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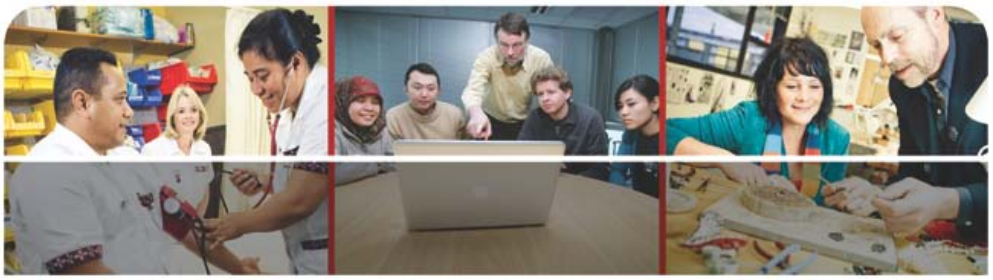

Evaluation of “Hearing Voices”

Mr Arana Pearson (BA) – Keepwell Ltd

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Keepwell ™

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NATIONAL CENTRE FOR TERTIARY TEACHING EXCELLENCE

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Evaluation of “Hearing Voices”

Key words: *Simulation training; Mental Health; Consumer participation; Workplace education; Adult learning*

Executive Summary

This paper is an enquiry on the challenges of implementing research based ‘better practice’ into the workplace through effective training. This research evaluates the impact on practice and attitude in the workplace of an experiential learning approach in education. We used MP3 technology to train mental health workers through a simulation of what it is like to hear distressing voices. A survey of mental health workers who have attended the training over the past two years was planned, aiming at 100 responses. Two focus groups planned with students who had attended the programme. We interviewed a range of Stakeholders including workplace managers and tertiary training leaders to add a stakeholder perspective to the project. Finally, there is some reflection about simulation training that is based upon consumer experience. The goals of the project were to

1. Establish a knowledge base derived from fifteen years of practice in delivering an experiential learning programme - Hearing Voices. The workshop seems to be effective in changing attitudes and practice. We want to ask the sector if this is true and publish our findings. This has not been done before.
2. Establish the most effective experiential approach to teaching and learning about working with people who hear distressing voices
3. Identify further areas for research and information gathering that will contribute to improving training for mental health workers about hearing distressing voices.

This project sought to demonstrate how consumer participation in staff training, through experiential learning may change workforce performance. We demonstrated this programme of experiential learning does achieve attitudinal change that motivates practice change. The recommendation is where industry “hears the voices” of customer criticism regarding service attitude, that educators consider a programme of experiential learning that involves the consumer in the design and delivery with a programme of learning. For businesses that identify a need for improvement with the human interaction with its customers, that attitude be considered equally along with skill and knowledge in the design and measurable outcome of industry training programme development. Both consumers and staff benefit through the letting go of assumption or personal opinion and getting to understand one another through effective opinion survey, and reflective dialogue. Work place educators are encouraged to use principles of androgogy as distinct from pedagogy for effective adult learning.

Introduction

Hearing Voices is one of the first New Zealand experiential learning programmes to train mental health workers through a simulation of what it is like to hear distressing voices. People who hear voices are often labelled as psychotic and are treated with fear and suspicion in the general community and take a lot of resources in the mental health sector. After more than one hundred years of mental health patients’ rights and consumer rights activity service users are still disenfranchised. Moreover, the general population still perceives mental illness negatively. And hearing voices that are distressing is one of the most stigmatized experiences in psychiatry. Clinton, Michael & Olsen, Anne (1998) noted that mental illness remains as stigmatized today as it was 100 years ago. The Mason Report of New Zealand wrote:

> *There is no doubt that the feeling of alienation created by stigma is one of the significant reasons cited for loss of hope and relapse by those who experience mental illness.* (Mason, Johnston & Crowe, 1996, page 163).

Consumer participation within publically funded mental health services
There is a growing development of consumer participation within industry programme design and evaluation and also with sector training (Schneebeli C, O'Brien A, Lampshire D, Hamer HP 2010 pg 30-5). There is also a growing literature regarding a change in practice from ignoring or distracting people from the voices they hear towards listening to and engaging with the content of the voices (Beavan V & Read J. 2010 pg 201-5). Published research regarding best practice in speaking with voice hearers about the content of their voices is lead by Michael White in Australia with a voice hearer therapeutic community enquiry which ran from 1992 for five years (White, Michael 1997). White along with New Zealander David Epston pioneered narrative therapy (White, Michael & Epston, David 1990) which looks to recovery through narrative dialogue. Romme MA, Honig A, Noorthoorn EO and Escher, AD (1992) described an emancipator approach to coping with voices in the British journal of psychiatry. And also Prof Marius Romme and Sandra Escher in their seminal English book titled *Accepting Voices* describes a recovery approach through making sense of voices *(*Romme, M., & Escher, S. 1993)*.*These approaches are not currently standard practice in mental health service delivery. Nor are mental health workers sure whether they should engage with people about the content of the voices their clients hear. This workshop was designed to address these issues of stigma and discrimination with community attitudes and staff practice. This paper is an enquiry on the challenges of implementing research based 'better practice' into the workplace through effective training.

The Training Programme
Hearing Voices that are Distressing – a simulated training experience is a workshop that includes both didactic presentation and experiential learning through a simulation of hearing voices that are distressing. Handout information details the learning goals and supplies an evidence base (appendix 4).

The training event involves three components. During the first session an opening lecture is given. During the next part the simulation takes place. During the simulation, the workshop participants listen to a special audiotape-MP3 that simulates distressing voices. In addition, they move (in no specific order) through four workstations. These include going out into the community and performing a task, going to a "day treatment programme", going to "psychiatric emergency services" for a mental status exam, and taking a test at the "psychological testing centre". This MP3 is recorded by people who hear distressing voices, and the training is delivered by a person who hears voices and has used mental health services and been diagnosed with serious mental illness. We also attempt to include psychiatric patients to administer the simulated mini-mental status tests to the students whilst they are hearing the simulation of voices. The staff-students become a "voice hearer" in simulation, and the consumer's role-play being mental health workers. In this way, the simulation inverts the usual power dynamic of 'patient role' and 'staff or helper role' by reversing roles for the purpose of education and exchange of knowledge.

The final part concludes the training experience with a facilitated group discussion to reflect upon practice and consider new ways of working. A key feature of the training programme is its design and delivery by people diagnosed with mental illness and who have used mental health services and who also hear voices that are distressing.

The evaluation is the first opportunity to review the delivering of Hearing Voices and examine its educational benefits in Australasia. The training has been delivered by Keepwell, a New Zealand training organisation throughout New Zealand and Australia for over 15 years within university registrar and nurse training programmes within clinical and NGO mental health

services, and support worker training. Yet there has been no published evaluation of the programme despite feedback indicating the significant value of the programme from both health sector trainees and workplace managers. Keepwell has been the longest running trainer of programmes of this type in Australasia, and has delivered widely to the most people. Hearing Voices already has a wide coverage in the mental health sector, with estimates of over 3,000 people having gone through the course in Australasia since 1996. This evaluation aims to make a useful contribution to better practice in mental health worker training, by promulgating the findings. The New Zealand workforce includes 6,000 mental health nurse practioners and 20,000 support workers with 505 psychiatrists. In terms of community based services, there are tens of thousands of community workers, social and government agency workers and family and friends who have an interest in understanding mental illness and how better to help people with experience of mental illness. There are also implications for other workplace training programmes looking for innovative learning and attitudinal outcomes with their workforce development. And also workplace awareness of mental health supports for staff in the workplace, and for their general community.

Adult education theory development.

There has been a growing literature differentiating adult education from child education since 1945. Benjamin Bloom identified three domains in education. These domains are Knowledge or cognitive mental skills, Attitude or growth in emotional areas or feelings called the affective domain and Skills, being physical skill or manual psychomotor domain (Bloom B. S.1956). Knowledge, skills, attitude (or KSA) are familiar domains in which workplace trainers design their programmes. This research was interested in ascertaining attitude change in particular.

Pedagogy in Greek literally translates ‘child leading’ and American education theorist Malcolm Knowles developed a theory of adult motivation for learning which he distinguished as andragogy (literally ‘man-leading). In his theory, adults need to know the reason for learning something, experience is the foundation for learning activities and they need to be involved in the planning and evaluation of their instruction. He also says adults learn when their instruction has immediate relevance to their lives and work and they respond more to problem centered learning rather than content oriented. His sixth assumption for adult motivation to learn is they respond better to internal motivators rather than external ones (Knowles, Malcolm 1980).

Simulation training.

Kolb developed learning theory for adults (figure 1), and he says learning happens through a process cycle of abstract conceptualization (our lecture component); Concrete experience (our simulation); reflective observation (group discussion reflecting upon the simulation experience); and active experimentation (apply the learning in the work place) (Kolb. D. A. and Fry, R. 1975).

