

A Co-produced Innovation in Pre-Registration Paramedic

MH Specialty Placements

Following an Action Research Model

Abstract

This article describes how an innovative approach to mental health training for student paramedics can prepare our future workforce with the skills and knowledge to provide high quality care. Action research methodology is used to describe the delivery and evaluation of the placement, identifying its key and sustainable learning impacts for all involved. Key to its success was the co-production of the placement from the beginning to end including service users and qualified paramedics. The outcome of this placement enabled students to develop the confidence and ability to provide compassionate person-centred care as well as the skills to cultivate self-care and resilience.

Key words

- Mental health
- Co-production
- Learning

Introduction

Mindful of the current driver for parity of esteem between mental and physical healthcare (McShane 2013), for those in mental health crisis it is well evidenced that first presentation will often be within the pre-hospital setting (Hawley et al 2011). It has been recognized, “that historically and currently, paramedics are the first point of contact for patients with mental health episodes” (Berry 2014, p. 539). In the United Kingdom (UK) The London Ambulance Service NHS trust (2015), stated they had experienced over a 15% increase in mental health related calls between 2012 and 2015. A report published by the UK National Audit Office (Morse 2017), identified that the demand on ambulance

services is rapidly increasing and a contributing factor to this increase is perceived to be mental health related conditions.

Following a membership survey conducted by the College of Paramedics, paramedic clinicians within the UK have stated that they feel they have inadequate skills and knowledge to be able to provide sufficient care to mental health patients (Berry 2014). Recommendations following the Paramedic Evidence Based Education Project (Lovegrove 2013), suggest a stronger knowledge and skills focus during training in a number of areas including general mental health and wellbeing plus dementia.

Not only is it acknowledged that there is a requirement for more mental health training for student paramedics but it is also well documented that the ongoing well-being of qualified paramedics is an area which needs to be recognized and formally addressed. Due to the nature of work that the emergency services are subject to, it has been identified that these service staff, including paramedics, are at an increased risk of experiencing stress and mental health conditions (Deady et al 2017). This and the increasing service demands generally on the paramedic services, it is therefore suggested that paramedic stress and risk to mental health and wellbeing is likely to increase.

Action research

Action Research is commonly described as any research into practice undertaken by those involved in that practice, with an aim to change and improve it. Action research therefore concerns itself with both 'action' and 'research' and the links between the two, indeed the unique combination of the two is what distinguishes action research from other forms of enquiry. Crucially action research is 'research *in action*' rather than research *about action*' (Coghlan and Brannick 2010)

This article describes an action research model considered as a process of enquiry into the effectiveness of Mental Health Speciality Placements for first year paramedic students on the Bournemouth University (BU) BSc (Hons) Paramedic Science Programme in 2016, with a focus on the detail as to a change implemented and the subsequent impacts.

The BU University Practice Learning Adviser (UPLA) team are a small group of clinically and educationally qualified individuals (eg. Registered nurses and paramedics who are also mentors and education tutors directly employed by the university) who take responsibility to quality assure those practice placements supporting BU health and social care students. They do so using an established menu of jointly agreed (with practice partners and professional bodies) quality assurance mechanisms and through close working relationships with placement practice education teams (in both the NHS and private sector) as well as with on-site mentors. This serves to increase the likelihood of a positive placement experience for both BU healthcare students and practice partners. An important facet of these joint quality assurance processes is to regularly review student feedback, the resultant discussions seeking to develop and enhance the learning environments. Contemporary student feedback is always available as BU students are required to evaluate each and every individual placement via an online questionnaire as well as through the formal reporting concerns process (BU Concerns Protocol).

As part of the above review processes it was noted that upon placement evaluation review, a pattern emerged whereby there was a lack of consistency in learning experiences for the pre-registration paramedic students when undertaking their 1 week Mental Health (MH) specialty placement. Students either described feeling that they had experienced meaningful learning and insight into this specialty, or conversely, they had learned very little. This feedback was not related to any one placement at any one time, indeed qualitative comment more reflected the limited opportunities available for learning given the high clinical pressures often within the placement settings and presence of other pre-registration students and/or available of learning support staff (eg. Mentors or associate mentors). Students also suggested they felt ill-prepared prior for the MH Placement as to what they could expect to experience, and this was not limited to learning opportunities but also included some anxiety around an unfamiliar setting and concern commonly identified as to 'what not to say' to patients.

