MENTAL HEALTH NURSING:
“ADDRESSING ACUTE CONCERNS”

REPORT BY THE STANDING NURSING AND MIDWIFERY ADVISORY COMMITTEE

JUNE 1999
The Standing Nursing and Midwifery Advisory Committee (SNMAC) is a Statutory Body which advises Health Ministers in England and Wales on the provision of nursing and midwifery services under the NHS Acts. Members are appointed by Ministers following nominations by professional bodies, and include the Presidents of the Nursing and Midwifery Royal Colleges. Its secretariat is provided by the Department of Health.
CHAIRMAN’S FOREWORD

In bringing this report forward the Standing Nursing and Midwifery Advisory Committee acknowledges the significant contribution made by nurses caring for patients in the acute mental health setting. The practice of nursing in acute mental health care is one of the most challenging responsibilities in the new NHS. However, nurses, users and carers agree that the experience of admission to in-patient wards has become increasingly custodial, with a greater risk of violence and limited therapeutic activity.

The Committee has focused its attention on the acute in-patient setting for the purpose of this report in an attempt to address these increasing concerns. Ministers, members of the public, and the professions have become increasingly aware of the ‘care–deficit’ and, on occasion, the lack of a basic humane response in some of our hospitals. This is not to understate the considerable developments in nursing practice that have occurred over recent years or the continued efforts being made by many practitioners throughout the country. However, there is a sense that, while much attention has been directed at the development of community-based interventions since the implementation of the NHS and Community Care Act 1990, the acute in-patient areas have received less attention.

It is now essential to provide guidance that will support nurses and develop a system that is sensitive and responsive to individual need. The provision of a safe environment for patients and staff is paramount yet the evidence would indicate a signal failure to achieve this with alarming differences in standards and performance. In essence, we suggest that acute mental health nursing should be developed as an area requiring specialist expertise. This will involve codifying the skills that are required by the mental health nurse in an acute setting some of which, such as clinical leadership, risk assessment, the management of medication and integrated care planning, we have begun to identify in this report. It will also involve developing the research base of the profession. This is not to play down the importance of practice that is born of experience, but to reinforce one of the key findings, that little is known about the specific skills of nursing patients through an acute phase of mental illness. Work-based and post-graduate courses as well as a career structure for acute mental health nurses are urgently required to attract and retain expert nurses to the area.

We have taken a view of the whole system surrounding the practice of mental health nursing in acute units and make recommendations that address the framework that needs to be established to ensure safe, sensitive, appropriate care can be delivered.

Finally, the Committee is confident that the report is sufficiently robust in its enquiry methods to give confidence in its ability to assist in meeting the challenge of implementing the new National Service Framework for Mental Health.

Tony Bell OBE
SNMAC Chairman
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EXECUTIVE SUMMARY

1. This report on the role of the mental health nurse in acute care was requested in October 1997 by Paul Boateng, the then Parliamentary Under-Secretary of State for Health. A Sounding Board event in March 1998 informed the work which was overseen by a committee composed of SNMAC members and co-opted experts. The work included commissioning a literature review, studies of nursing observation of patients at risk and the management of aggression and violence, and consultation with users, carers and health care professionals. SNMAC endorsed the report in January 1999.

2. Concern about the standards of care provided in in-patient settings, particularly patients’ safety, dignity and access to therapeutic interventions, stimulated the report. The first section of the report attempts to account for changes in the demands on the clinical skills of acute mental health nurses and the second reviews the policy framework which provides the context for future developments in mental health nursing. The findings of the report are contained in sections on the practice of mental health nursing, safety, cultural differences, education, training and research and on the quality of work life experienced by mental health nurses, outlined below. SNMAC recommends actions that could be taken by the NHS Executive, Chief Nursing Officers, educational institutions, research funding bodies and NHS Trusts and Health Authorities to improve the care of the acutely ill.

3. The focus of mental health policy in recent decades has been de-institutionalisation, the closure of large hospitals, and the development of community care. One of the effects of the dramatic reduction in the number of in-patient beds has been to contribute to the level of acuity in in-patient units. Patients are now much more likely to be severely ill, have a dual diagnosis, and have greater social needs. The complexity of the care that patients require is much greater now than in the past and yet little attention has been given to the clinical skills and resources that nurses in in-patient facilities require in order to provide care at this level.

