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Development and implementation of educational prescribing resources to mental health pharmacists to improve the physical health of people with severe mental illness

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Background

People with serious mental illnesses (SMI) live on average 15-20 years less than the general population, partly due to physical health comorbidities. Improving the physical health knowledge of mental health pharmacists could assist in reducing the mortality gap in people with SMI. We describe the development and implementation of educational materials for mental health pharmacists at a large UK mental health trust.

Method

Physical health training needs were identified using a survey with pharmacists. We implemented (1) monthly, educational webinars covering different physical health topics, and (2) specific physical health guidelines, circulated to all mental health trust pharmacists. Questionnaires and interviews were undertaken with pharmacists to evaluate impact and implementation.

Results

106 individual staff attended the webinars. Common themes from the questionnaire (n=15) and interviews (n=8) were that the webinars were 'good-refreshers', concise and provided appropriate level, pharmacy specific information. Common barriers for webinar attendance were high workload and other work commitments. 50% of the interviewed pharmacists were not aware of the guidelines and only two pharmacists had read them. The implementation evaluation further revealed that the co-design approach with pharmacists enabled inter-professional relationships (i.e. acute and mental health pharmacists) and tailoring of educational content. Trust-wide pharmacy leadership buy-in and administrative support also boosted implementation.

Conclusion

These barriers reflect the challenges of developing interventions in a pressurised hospital setting. To overcome these barriers, co-designing with expert pharmacists is key. Regular meetings, establishing role clarity and accountability, building a relationship with the acute hospital pharmacy team, and dedicated funding enabled this. Continual education for clinicians is key to ensuring service users experience the best available care including physical healthcare expertise. To sustain the interventions, dedicated administrative and leadership resource is required to establish accountability and responsibility. We also identified the need to publicise implementations and improve access to resources.

Trial Registration: Non applicable

Consent to publish

SLaM clinical governance and Information governance approvals

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Beyond input-output: Applying dynamic systems theory to the complexity of implementing mental health interventions in non-western cultures

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Background

Global dissemination of western mental health interventions across widely diverse cultures leaves a potentially large implementation gap for non-Caucasian people [1]. Central to the uptake of mental health interventions are the extent to which they align with the cultural and personal values of local cultures, organisations, staff, individuals and their families.

Method

We explore the potential of integrating components of the Pragmatic Robust Implementation and Sustainability Model (PRISM) [2] within a dynamic system of cultural adaptation [3]. We model the complementary and contradictory perspectives on cultural concepts of distress and healing, highlighting how successful implementation depends on navigating the 'best fit' between these concepts and evidence based psychological techniques.

Results

Figure 1 shows the resulting model for the implementation of culturally adapted psychological interventions. We model the dynamic nature of the overlap between an individual's coping mechanisms, their family's, alongside organizational capacity to implement interventions and existing cultural and evidence-based practices to support mental health.

Conclusion

Integrating components of the PRISM within a dynamic system model of cultural adaptation allows us to represent the uncertainty and unpredictability of adapting mental health interventions more accurately in non-western cultures. Importantly, it also models the tension between self, other and organizational values, which may be particularly critical in collectivist cultures, or across generations in countries experiencing rapid development. Our case example suggests how we might navigate these uncertainties and complexities through a lens of 'best fit' rather than input-output.