This evaluation information was triangulated with feedback from key stakeholders eg. paramedic practice partners, service users, two members of the UPLA team (ML who is a qualified paramedic and EJ who is a dual qualified Mental Health/Adult nurse) and the paramedic academic programme team. At this point in the process, the evaluation reviews sought to examine whether a change was required or an intervention

was necessary to improve the placement experience through a systematic review of the evidence and collaborative reflection (Cohen et al, 2011, p.346) to identify and focus on a commonly agreed goal.

Given that this was not, at this point, a formal research study, there was no requirement to seek full and formal ethical approval. All the information available and discussed was routinely available via the BU quality assurance processes for teaching and placement feedback and the scoping material was obtained with verbal consent including consents in sharing information for publication and evaluation purposes.

Reflection Cycle - Emerging Findings

The emerging findings from the reflection cycle indeed suggested a key opportunity for change, with collaboratively agreed objectives including enhancement of current mental health placement provision for pre-registration paramedic students, parity of experience for all the students, focussed acquisition of relevant professional skills, knowledge and behaviours that are transferable including resilience and personal and professional development.

Planning

Collaborative consensus from the key stakeholders was that a new approach offering and supporting a paramedic mental health placement was required. It was agreed that rather than the students going 'out' to a mental health placement, the placement would be brought 'in' to them in the university setting. Following successful previous partnership working with the Dorset Mental Health Forum (Dorset MH Forum - a local peer led charity promoting wellbeing and recovery) in jointly delivering mental health education to pre-registration nursing students, it was decided that building on this partnership would be appropriate given its unique strengths including peer/service user facilitation of learning rather than being academic led. It is of note that the previous collaborative educational work was focussed on academic endeavour, this partnership working sought to meet the requirements of a quality assured practice placement thus also required to meet the professional degree requirements of assessment.

The two key members of the UPLA team (as identified previously) were keen to maintain the essence of action research collaboration by including participants also, in this case the paramedic students themselves. Therefore a 'co-produced placement model' was explored and agreed upon to meaningfully include all key stakeholders. As such, two formal 'Development Days' were planned with all key stakeholders including the two UPLAs and the paramedic academic programme team as representatives from BU, members of the Dorset Mental Health Forum (including peer support workers and the service users who were skilled facilitators of learning as well as qualified health and social care professionals), two second year paramedic students, and paramedic mentors plus education leads from paramedic practice partners.

Issues discussed at these meetings included the initial costings and key placement requirements. The latter pertained to ensuring that this bespoke placement still provided students with the opportunity to achieve the practice skills and competencies already identified within their Ongoing Skills Achievement Record (thus achieving parity of placement opportunity with previous cohorts) and also would align with the skills as identified for an undergraduate degree programme and for the paramedic profession. Key to these discussions was ensuring that all stakeholders shared the understanding that although the placement was being delivered in an academic environment, the focus required to be on professional practice and skills, and not academia/theory. Crucially, the students would retain placement contact with service users throughout this placement, uniquely through service users being involved in the co-delivery/facilitation of learning (which included the sharing of service user narratives) plus also in being part of the assessment processes eg. feedback on performance in role-plays and values conveyed by students linked to the '6Cs' (Nevins et al, 2016). Key to the effective co-production was the acknowledgement that all stakeholders had equal and valuable input and the process from inception to delivery being as important as the outcome and outputs.

Acting

As a result of the two successful development days it was jointly agreed that a 5 (consecutive) day mental health placement at BU was to take place, co-produced and delivered with the Dorset MH Forum. Agreed essential elements for inclusion were the following:

1. Maintaining a professional skills focus (“keeping it real”) to include recording the students’ practice hours record for each day reflecting mandatory attendance and students/practice staff to be wearing full uniform.
2. Mentors and paramedic practice partners to co-facilitate with the two BU UPLA staff in their practice mentoring role ie. for feedback and assessment of the students during the week
3. Assessment activities to include role-plays (using BU ambulance and clinical skills laboratories as the ‘realistic’ settings) with peer workers and/or service users, student self-reflection & personal development writings, focussed group-work, and paramedic scenario based problem solving.
4. Evidential workbook to be developed for students to share with future mentors as to skills achievement within the placement, progress planning where necessary, and for external examiner to select for review if required as a quality assurance mechanism.