4. Government policy is outlined, for England, in Modernising Mental Health Service: Safe, Sound and Supportive. The policy acknowledges that services have sometimes failed users in the past and sets out a programme of radical reform to ensure the safety of patients and public. Significant financial investment in mental health will provide additional beds, outreach services, crisis teams and more and better trained staff. The policy in Wales is broadly similar and is based on the principles outlined in Mental Illness Services—A Strategy for Wales.

5. The deficit of clinical leadership in in-patient settings is one of the root causes of the failure to provide therapeutic care for the acutely mentally ill. In recent years the focus of education, training, status and career opportunities have all shifted from acute in-patient mental health to the community and specialist services. Acute in-patient care is not seen as an area attracting specialist expertise despite the increasing complexity of care that in-patients typically require.
6. The SNMAC sub-committee found that there are a number of areas where the skills of acute mental health nurses need to be improved through research, training, and the development of evidence based policies and guidelines. These include:

i. Formal methods of assessment for measuring symptoms, social functioning needs, risks and the side-effects of medication.
ii. Methods for involving users and carers in planning their own care, as well as planning, delivering and evaluating mental health services.
iii. Care planning that provides a framework for practice and that facilitates communication among disciplines and across care settings.
iv. The management of aggressive and violent behaviour and the observation of patients at risk.
v. Evidence-based cognitive, behavioural and family interventions.
vi. The management of medication, including detection and alleviation of side-effects.

7. Patients in acute mental health settings are at risk of self-harm, suicide, physical attack and sexual abuse. Patient safety could be increased by:

i. Training nurses in risk assessment and risk management.
ii. Ensuring that the approach to risk is multi-disciplinary and co-ordinated across care settings.
iii. Standardising the nursing practices of observation and control and restraint, and examining staff and patient attitudes to these practices.
iv. Giving special attention to the needs of patients, such as adolescents and women, who may be particularly vulnerable to attacks or abuse.
v. Removing environmental dangers in the design and construction of in-patient units.
vi. Ensuring that there are enough trained, permanent nursing staff to provide each patient with appropriate care.

8. Users and carers from minority groups are dissatisfied with access to services, services provided, and the lack of involvement of minorities in the planning, delivery and evaluation of care. Educational programmes are widely seen as having failed to take account of cultural diversity and staff in in-patient units vary in their awareness of and sensitivity to cultural differences. Ethnic minority staff, who are over represented in mental health, report some experience of discrimination which might prevent, particularly black nurses, attaining leadership positions.

9. The current situation in acute in-patient units seems destined to deteriorate. The poor quality of work life contributes to the problems of recruiting and retaining highly qualified and motivated mental health nurses. Clinical leadership needs development.

10. SNMAC recommends investing in acute mental health nursing to enable educational opportunities and develop a career structure. The poor research base of mental health nursing must be improved to make possible the development of evidence-base guidelines and policies. Research on the components of a therapeutic culture and the skills of the acute mental health nurse should be given priority. Education consortia need to ensure a balance of university-based and work-based courses for all grades of nursing staff in the specific skills that are required to care for patients in the acute phase of illness.

The responsibilities of the Trust and Health Authority with regards to planning, provision, and auditing of care are emphasised in a series of recommendations.
and they are specifically encouraged to review ward staffing levels, skill mix, training and clinical leadership to ensure that staff have the resources they require to provide high quality care.
1. INTRODUCTION

1.1 In October 1997 the Standing Nursing, Midwifery Advisory Committee (SNMAC) was asked by Paul Boateng, the then Parliamentary Under-Secretary of State for Health, to study the developing role of the mental health nurse and the contribution of nurses to the provision of modern mental health acute care. A mental health sub-group of SNMAC was appointed to fulfil the remit to study:

“...the developing role of the mental health nurse and the contribution of nurses to the provision of modern mental health acute care. The Committee will advise on practice, leadership, organisational and educational issues that need to be addressed in the context of the White Paper "The new NHS".”

1.2 The sub-committee agreed with SNMAC that the primary focus of the study would be to enhance standards of nursing care, emphasising nursing interventions to support patients through an acute phase of illness, prevent admission, and enable speedier discharge. Two aspects of nursing care identified as needing more detailed work within the study were the observation of patients at risk, and the management of aggression and violence. Practice guidance on Observation of Patients at Risk and Assertive Community Treatment has been produced as an adjunct to this report.