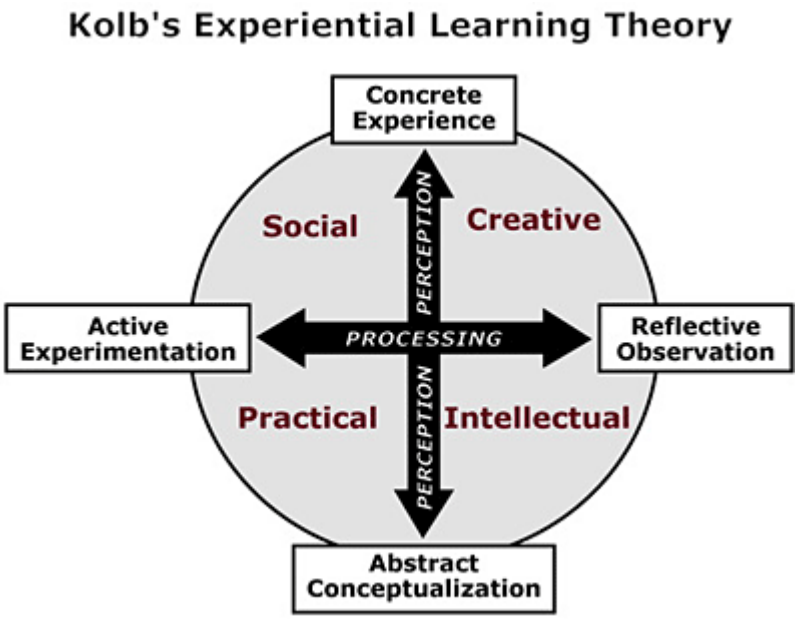


Figure one: Kolb's experiential learning cycle

A meta-survey of the research literature reveals a plethora of research in using simulation training in health but few that apply to psychiatry and the conclusions of that study were "Further research is needed regarding the implications of different simulation technologies in psychiatry" (Nancy McNaughton, Paula Ravitz, Andrea Wadell, Brian D Hodges. Feb 2008 pg 85-93).

Project Method

We used survey feedback and group discussion for this paper which is further reflective observation upon practice. Whilst simulation training has its critics, it is true that all methods of training delivery are vulnerable to learning outcome criticism. Critique of learning outcome is dependent upon a range of factors. Simulation training has been demonstrated to produce effective workplace learning outcomes when designed and delivered well (Kayes, D. C.2002). The benefits of using simulation training include safe learning environments where human beings are not at risk of being practiced upon, decreased cost of training, repetitive learning areas for students who identify need, and ultimately a more experienced workforce without the cost of experience being workplace mistakes. The conceptual idea for our training was designed by Dr Patricia Deeghan (Deegan P 2006) and she trained and certificated the author to deliver and adapt the method in 1997. One narrative study has been published in using this simulated method with student nurses (Hamilton Wilson J, Azzopardi W, Sager S, Gould B, Conroy S, Deegan P and Archie S 2009). I could find no workplace studies to replicate.

This research evaluates the impact on practice and attitude in the workplace. A survey of mental health workers who have attended the training over the past two years was designed; aiming at 100 responses (we received 95 which is a good result. See Appendix 1 for a copy of the online survey). We planned for two focus groups with students who attended the programme (and held four), two undergraduate nursing classes of 30 each, one group of undergraduate social work students of approximately 30 and one support worker certificate programme class of 30 students which increased our ethnic representation of NZ Maori and Pacific Island peoples. Support worker training runs concurrent with sector employment in New Zealand (Appendix 2). In addition, four Stakeholders were interviewed including a workplace manager and workplace training manager, and tertiary training leaders to add a

stakeholder perspective to the project (Appendix 3). Finally, there is some reflection about simulation training that is based upon consumer experience.

What we found

a) *The online Survey*

We designed, developed and implemented an online survey for past students of the programme to fill out. We put the survey online in March and left it open for input till October 2011. We sent out invites by e-mail to past students who had trained with us over the past two years and who were working in the sector and encouraged people to pass the invite on to their colleagues who had attended the training. We aimed for 100 responses and captured 95 responses. Our training is Australasian in focus and 63.2% of respondents were from Australia and 36.8% from New Zealand. 20.9% were clinical service workers including psychiatrists, clinical psychologists, social workers, occupational therapists and nurses, and 42.9% described their role as support workers. Over one third or 36.3% described their role as 'other' which included students, front line administrators, employment consultants, human resource worker, counsellor, customer service, cultural support coordinator, researcher and managers. New Zealand respondents resided in a range of North Island cities including Auckland, Wellington, Hamilton, Taupo, Tauranga, Rotorua, and New Plymouth. Australian respondents were from Adelaide, Brisbane, Sydney, Hobart, and Albury.

Ethnicity and gender.
In terms of ethnicity (see figure 2), 20.9% were New Zealand born European, 4.4% NZ Maori, 36.3% Australian European. Of interest, half the number of pacific Island ethnicity filling out our on-line survey as Australian aboriginal or Torres strait Islander (1.1% and 2.2% respectively). This is consistent with other survey feedback where pacific people are known to prefer group processes of participation that are face to face meetings rather than using technology. A similar trend expressed itself in our survey regarding NZ Maori where 4.4% of the respondents filling out the on-line survey were Maori. (We anticipated this trend and also included face-to-face group feedback processes). Asian survey participants were 5.5% and "other" representing 12.1% reflecting perhaps a growing response to workforce needs of migrant health and non-English speaking services, particularly in Australia. Of interest is the relatively high number of 17.6% of European ethnicity which reflects recruitment strategies for filled workforce vacancies. British people are particularly targeted for workforce employment. Perhaps this reflects a lack of effective workforce development in New Zealand, or perhaps the tendency for British workers to continue migrating to New Zealand and Australia as they have for over one hundred years of colonization now. It would be fair to say that psychiatry is part of colonization processes which see Maori and Pacific Island peoples way over-represented in mental health services. Certainly, New Zealand Maori perspectives on experiences such as hearing voices and best cultural practice are not widely known (Melissa Taitimu 2007). Overall, 74.8% of the survey respondents were European in Ethnicity which highlights perhaps an ongoing workforce development shortage of Pacific and NZ Maori workers in New Zealand which is home to indigenous Maori and has the largest Pacific city in the world. This result may also reflect a reluctance of the ethnic group to participate in survey technology, or perhaps, indicative of a lack of access to computer technology.
The online survey was predominantly female (81%) and only 19% were male respondents. There were no transgender respondents to the online survey. This reflects perhaps that mental health work remains predominantly a caring industry staffed by women.

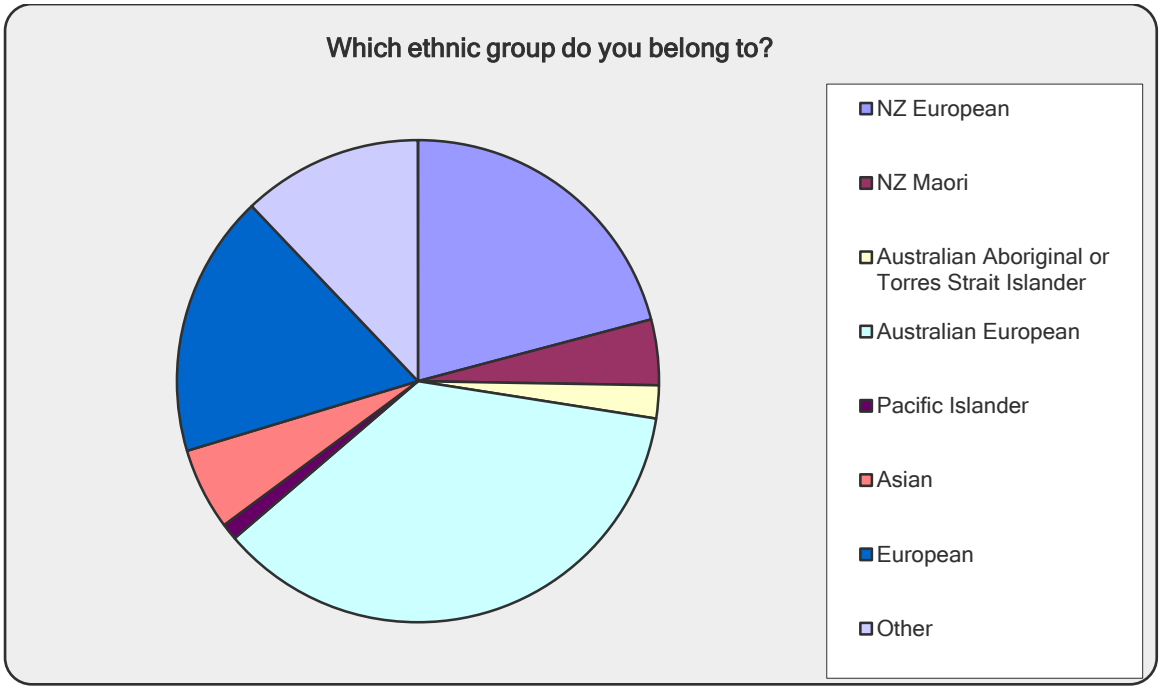


Figure two: Ethnicity of Online Survey Respondents

Funding for training.
Our programme is not funded through government training grants nor mechanisms (although the programme was introduced to New Zealand through public health funding in 1997, funding was withdrawn for delivery follow up). Mental health has never directly funded the programme. Yet, 83.3% of staff employers chose to support their staff either through discretionary funding or associated with polytechnic or university sponsored training. A relatively large number of staff, 16.7% needed to fundraise or pay for their own training in order to ensure their access to training, 5.6% said they funded their own training.

