an applied understanding of the ethical, legislative, regulatory and policy obligations of health professionals to support and promote mental health care of older people.
- Conduct a comprehensive, evidence-based health assessment of an older person with a focus on mental health.
- Plan, implement and evaluate holistic, person-centred mental health care with a healthy ageing focus.
- Critically reflect on and challenge, own and the practice of others to lead and promote best practice in older people’s mental health.
Masterclasses

1: Connecting with People Module: Compassion at Work

2: Legal and Ethical Foundational Knowledge: Care and Control decision-making

3: Connecting with People Module: Suicide Response Part 1

4: Comprehensive Health Assessment of older people

5: Planning & implementing person centred mental health care for older people

6: Connecting with People Module: Emotional resilience
Anticipated Outcomes

Graduates will have the specific knowledge and skills to provide high quality person-centred mental health care to older people.

The multidisciplinary structure of the proposed education supports this by providing opportunities for collaborative learning and better communication of older clients’ mental health issues and needs between members of the health care team.
References


Australian Commission on Safety and Quality in Health Care, 2017, National Safety and Quality Health Care Standards, 2nd edition, Sydney

Thank you
Participatory Action Research to Evaluate Suicide Prevention Networks in South Australia

Dr Monika Ferguson, Lecturer in Mental Health, Mental Health and Suicide Prevention Research Group, UniSA

Ms Lee Martinez, Whyalla Suicide Prevention Network and Lecturer: Mental Health, University Department of Rural Health, UniSA
Acknowledgements

Funding: This project was assisted by the Local Government & Research Development Scheme (South Australia).

The project was a collaboration between the University of South Australia and the Whyalla Suicide Prevention Network.

We wish to thank:
• Members of the Whyalla Suicide Prevention Network (Janice Eygenraam, Jane Owens, Carley Anderson, Chloe Loveday, Helen Whyte, Sue Kiely, Rachel Faulkner, Richard Parker, Tricia Munn, Trudy Robinson, Bernadette Abraham, Gary Misan)
• Professor Nicholas Procter, Dr Amy Baker & Ms Heather Eaton
• The Office of the Chief Psychiatrist, SA Health (Lynne O’Sullivan & Adam Clay)
Suicide Prevention Networks (SPNs)

- **Purpose**: is to increase the capacity of communities ‘to be suicide aware, able to respond to individuals in suicidal crisis and support those bereaved by suicide’ (SA Health, 2016)
- **Principles**: engagement of community, local ownership, empowering the community, local responsiveness, utilising all available resources, collective impact
- Linked to the South Australian Suicide Prevention Plan 2017-2021
Background

• All SPNs establish an individualised Suicide Prevention Action Plan, and devote significant effort to their implementation
• Evaluation of efforts often lacking
• Measures and tools needed to maximise the visibility of SPN work and achievements, and to contribute to future quality improvement
Aims

The aim of this project was to work closely with one South Australian SPN to develop an evaluation toolkit for use by all SPNs state-wide to measure their impacts.
Methodology – Why PAR?

Participatory action research (PAR): ‘a research approach that consists of the maximum participation of stakeholders, those whose lives are affected by the problem under study, in the systematic collection and analysis of information for the purpose of taking action and making change’ (Nelson et al., 1998, p. 885).

Key characteristics:
1) Participatory and collaborative; 2) Emancipatory; 3) A social process; 4) Practical; 5) Critical; 6) Reflexive; 7) Aimed towards transformation of both theory and practice (Kemmis & McTaggart, 2005)
Methodology - PAR Phases

PAR is grounded in reflection, data collection and action (Baum et al., 2006).