Mindful of the above, the resulting 5 day MH Placement was set out in an agreed timetable for the week from 9am until 5pm. Aspects delivered as part of the timetable included exploring the principles of wellbeing and recovery, identifying and practising core communication skills when supporting people experiencing emotional distress, describing and applying the paramedic process to people experiencing emotional distress, considering and supporting the role that carers and supporters play in a service users recovery plan, identifying and implementing coping strategies that support one’s own wellbeing, demonstrating understanding the Mental Health Act, Mental Capacity Act and the local role of mental health services eg. Crisis Teams, demonstrate understanding as to how personality disorders can impact on an individual’s ability to cope, to demonstrate understanding of how best to support people who are suicidal and/or self harming, to demonstrate an increased understanding of the impact that dementia can have on the individual and their family, to evidence effective and compassionate decision making in relation to people in emotional distress, to demonstrate effective interpersonal skills and communication skills when working with people who have complex mental health needs. All of the above with a focus on the role of the paramedic and making use of service user narratives, carer narratives, videos, group-work, role-play work, and actively exploring case scenarios developed with practice partners and service users.

Delivery was co-facilitated by all key stakeholders depending on their expertise, availability and educational experience. Students had to complete the workbook mentioned above during each day, thus building a portfolio of evidence to share at the end of the placement and with future placement mentors.

Prior to delivery of the bespoke placement, information for the affected students (n=30, ie the first year cohort) was disseminated through both the paramedic programme team and also the two second year students who developed their own information 'poster' to support their informal conversations with students. Opportunities were made available for students to ask questions and raise any concerns before the placement started in the academic summer term of May 2016.

Observing and Reflecting

All stakeholders agreed that feedback would be sought from students, facilitators, peer support workers and mentors at the end of each day as an iterative process to inform and make any responsive amendments necessary for the next day. As per action research - qualitative rather than quantitative data was sought, the emphasis on language rather than numbers, and reflective, involving critical reflection on both the process and the outcomes throughout. Therefore, feedback was sought from students digitally with responses collated on a large screen displayed 'wordcloud' at the end of each day and then collated alongside daily facilitator debrief comments. The students also offered free comments on 'post-it notes' as to what they felt they had learned that day. No changes were required to next day placement delivery following any of this immediate feedback.

As part of this feedback process, students were informed each day that their feedback would also be used to assist evaluation and possibly be used to inform publication and dissemination, as such they could choose not to offer feedback or withdraw comments at any time both during and after the placement. Contact details for both the UPLA team members were made available each day for this purpose.

The daily feedback evidenced frequently occurring single words such as understanding, informative, empowering, insightful, emotional, enlightening, challenging, thought provoking, inspirational, life-

changing, team building, powerful and kindness. It could be suggested that the students experienced learning at a deep level both personally and professionally.

Final Student Evaluation Analysis - Process

Student feedback was also sought at the end of the final day via an anonymous questionnaire with five broad questions about their experience to replicate the standard expectation of placement feedback, responses n=27 out of 30. The students could tick a box on the form indicating their consent was *not* given to use their anonymous comments to develop further initiatives, or be used for publication and reassured that their comments were anonymous. A copy of the questionnaire can be found in Appendix 1.

Overwhelmingly the feedback from students was more positive than had been anticipated. This was analysed thematically by EJ (UPLA team member identified earlier who also has experience as a researcher).

The manifest level (basic level of analysis with a descriptive account of the data: eg. what was actually said, documented or observed with no assumptions made) of analysis began with all feedback available. This was followed by interpretative analysis (higher level of analysis and is concerned with what “may be meant by the response” inferences and implications) whereby the data was read and re-read for an initial intuitive grasp of the themes seen as emerging. The raw data was therefore organised into themes, concepts and patterns.