Workshop design.
We asked trainees to rank aspects of the training workshop in measure of usefulness to them and their work (Figure 3). The training programme has a number of features in addition to simulation experience which included reflective discussion, and lecture style information referencing research articles. The survey feedback ranked listening to the MP3 simulation of the voices number one in terms of usefulness in relation to helping them with people who hear voices with 71.6% saying the simulation was very useful and this becomes 96.6% if we combine ‘very useful’ with the ‘useful’ tick box. Of least use to practice in the feedback was “the description of new research that demonstrated voices hearing was not always about mental illness” at 51.2% checking this aspect as useful. About midway in a ranking of usefulness to practice was “the theory the voices make sense within a context within a person’s life. At 64.7% ranking this aspect of the training as very useful. Still, even this aspect of the programme became 94% of respondents when we include both ‘very useful’ and ‘useful’.

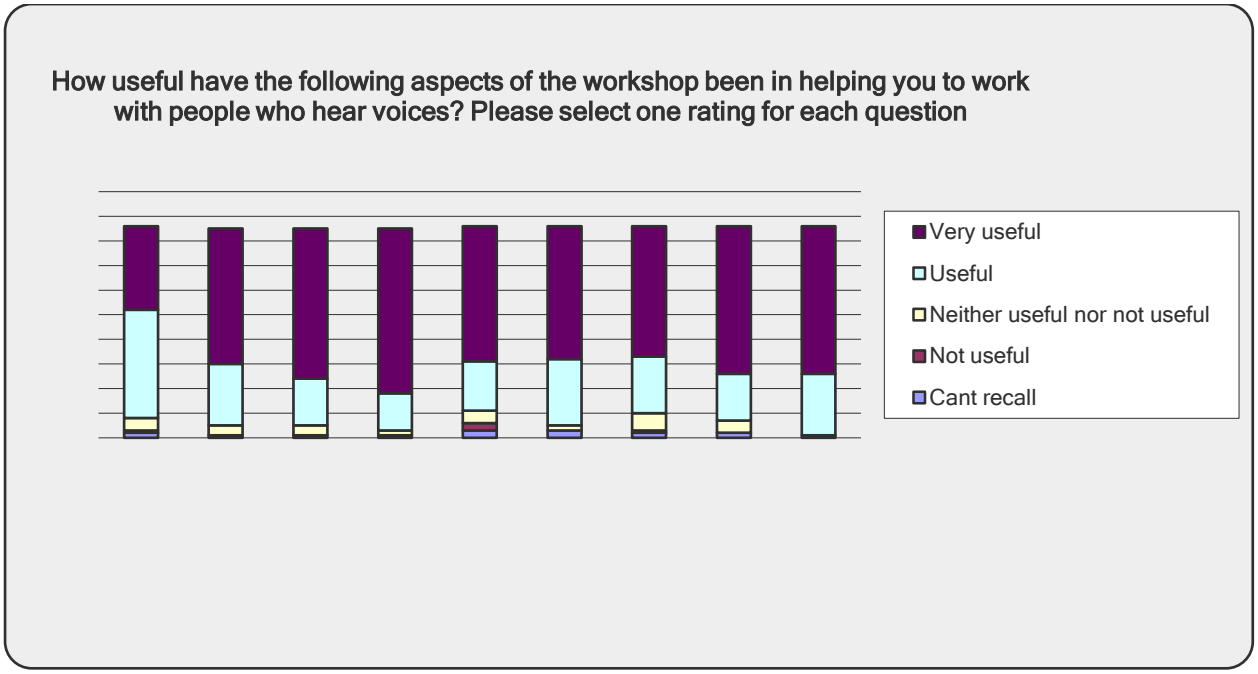


Figure three: Online Survey Trainees Ranking Usefulness of the Programme
(note, the measure on the left side is the number of respondents replying to this particular question. Not all 95 respondents answered question 10 which this graph relates to. 86 people completed answers to this question and the percentages relate to this number of respondents, with 86 being 100% of the people who answered question 10 as nine people skipped this question).

(Below: Categories associated with figure 3)

1. The description of new research that demonstrated voice hearing is not always about mental illness
2. The theory the voices make sense within the context of a person's life history
3. That it is helpful to talk with someone about their voice hearing experiences
4. Listening to the MP3 simulation of voices
5. Community task of visiting shops while listening to the MP3 simulation of voices
6. Mini mental status psychiatric assessment while listening to the MP3 simulation of voices
7. Simulated attendance at a day program (matches tasks) while listening to the MP3 simulation of voices
8. Psychological reading comprehension test while listening to the MP3 simulation of voices
9. Reflection through group discussion about the reality of living with voices and implications for my work

Impact of the training.
A key issue with training programmes is how memorable is the training and training content for the participants. Our survey found 12.1% of respondents from New Zealand had attended the training before 2006 yet they were still highly motivated to participate in the survey feedback and could articulate the impact of the training on their work place practice after longer than five years since having attended the training.

Work practice pre and post training.
Survey respondents were asked to rate their response to this statement: "Before attending the workshop I thought it was best not to speak with voice hearers about the content of their voices". Interestingly, the majority response was "undecided" at 36.5% and only 15.3% strongly disagreed with the statement. Yet after the training workshop, when asked the question "it is helpful to talk with someone about their voice hearing experiences" the majority response was "strongly agree" at 50.6% and when combined with the "agree" statement, this becomes 82.4% with the opposing view halved when compared with the previous question to 8.2%. This result is striking for two reasons. One is the marked and definite shift in work place practice in regard to speaking with people about the content of their voices. And also, contrary to assumptions, staff before training were not generally opposed to speaking with clients about the content of their voices. The majority response was one of being undecided. And the spread of opinion for and against the idea although

trending towards being against the idea, was not the definite view that emerged in the survey, rather our survey represented a range of staff opinion on this topic (see figure 4). The other question we asked was for staff to respond to the statement “People who hear voices should have the opportunity to be understood” and the answer showed a definite trend with “strongly agree” being the most numerous answer with 77.6% ticking that box and this becomes 89.4% when combined with “agree”. Nobody disagreed with this statement at all. And strikingly, 9.4% strongly disagreed with the statement. Maybe this result suggests the workforce maintains a core but strongly opinioned minority view of about 10% who hold to a value of not agreeing people should have the value of being understood.

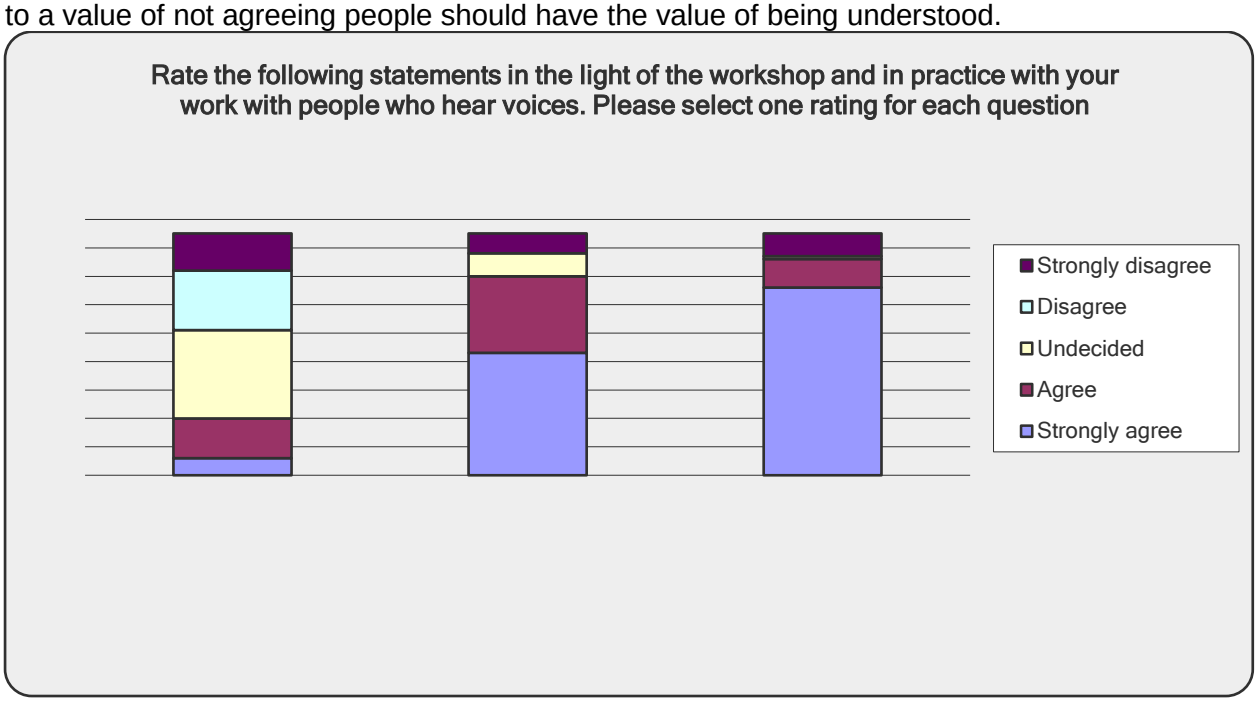


Figure four: Online Survey Trainee’s Attitudes to Talking with Voice Hearers.
(Note, figure four relates to survey question 13. The left hand scale is the number of people who filled out answers to this question, which in this case is 85 of the 95 people who filled out the survey and ten people skipped this question. For this graph then, 85 represents100% of the respondents who filled out answers to this question.