1.3 The remit was based on the findings of a prior study, also commissioned by SNMAC, which reviewed the literature on acute in-patient care, described services currently provided for acute in-patients, and indicated areas for future policy and professional initiatives. Six areas were identified as requiring urgent attention: admission and bed issues, patient safety (including suicide, self harm, patient observation and supervision), violence and staff safety, ethnicity, clinical interventions and human resource management. These issues helped to structure the design of the present study.

2. THE IMPACT OF CHANGES IN THE ORGANISATION OF SERVICES ON THE ROLE OF THE MENTAL HEALTH NURSE

2.1 The role of the mental health nurse has changed radically in recent years. In 1968, when the first review of mental health nursing entitled Psychiatric Nursing Today and Tomorrow was published there were approximately 130,000 in-patients mostly housed in old Victorian asylums. By 1994, the second review of mental health nursing, Working in Partnership there were only 25,000 in-patient beds and numbers have continued to decline.

2.2 The process of de-institutionalisation has led to changes in both the in-patient population and the settings in which care takes place. In-patient care now largely takes place in the wards of district general hospital psychiatric units, although some wards remain in Victorian mental hospitals. Hospital admissions are of much shorter duration than they were, and many patients who used to be treated in hospital are now treated in the community, leading to higher levels of acuity in the hospital in-patient population.

2.3 The in-patient population is now largely composed of people with serious and enduring mental illness, such as schizophrenia and mood disorder. A great deal of evidence suggests in-patients have greater levels of disadvantage, social exclusion, homelessness, and a much wider and more complex set of needs than they did in the past. For example, the number of patients who have problems...
both with substance abuse and/or dependence and a mental illness has risen steeply. Patients with a dual diagnosis place great demands on the clinical skills of nurses, who are often not trained to provide the complexity of care that they require.

2.4 Recent research suggests that the number of in-patient beds is inadequate to meet current needs in some areas, particularly Inner London. A one day census showed that occupancy rates can rise to 120% and have reached 180% in extreme cases\textsuperscript{6}, although in some parts of England and Wales, occupancy rates come closer to the optimum level of 85-90%.

2.5 Not all patients who are accommodated in acute units need to be there. Many could be treated in alternative residential or community care settings if appropriate alternatives were available\textsuperscript{7,8}. For example, patients who no longer need acute care sometimes remain on acute wards for unacceptably long periods of time.\textsuperscript{9} This is detrimental to the individual’s rehabilitation and compounds the problem of the shortage of beds for the more acutely ill patients. Although the NHS Executive backs the policy of a range of residential provisions, including, for example, 24 hour staffed accommodation in community settings\textsuperscript{10}, alternative accommodation for in-patients has been slow to develop.

2.6 Several reports have expressed disquiet about the environment in acute psychiatric facilities\textsuperscript{4,5}. Working in Partnership\textsuperscript{3} recommended that there be an urgent review of the therapeutic suitability of district general hospital mental health units. Meanwhile, there is concern that patients often do not have privacy, nor are they guaranteed the therapeutic and recreational facilities that are a necessary part of good care. There is clear evidence\textsuperscript{4} that women are particularly disadvantaged with regard to both privacy and safety.

In summary, the process of de-institutionalisation has had a dramatic effect on the in-patient population. Patients in a chronic but stable phase of their illness are now cared for in community settings, rather than long-stay wards. Hospital admissions are shorter than they were traditionally, and many modern patients have a dual diagnosis of drug or alcohol addiction as well as a mental illness\textsuperscript{11}. The average patient in hospital is now more acutely ill, more likely to have more than one diagnosis, and to have greater need for social support than ever before. In turn, nurses require higher levels of clinical skill to meet the challenge of the increasingly complex problems and needs presented by patients requiring in-patient care.
3. THE POLICY FRAMEWORK AND ITS IMPACT ON THE ROLE OF THE MENTAL HEALTH NURSE

3.1 In Modernising Mental Health Services: Safe, Sound and Supportive¹² the government sets out its strategy for mental health services in England for the new millennium (the policy framework for Wales is set out in Appendix 4.). Mental illness is associated with increased risk of suicide, involvement in violence, stigma and social exclusion, and this document acknowledges that mental health services have sometimes failed users in the past. The services will be radically reformed to ensure the safety of patients and public, that the full range of services are available when they are needed, and that patients, service users, families and carers are involved with service providers to build healthier communities.