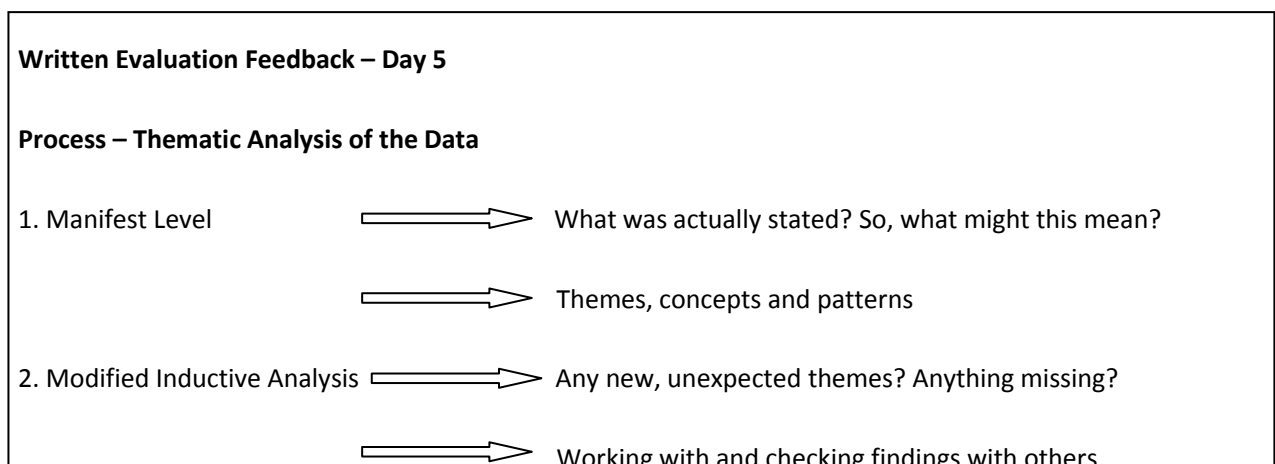
Modified inductive content analysis was also used where themes and constructs were derived with no former framework or counting- latent level analysis. This process identifies and forms emerging categories. This approach was used as EJ wished to explore the rich data to search for any new themes that may have emerged eg. Student group cohesion and sustainable impacts on practice (professional and personal) . True inductive content analysis would use absolutely no previous framework, however, the knowledge gained from co-production team during the scoping phase impacted on EJ’s “knowing and knowledge” therefore the process could not be seen as inductive in its purest form).

Throughout the data analysis, themes emerged. A degree of immersion in the data was necessary for this process. A modified constant comparative strategy was therefore subsequently used. This analysis method focused on a process whereby categories emerged from the data via predominantly inductive reasoning rather than through coding from predetermined categories with the overall interpretation “confirmed” lightly with the key BU team. Although not a pure (true) constant comparative strategy as is described within the theory and process for grounded theory, EJ used it as a means of addressing the quality issues.

Table 1 below formally summarises the data analysis process

1. Preparation	Selecting a unit of analysis which may be a word or a theme (eg. resilience, professional and personal skills, humanising care)
2. Organisation	Open coding, creating categories and abstraction. Notes and headings written in the text whilst reading it. Written material re-read, adding further headings to ensure capture of all content.
3. Identifying Emerging Themes	Revisiting the data, codes and themes to elucidate emerging themes and ensure consistency

Figure 1 below describes the process in its simplest form.



Findings

Key Impacts

There were significant key impacts identified by the students that strongly emerged including the following:

- a) Wishing to challenge and change the existing perceived negative paramedic cultural approach towards patients presenting with mental health issues expressed as seeking personally and professionally to 'make a difference'
- b) Understanding the importance of respecting one's own mental health in the context of supporting and developing resilience.
- c) Recognition as to the importance of humanising care approaches and person-centred care, to be realised through the strong focus on recovery philosophy and recovery approaches to mental health.
- d) There were multiple requests to repeat the innovation for following undergraduate paramedic cohorts with consideration as to all professional groups too,
- e) There was realisation as to the significant growth of the cohort from a skills perspective and as a peer group through working together collaboratively throughout the placement.

Emerging Broad Themes

The broader themes that emerged included the following:

a) Resilience:

"It's ok to ask for help"

"I now have the skills to help myself and others to maintain mental wellbeing"

"Personal wellbeing is paramount"

b) Personal skills

"The placement challenged my opinions"

“I have a clearer understanding of myself”

“I feel my confidence has grown”

“I am going to be more open-minded and accepting of people’s problems and situations”

c) Professional Attitude

“Seeing the person not the mental disorder because each and every mental health patient will react and have symptoms differently, treat each with respect and dignity”

“The individual, their emotions and the journey they may travel from diagnosis through to recovery so

I will be more compassionate and understanding towards patients in crisis and their family/care givers.”