What did you want to get out of this workshop?
In response to the question ‘what did you want to get out of this workshop?’ staff answered with a range of identified needs. The most common response is represented by

> *an insight into what causes people to hear voices. The impact of it on people’s daily lives and some practical advice on how to assist and support people that hear voices*

Nearly half of the survey respondents included ‘*greater understanding’* as their motivation for attending training and also *‘insight’* was often listed along with ‘*lived experience wisdom’*. A number of those surveyed attended in order to understand the ‘*stigma’* surrounding the experience and who want *‘demystification’* of the experience. Another theme in workforce expectations was the *gaining of practical strategies*. Mostly staff wanted ‘*greater understanding’*.
Did the workshop deliver this to you? Please comment here on why or why not.

On the question ‘Did the workshop deliver on your training expectations?’ the overwhelming response was affirmative.

> *‘Yes-through the experience of the simulation, observing the changes in my colleagues and the opportunity to discuss the personal experience in the debriefing session’.*

'Yes, active, interactive and insightful drawing on personal and others experiences' 'absolutely- I found the training to be incredibly powerful and it has really affected my view on consumers suffering from mental health issues and the differing ways people react to hearing voices'.

There was evidence that stigma was reduced with comments like

'Yes. I came away with much more courage and humanity in my dealings with those struggling with hearing voices. I was very engaged and informed and moved'. Absolutely- I found the training to be incredibly powerful and it has really affected my view on consumers suffering from mental health issues and the differing ways people react to hearing voices'

The effectiveness of the delivery was appreciated by both clinical and non-clinical workers alike. One clinical view is representative for clinicians with this comment

'A sensory experience which enabled me to have an greater understanding of what the clients I am working with cope with on a day to day/hour by hour basis. The experience was very enlightening and improved my clinical understanding and enhanced my empathy towards those experiencing sensory hallucinations. The simulated 'lived experience' has to be the most valuable, informative further education I have undertaken and is hugely complimentary to academic study'.

Several people stated it was the best training programme they had been on

'*it was fantastic, one of the best training I have been to in my two years of working in the mental health sector. It was engaging, interactive, creative and informative.*

A range of people said there was a need for more training of this type.
Not everyone was so glowing, one person wrote

'not to my expectation'

and several said they wanted more strategies or focus upon supporting people

'I am more aware of the challenges faced by people who hear voices in their everyday living and have a greater understanding of how to effectively engage with them. I learned some strategies to enable people to more effectively cope with hearing voices, but would have liked more focus put on supporting people who experience hearing voices during the course of the training'.

How has this workshop influenced your practices in working with people who hear voices? Please give examples.

This question sought to elicit information about change of practice in the workplace. The biggest change identified in workplace practice. Staff say the biggest change is their discussion with voice hearers about their voices. Nearly half (37 out of 79) responses indicated they had changed their practice from being unsure about speaking with voice-hearers about their voices experience to actively engaging with people in discussion about their experiences. Typical comments include:

'I am no longer hesitant to engage around the meaning of voices and the experience for people'

'It has changed the way that I used to work with people who have hearing voices'.

One respondent gave an example of change in practice and detailed the learning as

> *Eg: The voice saying "you have to leave your work right now". You can choose to leave and go or you can choose to stay. One of our members hears that voice all of the time saying the same thing. Now when they approach us to say "am I meant to be leaving" we ask them if they want to leave. They reply no, so they stay regardless of what the voice tells them they should be knowing. They are learning that the voices only have power over them should they chose to do what the voice says. It has been a great learning curve for me as I had always assumed there was no choice in it, that the person does what the voice says'.*

Active engagement was described by others:

> *'when person is distressed, we talk about the voice(s), not ignore it/them as clinician often tells us to do. Use the working with voices workbook with clients.*
>
> *The above two examples are good examples of alternatives to medication: instead of upping the drugs and feeling helpless, we can do something, together, to try and figure out those voices'.*

The training programme appears to work across a range of staff roles from clinicians to support workers, to peer support workers. One counsellor commented:

> '*It has given me the foundations of a structure to begin to build my counselling style on when confronted with this condition. I feel more confident*'.

A residential support worker said:

> '*I am prepared to engage in conversation about voices in a more comfortable, curious and supportive way. I can appreciate how this may be helpful for those who hear voices.*

Family members also report a change in their practice as a result of the training such as this comment

> *'I work with families of people who experience psychosis. This workshop has helped me to educate families about the experience and also to encourage them to do the workshop themselves. Tangata whai ora are open to talking to me about this when they know I have done the workshop'.*

An employment service worker wrote this comment

> *…will be there willing to seek help to find employment despite their situation'.*

The next most common effect in the workplace practice was increased understanding among 14 out of 79 respondents with comments such as

> *'I think that it gave me a better understanding of what it might be like to hear voices, and how hard it would be to carry out everyday tasks while hearing voices. I guess it has increased my empathy for individuals that hear voices because I feel that I have an increased understanding'.*

Moving stigmatized beliefs was also a reported effect on staff having attended the training and 12 respondents specifically mentioned a shift in former fear, judgment and belief with comments such as

> *'take stock of myself and how I judge and respond to others',*
> *'It has helped me adopt a more respectful attitude towards those who hear voices',*
>
> *…am not as fearful that I may make a situation worse',*
>
> *'Am more aware of what the person is going through & less frightened about it due to greater understanding of it',*

Increased empathy (5 respondents) and increased confidence (3 respondents) were also signaled in the feedback to this question with statements such as

> *'This workshop has given me compassion for those who hear voices…'*,
>
> *I feel more confident in supporting people with techniques to manage their voices'.*

And these values really permeate the other comments made.

One person said *'no change in my practice'*. There was no other supporting information to this comment so we are unclear whether their former practice was exemplary of the approach taught or not.

What out of the workshop most helps you to work with voice hearers?

This question was designed to elicit responses that would demonstrate perhaps the linkage between work place practice and the experiential training programme and to become clear about the most useful aspects of the training from the workshop attendee's point of view. Half of the respondents to this question said the experience of the simulation was the most helpful content of the workshop Typical comments include:

> '*The ability to imagine what is 'walking in another shoes might b like' then with this understanding support the individual to focus on positives and further develop resilience and strengths to maintain a sense of wellbeing'*
>
> *'I think the MP3 player…and it humanizes people and the experience for when normally such an experience is for us without voices a strange and horrifying concept that these people live with and some function quite well – I didn't fully appreciate a voice hearer really could "function"*
>
> *I think that going through the process of actually hearing the voices, feeling and experiencing what is it like was the biggest eye opener…it gives understanding to those who do hear voices because the experience of going through it for simply an hour in the workshop was unbelievably hard…I now have compassion and understanding'.*

The second most helpful part of the workshop in workplace practice with voice hearers was the knowledge content of the programme which was delivered through both lecture and group discussion. Typical responses were

> *'Confidence that I can assist, I always knew that I could however the information provided and discussion around all of the learning objectives has increased my motivation and confidence. When we spoke about the amount of time we have to assist people so that outcomes can be better I felt inspired to make a difference with the time that I have. The workshop was a very positive learning experience'*

Some people identified a reduction in fear of stigma as and discrimination as a result of their training experience most helped them work with clients. Comments such as

> *'Understanding more trust has been built with my clients in order to help the client discuss their voices with me and not have the fear that they will be admitted to hospital',*
>
> *'normalising it and making me feel confident to talk about it'.*

How can we improve this workshop? Please give examples.
We asked this question in the survey in order to gauge possible further critique and to also assess pointers for further development that may be needed for follow up needs of the students. The majority of feedback suggested a high level of satisfaction with the programme the way it was. Responses in support of this view include

> *'I really can't think of anything to improve this workshop'*
>
> *'I don't know of anything that could be done better. It is one of the most helpful training I have ever attended'.*

The next order of feedback to this question was a request for a longer training duration, for a two day programme that would include scenario work, more case examples of voice hearers who have recovered. Typical responses included

> *'more information around voice profiling'*
>
> *'provide more example and more theory how to work with people hearing voice'*
>
> *'Could be run over two days with more coping strategies and support techniques included and the power point presentation covered more completely'*

Some people suggested more reflective time in the programme in order to debrief the experiential component with comments such as ……

> *Allow more time for de brief. Debrief in groups before coming to the larger group'.*

There was interest in other illnesses information with

> *'more understanding of other illnesses apart from Schizophrenia…(and maybe found out more from people) about their personal experiences with clients that hear voices'.*

Some people wanted more information on building trust and rapport

> *'The workshop was fine and the content was great. I think maybe there could be just a little more on some strategies to build trust and rapport with clients for them to feel they can open up'*

Feedback underscored the need to maintain low class numbers

> *'Keep participant number to a set number so that all participants have the opportunity to gain the most from the training'.*

Cost was mentioned as a barrier to accessing training

> *'The cost has become a problem with employers now not being able to ensure all their staff experience the workshop'.*

Finally, please give your views on any other aspects of the workshop here.