3.2 The following areas are identified in the white paper as requiring attention:

- the assessment of individual needs
- the quality of treatment and care at home and in hospital
- access to services - should be on a 24 hour basis
- patients, service users and carers need to be involved in their own care and in planning services
- public safety requires more effective risk management and the improvement of secure hospital services
- Primary Health Care Groups must work with specialist teams to integrate service planning and development
- information systems need to be designed to support services and to improve the management of resources
- Social services, education, employment and housing need to be working in partnership with mental health services
- guidance from the National Institute for Clinical Excellence will ensure the efficiency and cost effectiveness of services
- National Service Frameworks will determine service models and national standards.

3.3 The government will invest £700million over 3 years in the reform of mental health services. Funds will be allocated to provide:

- extra beds of all kinds
- better outreach services
- access to new types of anti-psychotic drugs
- 24 hour crisis teams
- more and better trained staff
- regional commissioning teams for secure services
- development teams

3.4 Agencies including the Social Services Inspectorate, the Audit Commission and the new Commission for Health Improvement will monitor the progress of the reforms, using, among other tools, the new performance assessment frameworks for health and social care.

In summary, these policy changes, which promise financial investment in a range of service improvements, provide the context in which the role of the mental health nurse in acute settings will develop over the next few years. Nurses have a clear role to play in
ensuring that services are safe, sound and supportive, but action needs to be taken in the short, medium and long term to improve nurses’ education and training, the quality of their work life, and the research base of the profession, if they are going to be able to contribute fully to the vision of a modern, decent and inclusive society.

4. THE APPROACH TO THE STUDY

4.1 SNMAC set up a sub-group of members and co-opted nine nurses with expertise in education, management, commissioning, research and practice, to oversee the development of the study. A full list of SNMAC members and the membership of the mental health sub-group is given in Appendix 5. The findings reported in Section 5 below are the product of one year’s work which included reviewing the research literature, examining policies, consulting with users, carers and professionals, conducting research, and engaging in discussion with SNMAC colleagues and members of the mental health sub-group.

4.2 A sounding board event, organised at the beginning of the study, was designed to ensure that major stakeholders had a chance to contribute to the design of the study and the interpretation of findings. Participants included users and carers as well as members of a wide range of professional groups who could articulate the perspectives of practice, education, research, commissioning and policy. Full details of this event are given in Appendix 3.

4.3 The sub-group commissioned a study of hospital policies with regard to the observation of patients at risk\(^{13}\) and an audit of 29 cases\(^{14}\) where patients had committed suicide or come to serious self harm in in-patient settings was also conducted. (See Appendix 1 for the results of the study of observation).

4.4 The literature review and policy analysis conducted for the study which preceded the formal remit were updated. Two studies were found to be particularly relevant: a national study of control and restraint\(^{15}\), summarised in Appendix 2, and a study of nursing in an inner city in-patient mental health service.\(^{6}\)

4.5 Professor Kevin Gournay, project consultant, gathered information about models of education and training.
THE FINDINGS OF THE STUDY

THE PRACTICE OF MENTAL HEALTH NURSING

5.1.1 Users, carers and professionals agree that in-patient units are becoming increasingly custodial in their atmosphere. Our work suggests that users in acute care often feel that they are being deprived of therapeutic activity, have much less contact with nurses than they would wish, and at times feel unsafe. This is undoubtedly due to changes in the patient population, staff shortages, and the lack of other professionals to support nurses. We also found a number of areas where the reality of nursing practice does not approach the ideal.

5.1.2 Formal methods of assessment are rarely used by nurses. There are a number of very simple and reliable ways of measuring symptoms, social functioning, need, risk and medication side effects, which can be used by registered nurses with little additional training as part of a single multidisciplinary assessment process. A number of needs assessment tools which integrate the user (and carer) perspective have been developed.16

5.1.3 There are also well developed methods for involving users in the definition of preferred options for care and treatment.17 Schemes like the Crisis Card involve users in planning treatment options for the future and record, for example, what actions they would like to be taken in the case of relapse. In fact, users and carers are rarely provided with any information about the nature of their illness and treatment. We found little evidence of user involvement in planning their own care, let alone planning, delivering and evaluating mental health services. Further, users have no real role in designing and implementing professional education and training. The potential for partnership between mental health nurses and users has not yet been exploited.