“The way to treat one patient may not be the way to treat someone else and look at patients as individuals including repeat callers”

“I feel like I have learned to validate, respect and care for people in their time of need, no matter the mental state, besides, you could be the only person they speak to that day and make the difference”

d) Development of Professional Skills

“I have new communication skills in challenging situations related to mental health, building rapport, appropriate and safe questioning”

“Coping strategies for patients in practice and keeping clinically and professionally up to date”

“It is ok to ask difficult questions”

“Disseminating my knowledge to colleagues”

“How people can recover from bad situations - It should not be a hindrance to a ‘normal’ life”

e) Professional Impact

“Challenging stigma, understanding 1st person perspective.”

“If the repeat callers change their life, it is time well spent - Look at patients as individuals including repeat callers”

“Paramedics can make a big difference”

“Take the lead in jobs involving mental health”

“By passing my knowledge on to other people who have to learn more about too, so I can try to improve the understanding of the public and the HCPC”

“I will try and educate patients and colleagues with what I have learned, and remain passionate about my ability to make a difference”

“Professionally I have learned the impact that the ambulance service can have upon someone’s recovery and the influence we have.”

Evaluation Follow up

The students voluntarily took part in a short 30 minutes focus group (all students n=30) at six months post placement facilitated by the two previously involved UPLAs. The same broad evaluation questions were posed verbally, and responses noted in writing and shared concurrently with the students in real time using a large ‘displayed on screen’ word document. Again, it was reiterated that students could choose not to comment and/or withdraw comments at any time by contacting either of the two UPLAs. Remarkably, the comments were similar – almost completely replicating the words and sentences, this time offering examples from practice as to how they had implemented their new learning in the practice setting eg. ‘taking the lead in mental health calls’. This finding demonstrates that the impacts (including skills, behavior and attitudes) were not only maintained over time but put into practice. Interestingly, there was more explicit verbal evidence highlighting that having listened to the mentors during the placement as to their narratives pertaining to traumatic experiences whilst working, this enabled students to recognize their own need for support and thus were now able to formally access help through the avenues identified by the qualified paramedics during the placement week.

Paramedic Stakeholder Feedback

An unexpected outcome from the daily and final day feedback from all stakeholders was the ongoing knowledge and skills gained and subsequently implemented by the paramedics (practice mentors). All mentors shared their learning, from the discrete eg. Considerations of the Mental Health Act and Mental Capacity Act, to Recovery Focus philosophy and approaches, enhanced communication skills, development of skills for the facilitation of learning and teaching of students, experience in co-production, changes in how they practice pertaining to mental health patients eg. Recognizing the need to listen and the significant importance of their input at a time of crisis and distress including verbal and non-verbal communication.

Conclusion

The feedback and evaluation data demonstrated that the innovation was successful in many ways, indeed surpassed the initial expectations of the stakeholders, not least that all students passed the placement with exemplary supporting comments offered as evidence. All students expressed having insight into the experience of patients presenting to paramedics with mental health issues and in distress/crisis, they confirmed acquisition of relevant skills both personally and professionally to support such patients and a reduction in anxiety when supporting them as they will be increasingly required to do given the current health and social care environment in the UK for crisis intervention. Arguably, because the process of the placement allowed for ongoing practice and assessment of new skills there was a reduction in the ubiquitous theory practice gap for students. Of note, the students not only expressed their initial wish to change the cultural approach of paramedics to mental health call-outs and take the lead, they not only did so at follow up but shared their learning with peers and staff to begin this change process.

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Mental Health Paramedic Placement May 2016 - Evaluation

PLEASE HELP US ENHANCE AND DEVELOP THIS INITIATIVE FOR
FUTURE PARAMEDIC STUDENTS BY ANSWERING THE QUESTIONS
BELOW:

1. What do you feel you have learned from this placement?
(personally and/or professionally)

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2. How will you take that learning forward (personally
and/or professionally)

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3. What would you like us to keep for this placement?

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4. What would you like us to change for this placement?

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5. What learning are you most proud of from this placement?

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ANY OTHER COMMENTS?

Please comment overleaf if required:

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YOUR COMMENTS, SHOULD YOU WISH TO MAKE THEM, ARE ANONYMOUS HOWEVER WE MAY USE THEM TO DEVELOP SIMILAR FUTURE INITIATIVES AT BU AND/OR USE YOUR FEEDBACK FOR PUBLICATION. YOU WILL NOT BE ABLE TO BE IDENTIFIED IN ANY WAY.

PLEASE TICK THIS BOX IF YOU **do not** WISH YOUR COMMENTS TO BE UTILISED IN THIS WAY.