People in the survey took the opportunity of this question to further acknowledge their learning experience with comments such as

> *'I recommend this workshop to others as the best workshop I've ever been on. It was informative, fun, gave me greater understanding of others and gave me strategies that I've used repeatedly with clients. I haven't ever experienced a workshop of this type before or since. Arana was an awesome presenter, and it was great to see someone who experiences hearing voices role modelling community participation and success, because this also models hope for all who have the same condition and those who work with them'.*

Others re-asserted the efficacy of the MP3 simulation such as

> *'The power of the MP3 simulation cannot be underestimated and perhaps some discussion about personal thoughts that may arise after the workshop would be good'.*

Some people suggested more paper work

> *'As a clinician who wished to share my experience through providing an in-service to my colleagues I would have liked more information perhaps within the handout on areas such as : voice profiling; what it is exactly and how to do it; suggestions on ways to elicit information from clients in regards to their voices; listing of support networks available for voice hearers. I am sure all of this was provided verbally within the training, however, trying to take notes and listen to the presenter unfortunately means that some important information may be missed'.*

There were a couple of suggestions regarding the training venue that suggests attention be paid to good training environments and a lack of food provided (Keepwell does not provide free lunch at its training).

One person felt the training experience could have acknowledged Mental Health services more

> *'I did feel there was a strong undercurrent of "anti-mental health services" in the training….this is quite a separate agenda and learning from this is also different to the stated aims of the course...I strongly feel that some acknowledgement that not all providers of mental health care do so in such destructive, unthoughtful, uncaring and controlling ways'*.

The final comment to this part of the survey was

> *'A very worthwhile workshop and one that I have recommended to others over the last 6 years'.*

b) <u>*Group discussion feedback*</u>

We held 4 group discussions. Two undergraduate nursing classes of 30 participants each, one group of undergraduate social work students of 30 and one support worker certificate programme class of 30 students. These group discussions were events where permission was sought and five general open-ended questions were used as prompts for discussion and feedback (see appendix two). The student group discussion corroborated the feedback of the on-line survey and supported all the findings there. This strengthened our view the

programme works effectively with Maori and Pacific peoples also as the group composition included people from these cultures and brought an ethnic balance to the online survey demographic. Examples of group discussion feedback include the following comments :-

give you insight into others condition'

'There's no other way to understand'.

These students also valued the presenter being a voice-hearer with psychiatric service experience with comments such as

'Knowing the presenter is a voice hearer gives first hand knowledge'.

Suggestions for improvement include

'better quality headphones, these ones hurt my ears!'

'everyone with different tapes'.

General comment was summarized with

'insightful. Such important work that will have me thinking about lots of things now'.

Suggestions for improving the workshop include

'get more opinions from the people we are working with'

One person didn't like our humour

'I don't like the non-PC jokes, be more politically correct'

c) <u>Stakeholder interviews</u>

Four stakeholder interviews were conducted including undergraduate nursing tutor; social work undergraduate lecturer; clinical mental health service training manager; and support worker certificate tutor. The approach to these stakeholder interviews is documented here at appendix 3. After interviewing these people, I went back to them with a draft of the findings to clarify the feedback from both the online survey and group discussions with these key stakeholders. This was a useful process in testing the findings and confirming their validity. An unexpected result was the experience itself of listening to the voice simulation proved to be the leading value and memorable component of the training programme from which other learning was derived in many different ways. This was something I checked back with the stakeholders for confirmation. We also discovered how the attitude shift appeared to be a driver for behavior change in the workplace and not the knowledge or skill component and this was also an unexpected learning from the research. In fact, the process of education in this project suggests that staff attitude may lead the interest and willingness for staff to acquire skills and knowledge related to improved customer service. The feedback from these interviews corroborated the survey analysis and deepened our understanding of how the workshop programme is effective. Typical feedback included

'The training is effective because we use problem based learning and in the classroom is an extension of the workplace and the experience is directly related to their workplace experience to give them a better understanding.

'Education is pushing boundaries that staff become self aware of their values and boundaries and are able to advocate for their clients, talk about their scope of practice, and to expand that'.

Several commented on the reflective discussion component of the workshop with comments such as

'It doesn't work if we hurry the reflective process at the end…the boundaries of timetable can be restrictive, we need to make the flexibility in order for students to critically reflect'

'Reflecting is the "aha" moments for the students and links back into their work practice'. Support worker comment suggested the workshop had become a key for mental health with this comment

'We used to just lock in the course. Now it sets the scene for mental health and to capture what is happening in the workplace. Narration of stories is key to learning'.

A clinical service manager commented

'The reflection needs to keep the focus on how the experience was for them while they were hearing the voices simulation rather than their current client base.
'We notice better results with our staff who have been working for some years. The newer employees don't have the work place experience yet to value the training in the same way'.

Several stakeholders noted the practical challenges in ensuring consumer participation in their in-service training programs.

Discussion and Conclusion

Customer service attitude
New Zealand workers are renowned for sub-standard customer service attitude where telecommunications industry and government agencies score the worst. A national survey found the top three factors front line customer service staff should be doing to ensure their customers' expectations are met are:

1. Listen to me and understand what my needs are
2. Show a willingness to help me
3. Respond to me in a timely manner (JRANZ LTD & Kiwi Host 2010)

The mental health consumer who hears voices has made these same requests and the simulation training programme demonstrated that it changed staff behaviour towards listening with the customer about the content of their voices. There is also some evidence here that staff respond in a timely manner with more willingness to help people with their distressing voices.

This programme clearly shifts attitudes and staff service delivery in relation to front line worker interactions with mental health customers. Other workplaces that are immediately appropriate for this training programme include government service agencies such as Work and Income New Zealand (WINZ or Centrelink which is the equivalent in Australia), school teachers, librarians, department of corrections workers, police, hospital nurses and allied staff in departments other than mental health. It would also be of use to teller banking staff and managers, advocates, electricity providers, airlines and mobile phone sales and service.

Other workplaces where new programmes of simulation training would be useful are anywhere that customer feedback is consistently critical and there is an identified need for staff to understand better by 'walking a mile in my shoes' type of training. Creative partnerships would usefully be explored between other cultural groups and businesses such as different Pacific nations or Asian peoples and service industries; the transgender community and services; and disability groups such as the deaf or blind community. There are also opportunities for vibrant new training to be developed through collaborative partnerships involving all these groups of customers working together in designing, developing and delivering staff training programmes in, for example, telecommunications or government service sector.

What in the programme works best and what needs changing or amending?
Most of the feedback suggests the programme is fine as it is at present. The key strengths of the current delivery include "the programme is delivered by someone who hears voices and is designed by someone who hears voices" and "the experience of actually listening to a recording made by people who hear voices so that I can try and do the same tasks we ask of consumers whilst actually hearing voices myself".

However, improvements are suggested by this research. Organizing effective consumer participation in the training delivery is an identified difficulty in the stakeholder feedback. For all the progress made in mental health services regarding consumer participation in the past twenty years, there remains a capacity and process issue as to how best to organise consumer participation. Patient volunteers are one solution and employment of consumer educators is another. There are cost and capacity issues in the consumer participation requirement for training.

Facilitation needs to be lead by a person with effective presentation and facilitation skills as keeping staff focused upon their simulation experience and gleaning learning from that is a highly complex ability requiring a skilled educator, and such skills are rare in someone who also has a background of being a consumer of psychiatric services.

There is an interest in different ethnicity experiences of voices and some people have wondered if they would benefit from an MP3 recorded in , for example, Chinese language or Samoan or New Zealand Maori language.

Other possible improvements may include a review of the handout information. There was a suggestion of more resources of skills for actually working directly with voice hearers in a therapeutic or recovery manner such as: voice profiling; and suggestions on ways to build trust with voice hearers; and listing of support networks available for voice hearers.

How does it work?
Students clearly remember the training and are impacted for years after the training event. Also, clinical staff and others have a measurably high documented change of practice as a result of this training programme. The shift was a move in attitude from being unsure about speaking with voice hearers about the content of their experience through to a marked and majority shift in motivation to engage with consumers who were voice hearers. Employee's were also engaged with the subject by requesting more training and being actively occupied in suggesting more topics for deepening the learning experience. The survey feedback also documented examples of staff applying the ideas of the course and changing their practice. This change in workplace practice came about through staff experiencing for themselves what it was like to hear voices that are distressing within the simulation programme. Why are these results achieved? The question is, how does this particular training programme work?
Maybe the answer is something to do with androgogy theory which recognizes that adults learn in a particular way. What is possibly happening is the motivation to learn new behaviors is an internal process that Knowles identified as key to adult learning. Perhaps it is

true that through internalizing a personal experience and reflecting upon that experience is a most effective way to change adult behavior as Kolb theorized. This has profound implications for consumer and patient advocates who are interested in service change yet feel frustrated at apparent lack of results from their current methods (Tomes, Nancy 1998).