5.1.4 The process of planning care is fragmented both among professions and across settings. In hospital, treatment and care plans are usually developed on a unidisciplinary basis. Patients may have several care and treatment plans variously written by medical staff, nurses and other professionals, which are not shared or owned by the multi-disciplinary team.4 Care plans which are instigated at admission often cease at discharge rather than following the patient to another setting. When vital information about the patient's care and treatment is not passed from one setting to another, the results can be tragic as a number of independent enquiries have pointed out.18,19

5.1.5 The Care Programme Approach (CPA) in England is central to effective mental health nursing care. The essential elements of CPA are regular assessments, the involvement of users – and, where appropriate, carers - in care planning, and a key worker to co-ordinate care planning and implementation. Care plans which are comprehensive, multi-disciplinary, dynamic and subject to regular review provide a framework for practice and facilitate communication. The CPA facilitates the identification of the most needy users of mental health services, however, this approach has been adopted slowly and is not yet used in all settings.

5.1.6 There is considerable concern about the frequency of aggressive behaviour and violent incidents in-patient settings. Research conducted in the course of this study showed that nursing staff are not always trained properly in the management of aggression. When training occurs, recipients are often ignorant of trainers’
background, such as who trained them and who employs them, leading to problems of accountability. The term “control and restraint” has no standardised meaning, and the content, standards and duration of training varies greatly. There is no assurance that present training in control and restraint techniques covers adequately the theoretical, preventative and defensive aspects of care nor that it lays enough emphasis on the nurses’ responsibility for the safety and dignity of patients. Consequently, staff may lack confidence in their ability to use control and restraint techniques, which increases the risk of injury to both patients and staff. Post-incident debriefing, which should happen in all cases, is estimated to occur in about 75% of cases.

5.1.7 Despite the fact that there are now a range of evidence based cognitive, behavioural and family interventions, which could be a component of in-patient care, these are rarely used by nurses. Apart from a few exemplary programmes, no training in evidence based interventions is available to the majority of nurses working in in-patient settings.

5.1.8 Nurses’ skill in the management of medication has recently been questioned, and some evidence suggests that nurses are neither able to detect side effects nor to offer evidence based interventions which would enhance patients’ adherence to their treatment. At the same time, we know that relatively simple training programmes can improve nurses skills and knowledge. Nurses with minimal specialist training in this area may promote patients adherence to treatment and ability to cope with side-effects, thus improving their quality of life and decreasing the risks of relapse and readmission. We suspect that nurses could play a much greater role in ensuring that medication which has been shown to be efficacious in randomised controlled trials, is made to be effective when administered to patients under normal conditions.

5.1.9 Clinical leadership in in-patient settings requires development. These areas generally lack the presence of sufficient experienced senior nurses with expertise in assessment and clinical interventions who would provide supervision and leadership. Part of the problem stems from the fact that the focus of education, training, status attainment and career opportunities have all shifted from acute in-patient mental health to the community and specialist services. Investment in clinical leadership for in-patient areas would acknowledge the increasing complexity of care required for this client group and permit the development of a specific model of clinical supervision.

5.1.10 One of the ways that pressure on in-patient units could be relieved is by developing alternatives to admission. Up to 45% of admissions could be prevented if suitable community alternatives were in place to provide a response to crises. Research shows that assertive community treatment (ACT) which is a team based approach to providing a comprehensive range of medical, social and psychological interventions for people with serious and enduring mental illness (SEMI), can be effective in preventing admission to hospital. The Thorn Programme trains nurses in a range of clinical skills, such as the assessment of mental state, cognitive behaviour therapy, family interventions, and medication management that can be part of ACT.

5.1.11 Many admissions to in-patient facilities come via Accident and Emergency Departments. A recent audit by the London Ambulance Service showed that tens of thousands of people who suffer solely from mental distress are conveyed to hospital as a result of 999 calls. In addition, many patients who have attempted self harm are taken to A&E. A number of schemes that aim to improve patient care by having a mental health nurse on call in A&E have been piloted around the country.
With training, mental health nurses can assess patients, intervene (e.g. provide anxiety management), liaise with other agencies and services, such as the criminal justice system, and support and educate staff in the special needs of a range of patient groups. Before a liaison mental health nurse is provided they need to have had appropriate training, the support of a multi-disciplinary team must be available, and roles, responsibilities and lines of communication both within the hospital and between the hospital and related agencies, need to be defined. In addition, plans for auditing and evaluating the service should be laid down before the service is provided. Working in Partnership recommended that research into the potential of liaison mental health nursing be conducted, and it seems appropriate that this should be explored in the context of finding alternatives to admission to in-patient units.