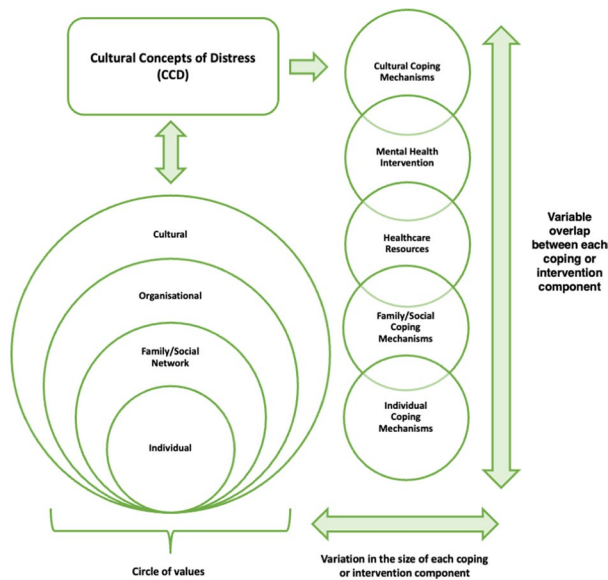
Trial Registration: Non applicable

Consent to publish

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Consistent with the PRISM framework we map both the individual (patient) and organizational perspectives at both the Values level, which forms the basis for how mental illness is conceptualized, and at the intervention level which impacts on what interventions are predicted to be most acceptable. The dynamic size and overlap of coping mechanisms and interventions allows us to model both the degree of connection, or overlap, between each of the components, and the relative contribution of them. For example, in collectivist cultures, we might predict that there would be a close overlap between individual, family and cultural coping mechanisms.

Fig. 1 (abstract P37). Combining the PRISM with dynamic mental health coping and intervention components

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Challenges to implementing person-centred outcome measures into routine paediatric palliative care

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Background

To successfully implement a newly developed measure into clinical practice, the challenges to implementation must be understood [1]. Previous research has focused on disease-specific or generic Quality of Life measures in paediatric healthcare, or the use of outcome measures in adult palliative care [2-4]. Evidence identifying the perspectives of all key stakeholder groups is needed to ensure successful implementation of new person-centred outcome measures (PCOMs) in the paediatric palliative care context.

Method

Semi-structured interviews with purposively sampled key stakeholders. Children with life-limiting or life-threatening conditions (LLTC), parents/carers and siblings of children with LLTC, and health and social care professionals (HSCPs) caring for children with LLTC were recruited from 9 UK sites. Commissioners of UK paediatric palliative care services were recruited via a non-governmental organisation or direct recommendations. Verbatim transcripts were analysed using a Framework approach analysis and inductive coding in NVivo.

Results

103 interviews were conducted with 106 participants (26 children, 40 parents/carers, 13 siblings, 15 HSCPs, and 12 commissioners). Potential challenges identified by HSCP and commissioners included: (1) gatekeeping by family members and (2) added workload for already stretched services. Potential challenges identified by children

included: (1) trusting who administered the measure and (2) privacy concerns around who could access the results. Family members also identified potential challenges relating to (1) added workload for HSCP and (2) privacy concerns around who could access the results.

Conclusion

Whilst some challenges were identified as concerns across multiple stakeholder groups, other challenges identified were unique to specific stakeholder groups. Understanding these different and overlapping perspectives of the perceived challenges is essential for the development of concomitant strategies for implementation of a new PCOM into paediatric healthcare practice. Which in turn helps to support uptake of a PCOM into routine practice.

Trial Registration: Non applicable

Consent to publish

Non applicable

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"Mindfulness for parents who care" or "Mindfulness for parent carers"? Re-framing a mindfulness course to align with parent carer's identity as a parent before a carer increases uptake:

A formative evaluation

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Background

Parent carers of children with special educational needs have an increased risk of mental and physical ill-health [1,2]. It remains problematic to engage parent carers in wellbeing support [3], with many parents not perceiving themselves as 'carers' [4]. Following low uptake to our Mindfulness for Parent Carers (MPC) group we carried out a formative evaluation and utilised ecological theory aligned with public health goals as outlined by Atkins et al [5]. We examined whether expressions of interest (EOI), and applications to, the MPC group were increased by aligning the promotion of the group with parent carer's identity and through settings that support that identity.

Method

For intake one, the course was promoted as 'Mindfulness for Parent Carers' via email, poster and telephone contacts to local carer charities, NHS services, and the voluntary action mailing list (a reach of 1,300 individuals). For intake two the course was promoted as 'Mindfulness for Parents who Care' via local workplace settings (18) and primary and secondary schools (397 including 15 special needs schools).

Results

For the EOI questionnaire, fourteen people completed the EOI questionnaire for intake one, and seventeen people for intake two. The difference was not significant ($\chi^2(1) = 0.29$ $p = 0.59$). For full applications, intake one had one application; intake two had six applications. There were significantly more applications made in intake two than intake one ($\chi^2(1) = 3.57$, $p = 0.05$).