The experience of the hearing voices simulation training may be viewed as an episodic event in a person's life. And several staff reported in our feedback they were actively sharing with other staff about their own episode of the workshop simulation long after the training event. It has been suggested that episodic memory is the last to have developed in our human evolution, and that our language and way of thinking is recursive, which as one leading researcher has said, can only

*….reinforce my belief that the essence of humanity is not the things we make, but rather the way we think. Our recursive understanding of each other, and our recursive ability to tell stories, whether fictional or autobiographical, is what truly set us apart from other species, but aligns us with our fellow humans, of whatever race or culture (*Corballis, Michael C. 2011 *pg 230*)

That learning outcomes were reported here over a range of cultures and a variety of job descriptions is perhaps testament to this ability for recursive understanding of one another, including for people who hear distressing voices.

Consumer and staff assumptions

Customer feedback that is critical of service delivery is only the beginning of a quality improvement cycle of service response. Such feedback requires involvement with consumers in order to understand and construct effective responses. Negative customer feedback points to a service delivery problem. Yet, staff feedback is also important to understanding the consumer feedback. After listening to staff feedback through the online survey, we discovered that customer feedback had also made a number of assumptions about the service providers that were also untrue. We discovered the staff did not actually hold the discriminatory views the customers were anecdotally accusing them off. Often the mental health consumer feedback includes 'they don't understand, they are not open to listening, they treat us only as symptoms and not as human beings, they are not open to speaking with us about our experiences of voices, and the system does not support a recovery discussion about our experience of voices'. When we asked the question of staff what were their views on speaking with consumers about the content of their voices, the majority answered 'undecided'. And in one training session we were able to effect a marked change in this view. Both consumers and staff benefit through letting go of assumption or personal opinion and getting to understand each other through effective opinion survey.

The funding of workplace training

Some feedback reflected cost as a barrier to access training. We found that in a publically funded system of service delivery that training is paid for through a complex range of service specifications aligned with service and political principles. In this environment, the designing, developing and delivering training that furthers the sector is vulnerable to the politics of exclusion through principles that are not driven by consumer identified need. Neither does innovation flourish with these constraints. A vulnerability of publically funded and delivered training is funding processes are open to be politically driven rather than outcome driven. The main success of our approach in the face of this barrier has been to adopt a business model that sells training on a choice basis and not through the usual agreed funding mechanisms. This particular training programme is welcomed for its outcomes by both staff and customers, remains unfunded in the mental health and public health sector after 15 years of successful and consistent delivery.

Reducing Stigma. Consumer participation
In developing and adapting an experiential programme designed and delivered by customers that are stigmatised and traditionally thought of as difficult clients, we have demonstrated attitude shift in the workers and work place practice. More than that, innovative training creates staff interest and confidence in working to satisfy what has previously been identified as 'the difficult customer'. This is a proven way to address stigma and discrimination as direct contact with people who have experienced mental illness is the most effective in tackling stigma and discrimination associated with mental illness.

Five conditions are needed for contact between people with mental illness and target groups to be effective. The members of the group must have *equal status*; there must be an opportunity for members/participants *to get to know each other*; information exchanged must *disconfirm a negative stereotype*; the participants must pursue mutual goals; and the participants must actively *cooperate* with each other (Couture, SM & Penn, DI 2003). This workshop programme satisfies all these conditions for an effective programme for reducing stigma which was confirmed by our survey feedback and interviews. A key to the success of the programme is an attitude of cooperation in seeking partnership with all who attend the training. By opening up respectful dialogue among voice hearers, consumers, health workers and others who attend training, we aim to bridge any perceived divide of perspective. This attitude in delivery is crucial to the successful learning outcomes of the programme.

There remain barriers to effective consumer participation. Workplaces and workplace training programs require further development into supporting consumer involvement in the delivery of workplace training. The effectiveness of simulation training is pivotal around excellence in consumer lead presentation skills and this ability is a high level job in itself requiring individual support and development. This is pivotal for effectiveness of a program of simulation training.

More questions
There are a range of questions this research project opens up. We have looked at attitude change with regard to staff using simulation training experiences here. What we still have no research on is customer outcome for this particular consumer group. That is a question outside this particular research project that would involve recovery outcomes measures. Outcome measurement in mental health is a difficult challenge that remains systemically unsolved. Outputs are rather easier to measure and fund such as FTE staffing and client throughput statistics. Although this research looked at staff training, we are also not reporting here on increased customer satisfaction as a result of the simulation training programme as this project did not seek to measure that although anecdotally, the consumers who participated with the training delivery reported how happy they were to be part of a different staff engagement with regard to the dialogue part of the programme (Personal communication). We note feedback which requests further training in supporting people who hear distressing voices. There is opportunity for further voice hearer programme development, particularly with experiential learning that practice skills involving communication with people and the content of the voices people hear.

The paper also broaches the topic of employee attitude as a key focus for training programmes and business productivity. The assumption that improved staff attitude towards customer experience leads to increased business productivity is also not something we measured in this paper.

The mental health system and health in general still tends to prioritize knowledge and skill components in training over attitude considerations as a motivation for practice. Anecdotally 'bad bedside manner means an excellently skilled doctor' remains embedded in the kiwi culture where skill and apparent outcome dominate attitude in New Zealand. What this

project sought to demonstrate was how consumer participation in staff training, through experiential learning may improve workforce development. We demonstrated this programme of experiential learning does achieve attitudinal change that appears to motivate practice change. The recommendation is where industry “hears the voices” of customer criticism regarding attitude, that educators consider a programme of experiential learning that involves the consumer in the implementation, design and delivery of a programme of learning. And that particularly with businesses that identify a need for improvement with the human interaction with its customers, that attitude be considered equally along with skill and knowledge in the design and measurable outcome of industry training programme development.

References

1. Clinton, Michael & Olsen, Anne (1998).'Collaboration for Mental Health' Australia: keynote address at the *8th Annual TheMHS Conference book of papers1998 Sydney*.
2. Mason, Ken; Johnston June, & Crowe, Jim (1996). Inquiry Under Section 47 of the Health and Disability Services Act in Respect of Certain Mental Health Services. *New Zealand: government* (commonly known as The Mason Report)
3. Schneebeli C, O'Brien A, Lampshire D, Hamer HP (2010) "Service user involvement in undergraduate mental health nursing in New Zealand". *International Journal of Mental Health Nursing* Feb;19(1):30-5.
4. Beavan V & Read J. (2010) Hearing voices and listening to what they say: the importance of voice content in understanding and working with distressing voices. *The Journal of Nervous and Mental Disease*, 198(3):201-5.
5. White, Michael (1997) *Companions on a Journey: An exploration of an alternative community mental health project* Dulwich Centre Adelaide http://www.narrativetherapylibrary.com/catalog_details.asp?ID=71 accessed 28 March 2012
6. White, Michael with Epston, David (1990). *Narrative Means to Therapeutic Ends*. WW Norton & Company, New York).
7. Romme MA, Honig A, Noorthoorn EO and Escher, AD (1992) Coping with hearing voices: An emancipatory approach, *The British Journal of Psychiatry* 161: 99-103.
8. Romme, M., & Escher, S. (1993). *Accepting Voices*, London, England, MIND publications
9. Bloom B. S. (1956). Taxonomy of Educational Objectives. Handbook 1 *The Cognitive Domain.* New York: David McKay Co Inc.
10. Knowles, Malcolm (1980). *The modern practice of adult education: From pedagogy to andragogy*. Wilton, Connecticut: Association Press.
11. Kolb. D. A. and Fry, R. (1975) Toward an applied theory of experiential learning. in C. Cooper (ed.) *Theories of Group Process,* London: John Wiley
12. Nancy McNaughton, Paula Ravitz, Andrea Wadell, Brian D Hodges (Feb 2008). Psychiatric Education and Simulation: A Review of the Literature *Canadian Journal of Psychiatry*. Vol. 53, Issue. 2, p. 85-93 (9 pp.)
13. Kayes, D. C.(2002). Experiential learning and its critics: Preserving the role of experience in management learning and education. *Academy of Management Learning and Education, 1*, 2, 137-149.
14. Deegan P (2006) *Hearing voices curriculum. Complete training and curriculum package*. National Empowerment Centre Store, accessed at http://www.power2u.org/mm5/merchant.mvc on the 28 March 2012.
15. Hamilton Wilson J, Azzopardi W, Sager S, Gould B, Conroy S, Deegan P and Archie S (2009) A narrative study of the experiences of student nurses who have participated in the hearing voices that are distressing simulation, *International Journal of Nursing Education Scholarship* 6(1): Article 19.
16. Melissa Taitimu (Maori descendant: Te Rarawa, Te Aupouri). (2007) *Nga Whakaawhitniga: Standing at the Crossroads: Maori constructions of extra-ordinary experiences and schizophrenia.* (PhD research project University of Auckland, New Zealand).
17. JRANZ Ltd & Kiwi Host (2010) *Customer Service Pulse*, (Kiwi Host report) accessed on 28 March 2012 at http://www.kiwihost.co.nz/uploadGallery/JRA%20Survey%202010-web.pdf)

18. Tomes, Nancy (1998) *From Patients' rights to consumers' rights: Historical reflections on the evolution of a concept* (Keynote address, 'Making History: shaping the Future – Proceedings of the 8th Annual TheMHS Conference, P.O. Box 192 Balmain NSW 2041 Australia) 1999.
19. Corballis, Michael C (2011) *The Recursive Mind: The Origins of Human Language, Thought, and Civilization*. Princeton University Press
20. Couture, SM & Penn, DI (2003) Interpersonal contact and the stigma of mental illness: a review of the literature*. Journal of mental health,* 12.3 291-305

APPENDIX 1

KEEPWELL ™

Keepwell Ltd

Motivation for recovery in mental health

P.O. Box 10 771
The Terrace
NEW ZEALAND
Fax +64 (4) 384 1233
www.keepwell.co.nz

Hearing Voices Evaluation 2011

Sometime in the past few years you may have attended "hearing voices that are distressing" workshop that simulates voice hearing using MP3 players. We want to invite you to participate in this, the first systematic evaluation of our training and we would appreciate your feedback so that we can improve the programme and find out what are the most effective experiential approaches to teaching and learning for people who hear voices.