In summary, users, carers and professionals agree that in-patient units are becoming increasingly custodial in their atmosphere. Mental health nurses, perhaps as a result of the shift in focus and resources from hospital to community, either do not have, or are prevented from using, for example by lack of staff, professional skills in assessment, planning and implementing care. “Working in Partnership” emphasised the potential for collaboration between mental health nurses and the users of service. This report stimulated some action, but user participation in the planning, delivery and evaluation of mental health care is still in its infancy. In acute care, one of the most fundamental problems is that users do not feel involved in the planning of their own care. Care is fragmented with each discipline and service formulating its own plans and keeping its own records. This means that the potential for failures in communication between the hospital and community is always present.

Recommendations for action:

NHS Trusts and Health Authorities must:
- Implement formal methods of patient assessment in the context of the care programme approach.
- Ensure that mental health users and carers are involved in planning and evaluating their care.
- Exploit the potential for liaison nurses in A&E.

NHS Trusts and Health Authorities can:
- Ensure effective ward clinical leadership that addresses problems in nursing practice, in particular medication management.
- Promote opportunities for nurse consultants with specialist skills nursing acute in-patients.

Educational institutions to:
- Develop post registration and post-graduate courses in the nursing of mentally ill patients in the acute phase of illness.

The Chief Nursing Officers to:
- Promote the recognition of acute mental health nursing as an area requiring specialist expertise to be set in a career structure that will attract and retain expert nurses in the clinical setting.

- Develop a clinical leadership programme for mental health nurses

5.2 THE SAFETY OF PATIENTS AND STAFF IN HOSPITAL
5.2.1 The Confidential Enquiry into Homicides and Suicides by people with mental illness suggests that up to 4% of the nation’s suicides are committed by in-patients in psychiatric hospitals. Patients are also at risk of physical harm from other patients, including sexual abuse. We have identified a number of shortcomings which may be related to the number of patients who come to harm in hospital, either by their own hand, or as a result of attacks or abuse by other patients or staff.

5.2.2 Although there has been considerable development in the field, structured and systematic assessment of risk is rarely used by nurses in routine clinical practice. Where risk assessments are carried out by nurses, psychiatrists, or other agencies such as probation and social work, they are recorded in the notes of the relevant discipline or service and may not be communicated to all staff involved in caring for the patient. We found that risk management, which should logically follow from risk assessment, is poorly defined and practice is highly variable. Training in risk assessment and management does take place in some areas, and varies greatly in quality across the United Kingdom. Established methods of risk assessment were disseminated by the University of Manchester and the Department of Health in their joint publication Learning Materials on Mental Health (Risk Assessment).

5.2.3 Research on the nursing practice of observing patients who are at risk from self harm, or of causing harm to others, shows that there is no consistency in the definition of terms, principles or processes. In some trusts there is no written policy for observation. Trusts vary greatly in the indications for observation and in the personnel that are thought appropriate to perform. Where policies and procedures do meet a reasonable standard, they may not be implemented properly. Detailed results of the study are given in Appendix 1.

5.2.4 Unfortunately, users often perceive observation as a custodial and aversive procedure and complain that when they are under an increased level of observation they are often deprived of access to therapy or meaningful occupation. Nurses may reinforce these views of observation because they often share the same negative attitudes, and because they do not have skills and confidence to engage with the patient or clear guidelines as to the kind of nursing care that a person under observation should receive.

5.2.5 Although some of the incidents of suicide or serious self harm might not occur if nursing skills in assessment and observation were improved, the job of the nurse is often made more difficult by the architecture of in-patient units. Some serious incidents might be avoided if environmental dangers in in-patient wards were corrected. These include design faults, which prevent nurses from observing patients properly, or windows, particularly in upper floor wards, that are unsuitably glazed.

5.2.6 There is widespread concern that some users, particularly women or young people, are vulnerable to violence, intimidation or sexual assault. Women are often nursed in unsuitable environments, where they may be vulnerable to threats of assault or abuse, or do not have the privacy they require. Many traditional wards do not have women-only quiet areas where they can get away from threatening or aggressive patients, who are mainly male. While most wards now have single-sex sleeping and washing areas, in reality it is often difficult to separate these from mixed sex areas so that male patient may pass through or be adjacent to areas set aside for female patients. Women may not always have the choice of a female key worker. Patients under the age of 18, who are often nursed in acute units, would be more appropriately cared for in child and adolescent mental health
services with specialist staff. The needs of young patients differ from those of adults and they are often particularly vulnerable to exploitation. When adolescents are present in an adult facility this adds to the complexity of care required and increases the demands on the nursing staff.