Planning Phase
- Review literature/SPN documents
- Meetings with Whyalla SPN committee
- Develop methodology for evaluating SPN activities

Action & Observation Phase
- Review SPN documents
- Collect data
- Design evaluation toolkit

Reflection Phase
- Revise and refine evaluation toolkit
- Disseminate evaluation toolkit
## Methodology – Data Collection

| Phase 1: Phone Interviews | • Members of Whyalla SPN committee (n=5)  
• 25-60mins; audio-recorded; transcribed |
|---------------------------|------------------------------------------------------------------------------------------|
| Phase 2: In-person Focus Group | • Members of Whyalla SPN committee (n=9)  
• 60mins; audio-recorded; transcribed |
| Phase 3: Online Survey | • Whyalla SPN stakeholders (n=16)  
• SurveyMonkey |

This project received ethics approval from the University of South Australia Human Research Ethics Committee.
Results – Evaluation Toolkit

• Contents:
  – Identifying priorities for evaluation
  – Selecting an appropriate evaluation methodology
  – Quantitative evaluations – surveys
  – Qualitative evaluations – interviews and focus groups
  – Tracking community connections (e.g. media, presentations, information sessions, etc.)
  – Tracking fundraising
  – Considerations when conducting evaluations
Identifying Priorities

Using this Evaluation Toolkit

Identifying priorities for evaluation:
The first step in undertaking an evaluation begins with identifying priority activities for evaluation. This can be achieved through:
1. Consulting your SPIN Action Plan and identifying key action areas;
2. Discussing action areas within your committee (e.g., during scheduled meetings); and
3. Brainstorming any additional action areas within your committee.

Evaluation of your network's activities is a key priority and should be seen as an ongoing process - one that both examines the impact of your activities, and drives the design of new activities (Figure 1).

Examples of priority activities:
- Occupying a stall at a local market, fair, open day, etc.;
- Providing financial sponsorship for a local activity;
- Providing funding for individuals to attend suicide prevention/mental health awareness training (e.g., ASIST, Mental Health First Aid);
- Marketing campaigns (e.g., distributing flyers/promotional material for the SPIN or another suicide prevention organization/innitiative at a local event);
- Providing information to the community (e.g., suicide prevention or postvention resources);
- Relationships, collaborations and partnerships (e.g., social media, local media, local community organizations, government departments, etc.); and
- Working with and supporting another community organization event (e.g., R U OK day).

Figure 1. Activity evaluation cycle

Table 1. Key details when identifying an activity for evaluation

<table>
<thead>
<tr>
<th>Evaluation component</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Including age group, gender, occupational group, etc.</td>
<td>Young males (aged 16-24 years)</td>
</tr>
<tr>
<td>What</td>
<td>Including specific details about what the activity was, where it occurred and when it happened (including start and end date)</td>
<td>2-hr community-based suicide prevention education session in August 2017</td>
</tr>
<tr>
<td>Purpose</td>
<td>Reason for the activity</td>
<td>To reduce the stigma associated with suicide and increase awareness</td>
</tr>
<tr>
<td>Outcome</td>
<td>Anticipated outcomes associated with the activity, including immediate, short-term and long-term</td>
<td>Funds raised, contacts made, attitudes towards suicide, stigma, etc.</td>
</tr>
<tr>
<td>Evaluation time-frame</td>
<td>Including specific details about the time-frame for evaluation</td>
<td>Pre- and post-training</td>
</tr>
</tbody>
</table>
Sample Surveys

Box 3. Sample feedback form for use at various events

[Insert event name here] Feedback Form

We're interested in your experiences with [insert event name here]. Your feedback is important for improving similar events in the future.

1. What was most helpful to you about [insert event name here]?

2. What was least helpful to you about [insert event name here]?

3. Would you attend [insert event name here] again in the future?
   - Yes
   - No
   - Unsure

4. Would you recommend [insert event name here] to your family/friends?
   - Yes
   - No
   - Unsure

5. Do you have any suggestions for how [insert event name here] could be improved?

Thank you for taking the time to complete this brief feedback form.