You have received this invitation to participate in our on-line evaluation process and invite you to fill out the survey related to the training you attended. Please take the time to click on the link provided below and to fill out our on-line survey.

The feedback you provide is immensely useful for our ongoing programme of course development and also for your service managers and funders who want to know about training they make available for you to attend. Feel free to share this request for feedback with other colleagues you know who attended training with you if we have not got your e-mail address on file.

All the writing up of this survey will be anonymous and no-one will be named in the report. Neither will any institution be named when we write up the feedback.

Please respond by two weeks from now.

https://www.surveymonkey.com/s/KeepwellEvaluation2011

Click Here (above) to take survey please

Hearing Voices That Are Distressing Evaluation 2011

1. Introduction

You have received this invitation to participate in our on-line evaluation process, which asks you to fill out the survey related to the training you attended. Please take the time to click on the link provided below and to complete our on-line survey.

The feedback you provide is immensely useful for our ongoing programme of course development and also for service managers and funders who want to know about training they make available for you to attend. Feel free to share this request for feedback with other colleagues you know who attended training with you.

I have been delivering hearing voices simulation training since 1996 throughout Australia and New Zealand. Till now there has been no formal evaluation of the programme. Keepwell is working with a reputable research partner and the Aotearoa national centre for tertiary teaching organisation to conduct this evaluation. We appreciate your feedback, which will help us to improve the programme and find out what are the most effective experiential approaches to teaching and learning.

Please be assured that all responses are confidential and no individuals or organisations will be named in the evaluation report.

Faithfully,
Mr Arana Pearson (BA, QBE)
Director
Keepwell Ltd

2. Demographics

This section will collect some information about where the training was held

***1. Which Country was the training in?**

3. Demographics NZ

***2. Where did your training take place in New Zealand?**

	Town	Year	Month
1			

4. Demographics Australia

***3. Where did your training take place in Australia?**

	Town	Year	Month
1			

5. Demographic cont

***4. Gender**

○ Male ○ Female ○ Transgender

Page 1

Hearing Voices That Are Distressing Evaluation 2011

***5. Which ethnic group do you belong to?**

- ◯ NZ European
- ◯ NZ Maori
- ◯ Australian Aboriginal or Torres Strait Islander
- ◯ Australian European
- ◯ Pacific Islander
- ◯ Asian
- ◯ European
- ◯ Other

6. Who paid for your training?

◯ Employer ◯ Self ◯ Other

***7. What best describes your role?**

◯ Clinician ◯ Community/support worker ◯ Other (please describe)

Other (please specify)

6. Feedback on workshop delivery

8. What did you want to get out of this workshop? Please comment here

9. Did the workshop deliver this to you? Please comment here on why or why not

7. Feedback on workshop delivery Con't

Page 2

Hearing Voices That Are Distressing Evaluation 2011

10. How useful have the following aspects of the workshop been in helping you to work with people who hear voices? Please select one rating for each question

	Very useful	Useful	Neither useful nor not useful	Not useful	Cant recall
1. The description of new research that demonstrated voice hearing is not always about mental illness	○	○	○	○	○
2. The theory the voices make sense within the context of a person's life history	○	○	○	○	○
3. That it is helpful to talk with someone about their voice hearing experiences	○	○	○	○	○
4. Listening to the MP3 simulation of voices	○	○	○	○	○
5. Community task of visiting shops while listening to the MP3 simulation of voices	○	○	○	○	○
6. Mini mental status psychiatric assessment while listening to the MP3 simulation of voices	○	○	○	○	○
7. Simulated attendance at a day program (matches tasks) while listening to the MP3 simulation of voices	○	○	○	○	○
8. Psychological reading comprehension test while listening to the MP3 simulation of voices	○	○	○	○	○
9. Reflection through group discussion about the reality of living with voices and implications for my work	○	○	○	○	○

8. Feedback on workshop delivery Con't

11. How has this workshop influenced your practices in working with people who hear voices? Please give examples

Page 3

Hearing Voices That Are Distressing Evaluation 2011

12. What out of the workshop most helps you to work with voice hearers? Please tell us why that is

9. How the workshop has influenced my practice

13. Rate the following statements in the light of the workshop and in practice with your work with people who hear voices. Please select one rating for each question

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1. Before attending the workshop I thought it was best not to speak with voice hearers about the content of their voices	◯	◯	◯	◯	◯
2. It is helpful to talk with someone about their voice hearing experiences	◯	◯	◯	◯	◯
3. People who hear voices should have the opportunity to be understood	◯	◯	◯	◯	◯

10. How can the workshp be improved

14. How can we improve this workshop? Please give examples

15. Finally, please give your views on any other aspects of the workshop here

11. Survey results follow up

Page 4

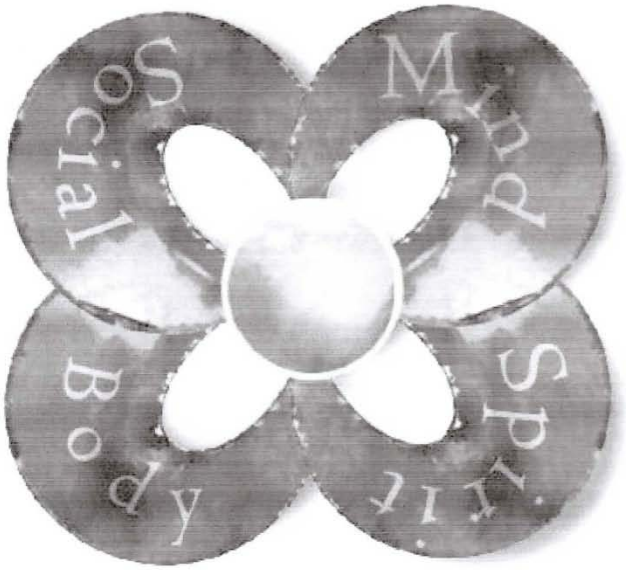
16. I want to receive a copy of the completed report

◯ Yes ◯ No

type in your e-mail address here to receive a copy of the report

12. Survey End

www.keepwell.co.nz
www.keepwell.com.au



APPENDIX 2

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P.O. Box 10 771
The Terrace
NEW ZEALAND
Fax +64 (4) 384 1233
www.keepwell.co.nz

Hearing Voices that are distressing: Evaluation Permission

We want to find out how effective this training is.

We would like you to feed back verbally at the end of the training event today which we may use in research.

This is voluntary and you don't need to complete the questionnaire or feedback in the group discussion if you don't want to.

This is anonymous and you will not be identified in any way.

……. ……

Signature Date

Group facilitated question prompts:

1) **How effective do you think this approach is?**
2) **Why/why not?**
3) **Examples of what works**
4) **Areas where the workshop could be improved**
5) **Any other comments you have about the program**

APPENDIX 3

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The Terrace
NEW ZEALAND
Fax +64 (4) 384 1233
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Hearing Voices Evaluation 2011

Institutional Stakeholder Confirmation & Questionnaire

Thank you for agreeing to participate in our systematic survey of our training. As agreed we will meet (or I will phone) you at .....(time) on .....(day/date). You have received this invitation in follow up from our recent telephone conversation as preparation for our time together to discuss your experiences of the workshop. Your feedback you provide is immensely useful for our ongoing programme of course development and also for your service managers and funders who want to know about training they make available. We are also asking people who have attended our training to register their experiences through our on-line survey. And in addition, this personal approach is aimed at institutional learning organisations and managers or team leaders of services.

Sometime in the past few years you, your students or your staff may have attended a hearing voices that are distressing workshop that simulates voice hearing using MP3 players. We want to invite you to participate in this, the first systematic evaluation of our training and we would appreciate your feedback so that we can improve the programme and find out what are the most effective experiential approaches to teaching and learning for people who hear voices.

All the writing up of this survey will be anonymous and no-one will be named in the report. Neither will any institution be named when we write up the feedback.