5.2.7 There are now more than 50 psychiatric intensive care units (PICUs) in England and Wales. Their main aim is to provide a very high standard of care to patients in the acute phase of their illness. However, it appears that there are considerable differences across units in terms of their organisation and purpose. For example, the practice of seclusion, where patients are separated from other patients and placed in a quiet environment, is used in some Trusts but not in others. There is a clear need to evaluate the impact of different ways of organising and different interventions on the outcome of patients illnesses so that optimum standards of practice and training can be based on research evidence.

5.2.8 Assaults on staff and patients in mental health in-patient units are unacceptably high. As we mentioned in the background chapter, the patient population of in-patient units is now more acutely ill, and present with more complex mental health problems than they did previously. Violent or disturbed behaviour is a manifestation of acute mental illnesses which impair reality testing, judgement and impulse control. The tendency to violence can be exacerbated by the use of illicit drugs and alcohol. The increasing number of assaults in in-patient units is therefore one of the consequences of the change in the composition of the patient population. A number of other factors, such as poor staffing levels and an over reliance on bank and agency staff, inadequate education and training of staff, and the increasingly custodial nature of the care provided in mental health units, also contribute to the high levels of violence.

5.2.9 There is widespread acknowledgement that patients and staff often suffer injury during the implementation of control and restraint procedures. We therefore surveyed the kind of control and restraint training available in England and Wales and found that the techniques taught vary greatly. There also appears to be a great variation in the qualifications of trainers and standards of training. This may account for the finding that there is a high incidence of nurses being injured in the course of training in control and restraint procedures. Full details of the survey of control and restraint procedures are given in Appendix 2.

5.2.10 Some services report an increasing reliance on police assistance in dealing with violence incidents. This has led to concern about the way that incidents are handled, particularly about the use of CS gas.

5.2.11 We found that nurses are often unclear about legal issues apart from those that relate to the Mental Health Act. For example, nurses seem unclear regarding their right to search patients; to prosecute patients for assault, and other matters.
In summary, there are major concerns about the safety of patients in acute units. Basic mental health nursing skills in risk assessment and management, particularly the observation of patients at risk, are not standardised procedures, are variably taught and implemented, and are perceived negatively by patients, and in some cases by staff. Staff safety is another important concern. There are no agreed standards or validation for the education and training in the management of violence and aggression, neither is there any consistency in hospital policies.

Recommendations for action:

**NHS Trusts and Health Authorities must:**
- Ensure that staff are trained in risk assessment and management.
- Implement and audit policies on safe and supportive observation.
- Audit and correct environmental dangers.

**NHS Trusts and Health Authorities can:**
- Audit and review the management of violence and aggression including the practice of seclusion and use of control and restraint.

**NHS Executive:**
- Professional and statutory bodies and the National Institute for Clinical Excellence (NICE) to develop multi-disciplinary evidence-based guidelines on observation, seclusion and the management of aggression and violence.

**CULTURAL DIFFERENCES: RACE, ETHNICITY AND RELIGION**

5.3.1 Issues and concerns relating to cultural diversity have emerged from all aspects of our work. Although minority ethnic groups comprise a small proportion of the total population of the United Kingdom, some groups are over represented in in-patient units, whereas other groups seem not to use NHS mental health services. In addition, because ethnic populations are concentrated in specific locations, in some units the majority of patients will be from a minority population. For example, a recent study showed that in Inner London only 45% of the in-patient population was white and in other inner city areas the situation is similar though less extreme.

5.3.2 Users and carers from minority ethnic groups are dissatisfied with access to services, services provided, and the lack of involvement of minorities in the planning, delivery and evaluation of care.

5.3.3 Staff in in-patient mental health services vary in their awareness of, and sensitivity, to racial and cultural differences. While there is evidence that some monitoring of issues connected with cultural differences does take place, many believe that when issues of concern become apparent, remedial action is often inadequate.