Box 1: Sample questions from an online survey conducted by the Whyalla Suicide Prevention Network using SurveyMonkey®

Demographic questions:

1. What is your gender?
   - Female
   - Male
   - Gender diverse

2. What is your age (in years)?

3. What is your current work status?
   - Full-time
   - Part-time
   - Volunteer
   - Student
   - Unemployed
   - Retired
   - Other (please specify)

4. What is your occupation?

5. What is your postcode?

Your experiences with the Suicide Prevention Network (SPN):

1. When did you first hear about the SPN and how did you hear of it?

2. In the last 18 months, which of the following SPN events/activities have you connected with or heard about? (You can select more than one):
   - Stand up for Mental Health
   - RUOK Day
   - Creating Connecting Communities
   - AGM
   - ASIST
   - Youth Mental Health First Aid
   - Mental Health First Aid
   - Hope for Life "Be There" Workshop
   - World Suicide Prevention Day Fun Run

3. What other events/activities do you think the SPN should conduct in the future, if any?

4. Do you have any suggestions for how the SPN could be improved?

5. Do you have any further comments?
Final Product

Premier’s Advocate for Suicide Prevention / Premier’s Council on Suicide Prevention published a hard copy Toolkit in 2019

- Distributed to all SPNs May 2019
- Distributed to all new SPNs as created
Lessons Learned

Benefits
- SPN/UniSA co-researchers
- Deep insights
- SA Health input

Challenges
- Geographical distance
- Busy volunteers
- One SPN
Use of the Toolkit by the Whyalla SPN
World’s Biggest Comic

1. **TAKE NOTICE**
   - Find a moment to enjoy nature. Explore your garden. Look up at the stars!

2. **CONNECT**
   - Connecting with family and friends gives you a sense of belonging. Why not organise a family picnic or go camping?

3. **BE ACTIVE**
   - Being active helps you to stay fit and healthy both mentally and physically. Do some work in the garden or kick the footy with your mates.

4. **KEEP LEARNING**
   - Learning challenges your mind and gives you a sense of achievement. Why not start a new hobby like cooking?

5. **GIVE**
   - Scientific studies show helping others gives our lives meaning, increases life satisfaction and makes us happier. Consider volunteering or planting a tree someone might sit under one day!

*Art by Ethan Doyle*
TO HELP ONE PERSON IS TO HELP ALL PEOPLE!

ARTWORK BY LEITH O'VALLEY

THERE'S A STORM IN MY HEAD!

WE CAN'T ALWAYS CONTROL THE WEATHER INSIDE US - BUT WE CAN USE AN UMBRELLA WHEN IT RAINS!

WHAT'S THAT SUPPOSED TO MEAN?

IF YOU ARE GETTING CAUGHT UP IN YOUR THOUGHTS AND FEELINGS, THERE'S SOMETHING YOU CAN TRY TO STRENGTHEN THE EXIT.

SCAN ME

SIMON - I'M TRYING TO THINK WHAT TO SAY TO MONICA. I DON'T WANT HER TO THINK I'M GIVING UP!

YOU'RE RIGHT, MONICA. WHAT'S INDEX? WHAT'S YOUR PROBLEM WITH IT?

LET'S MOVE!
Think about your favourite story: something awful or challenging always happens to the hero. They may encounter an enemy far more powerful than themselves, or a seemingly insurmountable obstacle.

And then, we get to see what they are made of.

We can give a voice to those who feel trapped inside their own heads. We can help remove the stigma that prevents people seeking help.

Through our vulnerability and bravery, we can help others awaken the courage to be themselves.
Chez Curnow, Country SA PHN, Mental Health and AOD Manager, and Lee Martinez, Whyalla Suicide Prevention Network committee member © Whyalla News
Future Directions

• Next steps will be to test the usability and impact of the Evaluation Toolkit
• Refine and update the Evaluation Toolkit as necessary
• Encourage widespread use of the Evaluation Toolkit to provide a consistent evaluation framework, and to increase the sharing of achievements between networks – to ultimately lead to improved suicide prevention outcomes across SA
Additional Information

Further information about this project and the Evaluation Toolkit can be found here:

References

Thank you