(Here below is a guide to the discussion we will have and not to constrain the conversation)

1) **How effective do you think this approach is?**
2) **Why/why not?**
3) **Examples of what works**
4) **Areas where the workshop could be improved**
5) **Any other comments you have about the programme?**

Appendix 4. Sample workshop handout information

Keepwell™ Presents

HEARING VOICES THAT ARE DISTRESSSING – A SIMULATED TRAINING EXPERIENCE

2012

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The Terrace
NEW ZEALAND
Fax +64 (4) 384 1233
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Motivation for recovery in mental health

Presenter's Information

Arana Pearson is a musician and writer who became involved in the mental health service sector some years after his own experience of using mental health services in New Zealand. He was employed in the role of 'consumer support and liaison' in a mental health service in 1996 for four years, was the first chairman for the national consumer advisory group in the New Zealand "project to counter stigma and discrimination associated with mental illness" (*Like Minds Like Mine*), and he lead the development of the "Serious Fun 'n Mind" charitable trust in the Bay of Plenty. The Mental Health Commission of New Zealand employed Arana from 1999 till 2003 in the role of 'consumer advisor: Tangata whai ora takawaenga'.

Arana released a CD music recording of the mental health consumer anthem "I'm Just a Little Mad" (2000) and a relaxation CD of piano music (2003) and is the Australasian director of **Mad Pride**™ events. In 2005 he was an invited performer at the Yale university international conference on Mental Health in the United States of America.

He has trained with leading user activists such as Dr Patricia Deeghan and Mary Ellen-Copeland of the U.S.A. Merinda Epstein of Australia, and Ron Coleman in the United Kingdom.

Arana is currently director and principal trainer for Keepwell Ltd in Australia and New Zealand, specialising in delivering recovery-based training to the mental health sector throughout Australasia. Keepwell won a gold award for excellence in mental health training in 2006 at the Australasian Mental Health Services conference of Australia and New Zealand.

Arana hears voices and has advocated for better understanding, acceptance and support for people who hear voices in New Zealand over the past 11 years. In September 2008 he appeared on TV3 on the *Inside New Zealand* documentary and in April 2008 featured on the prime time Australian television programme *Enough Rope,* hosted by Andrew Denton, that broadcast to over 1 million people about the experience of hearing voices, recovery and mental illness.
\
Yours faithfully,

Arana Pearson BA (Chair of NZ National Hearing Voices Network)
Tangata arahi ki te ao marama

Outline of the day

The Hearing Voices that are distressing – a simulated training experience is a workshop that includes both didactic presentation and experiential learning through a simulation of hearing voices that are distressing. The training event involves three components. During the first session an opening lecture is given. During the next part the simulation takes place. During the simulation, the workshop participants listen to a special audiotape that simulates distressing voices. In addition, they move (in no specific order) through four workstations. These include going out into the community and performing a task, going to "day treatment programme", going to "psychiatric emergency services" for a mental status exam, and taking a test at the "psychological testing centre". The final part concludes the training experience with a facilitated group discussion to reflect upon practice and consider new ways of working.

Learning Objectives

1. For participants to experience the world of a psychiatric disability through a simulated experience of hearing voices that are distressing.
2. Gain a better understanding of the challenges that people with a psychiatric disability face and to increase empathy.
3. To promote community health by being able to understand and relate more effectively with people who experience distressing voices.
4. To suggest innovative ways of addressing programme responses to more effectively address the individual needs of people who experience voices that are distressing.
5. To source and use resources of proven non-medication tools for helping people who experience distressing voices
6. To evaluate personal practice and working environment regarding the treatment of people who experience voices that are distressing.

GENERAL GUIDELINES FOR TALKING
WITH SOMEONE ABOUT THEIR

VOICE HEARING EXPERIENCE

1. Remember that the voice hearing experience is a very personal one. Approach the person with respect for their experience and their right to disclose at their own pace.

2. Sharing the voice hearing experience happens best in the context of a long term, supportive, and trusting relationship. 'Strangers' should not feel they can simply interrogate someone about their voice hearing experience.

3. Don't wait until a person is in acute distress before talking with them about voices. Engage people on the subject when they are feeling well and have consented to share with you.

4. It's important to ask 'when' as well as 'when not' questions. That is, it is as important to know when voices occur as when they rarely or never occur.

5. Do not push people to disclose too quickly. Sometimes voices threaten the person with harm if they disclose too much too soon.

6. Always let the person know that they have the right to say "I don't want to answer that question at this time". Let the person know they can change the subject at any time.

7. Don't play junior analyst! It is important to listen to what people are saying and to inquire as to *their* understanding of what they report. Do not interpret 'symbolism', etc.

8. If you want to talk with someone about their voice hearing experience, make sure you have time and a private place to talk.

9. Make sure you discuss issues of confidentiality with the person prior to actually talking with them about their voice hearing experience. A person should know in advance:

   - Who (if anybody) you will tell about the content of the discussion.

   - What, if any, notes will be put in the file.

   - Under what, if any, circumstances you would be obliged to report danger to self/others as well as what you would do, i.e., hospitalise, call Psychiatric Emergency Team., etc.

QUESTIONS YOU MIGHT WANT TO ASK VOICE HEARERS

1. Are your voices male, female, genderless?
2. Are they familiar voices of people you know?
3. How many voices are there?
4. Do they whisper, mumble, talk loud, varied?
5. Are there voices that are helpful, or that you like, or that give good advice or that like you?
6. Can you tell me some of what the voices say to you?
7. When do the voices come? Do voices come at certain times only, or all the time, or any time?
8. Do you feel like you have some power over the voices? Is there anything you know how to do to make the voices start up to stop?
9. Do the voices seem to have more power over you? All the time or just sometimes?
10. Can you remember when the voices first started?
11. Do any of your voices get upset if you share information with me? If so, is there anything we can do about that?
12. If the voices are commanding: Do you have to obey?
13. Have you ever tried to disagree with what your voices say? What happens?
14. Do you want help in learning to make the distressing voices calm down or go away? Are there voices that you don't want to go away? How might I be helpful?
15. How are your voices affecting you in terms of work, relationships, having fun, meeting your life goals, being able to sleep, etc.?
16. Are you using drugs or alcohol?
17. Do you know where the voices come from? How do you understand them?
18. Have the voices changed at all over time, for instance maybe they have gotten louder or softer, nicer or more mean, etc. Are they inside your head? Do they come from outside? Do you know why they come?

CREATING SAFE ENVIRONMENTS
TO TALK ABOUT VOICES THAT ARE DISTRESSING

1. Introduce people to the literature about hearing voices. Have it available and visible in your service.

2. Bring experienced voice hearers in to talk about their experience and what they do to help themselves.

3. De-stigmatise the experience by talking about historical figures who have heard voices and contributed to our culture. Carl Jung (Swiss psychiatrist and founder of Jungian psychology), George Fox (founder of the Quakers), William Blake (poet), Socrates (Greek philosopher), many religious figures (Jesus, Abraham, St. Francis of Assisi, etc.), Robert Schumann (classical music composer), etc. were voice hearers.

4. Openly 'give permission' for people to talk about their voice hearing experience. Explain that talking about voices will not automatically lead to medication increase/hospitalisation.

5. Explain specifics of when, if ever, you might become concerned and feel you have to report to a supervisor, psychiatric emergency services, etc. For instance you might say, 'this is a place where it is okay to talk about your voice hearing experiences. We want to be here to support you and help you learn to cope. You will not get into trouble if you talk about your voices here. However I want you to know ahead of time that if voices are telling you to kill someone, including yourself, and you are certain you cannot resist that command and you have hurt others/self before when the voices have been this intense then you and I will have to report the situation to my supervisor and figure out what to do to help you keep safe.'

6. Make sure staff, family members and significant others are trained not to over-react out of fear and ignorance when the voice hearing is observed in the person they care about.

7. Get a peer run support group for voice hearers going in your area.

8. Make sure the environment allows for private space in which to talk and promote long term, trusting relationships with specific or "primary" staff counsellors/workers. VALUE RELATIONSHIP.

9. Hire voice hearers to work with voice hearers.

Differences Between People Who Report Being Able To Cope With Voices And Those Who Experience Them As More Distressing

Adapted from Romme M & Escher S, (1993) Accepting Voices Mind Publications, London p.15

Hypothesized Phases of Coping with Voices (from Romme & Escher 1993, p.17)	***Suggestions for Helping Professionals who want to assist and support their clients who hear voices that are distressing.*** (from Romme & Escher 1993, p.26)
Phase One: The Startling Phase Voices usually begin with a sudden onset and are usually experienced as being quite frightening. One person described this as a period marked by 'fear, anxiety and escape'.	1 Accept the patient's experience of the voices. These voices are often felt as more intense and real than sensory perceptions. 2 Try to understand the different languages used by patients to describe and account for their experiences, as well as the language spoken by the voices themselves. There is often a world of symbols and feelings involved; for example, a voice might speak of light and dark when expressing love and aggression.
Phase Two: The Phase of Organisation This is the phase of exploring what/who the voices are and learning some way of coping with them. One person described this phase as being marked by 'investigation of what the voices mean and accepting them an independent entities'.	3 Consider helping the individual to communicate with the voices. This may involve issues of differentiating between good and bad voices and of accepting the patient's own negative emotions. This kind of acceptance may make a crucial contribution to the promotion of self-esteem.
Phase Three: The Stabilisation Phase This is the period in which a more consistent ongoing means of dealing with voices is developed. One person said this phase included 'accepting myself, exploring what it is that I try to escape from, reversing the confrontation with the voices and not trying to escape any more.	4 Encourage the patient to meet other people with similar experiences and to read about hearing voices, in order to help overcome the isolation and taboo.