5.3.4 Educational programmes are perceived as having failed to take into account the racial and cultural diversity of our society. *Working in Partnership* recommended that education and training programmes should reflect the way that diversity of belief systems and cultural expectations contribute to the life experience of people who use services. This has not happened in all cases. Members of minority ethnic and racial groups are often not involved in the planning, teaching and evaluation of educational programmes.
5.3.5 *The Labour Force Survey of 1988-1990*\(^{36}\) found that the proportion of nurses from some ethnic groups is higher than their proportion in the population. West Indians, Chinese and Africans are over-represented while all South Asian groups, including people of Indian, Pakistani and Bangladeshi origin are all under-represented in the nursing profession. A report on *Nursing in a Multi-ethnic NHS* published in 1995 found that ethnic minority nursing staff are more likely to be working in specialties such as mental illness and learning disabilities, which they identify as having lower prestige than some other specialties.\(^{37}\) Statistical analyses in this report suggest that certain ethnic minorities, particularly black nurses, are at a disadvantage in terms of promotion opportunities in the NHS. Qualitative responses to the study questionnaire supported the conclusion that racial harassment from patients and other staff is a regular feature of the working lives of nurses from ethnic backgrounds. If nurses from ethnic backgrounds experience discrimination which prevents them from achieving their career goals this is destructive to the individuals concerned and is detrimental to the development of the nursing profession which loses the benefit of their experience and expertise. The fact that there may be fewer nurses from ethnic backgrounds in leadership positions means that the aspirations of new recruits may be diminished and they may fail to find appropriate role models.

**Recommendations for action:**

**NHS Trusts and Health Authorities must:**

- Involve members of minority and ethnic users and carers in planning, teaching and evaluating training programmes.
- Collect and analyse data on nurses’ characteristics, including ethnic background and grade to assess the extent of local discrimination.
- Implement the NHS Executive programme of action for minority staff which has goals for recruitment, selection, and development of minority staff, and for ensuring that NHS workplaces are free from racial harassment and discrimination.

**EDUCATION, TRAINING AND RESEARCH**

5.4.1 The main implication to be drawn from the findings of this study to this point is that more and better training in the skills of mental health nursing need to be provided for staff currently working, or preparing to work, in acute mental health settings. Training in essential skills is either not available or access is severely limited. For example, despite the complexity of problems presented by patients with a dual diagnosis, there is only one comprehensive training programme in the UK which provides staff with relevant skills.\(^{58}\) Most importantly, training in the skills of risk assessment and management, observation, prevention of violence, de-escalation techniques, and control and restraint, which have the potential to save lives and prevent injury to patients and staff, varies greatly across the UK. We found that basic nursing skills, such as patient assessment and care planning, communicating and integrating care with other professionals, and dealing with medication were lacking and should be the target of increased attention from education and training consortia as well as educationalists. Current trends in health policy demand that mental health nurses increase their skills in evidence-based health care and in patient involvement and evaluation. Skills in these areas are based in science and social science and require that nurses have proper academic preparation and supervision of practice.
5.4.2 The policy of involving users and carers, including representatives of minority groups, in all parts of the educational process, including the planning of programmes, teaching and delivery, and in processes of monitoring and evaluation has not yet been implemented.

5.4.3 Education and training initiatives are compromised by poor and often distant relationship between the Universities and Trusts. Staff working in service settings complain that the education and training offered by Universities is often irrelevant to contemporary services. Despite the recommendation of Working in Partnership, Lecturer / Practitioner models have not been fully developed and teaching staff often still lack robust recent clinical experience. It is important that efforts to improve the educational preparation of nurses in acute mental health should not focus exclusively on higher education. Many of the skills required need to be taught in the unit and more work-based training for all staff at all levels is urgently required.

5.4.4 There have been some welcome changes in the education of community mental health nurses. The Thorn programme (University of Manchester) is one example which accepts students from disciplines other than nursing. This move towards multi-disciplinary education is in accord with the central recommendation of the recent review of training commissioned by the Sainsbury Centre for Mental Health. Taken together the Thorn Initiative and the Masters Programmes in mental health offered at Sheffield, Manchester, Birmingham and Middlesex have produced approximately 400 graduates to date most of whom are nurses. However, this figure needs to be considered in light of the fact that there are about 8,000 community mental health nurses in England and Wales. It is clear that if assertive community treatment skills are to be made available to all those who need them, training initiatives need to be much more widespread. Some areas, such as the Midlands, have access to several training programmes, whereas Wales and some regions of England have no programmes at all.

5.4.5 While some research supports training in ACT and the Thorn Initiative, there is a paucity of research on the effect of training on nursing practice and the extent to which knowledge and skills “decay” after graduation. Some evidence suggests that skills may not be used after training. Most importantly, there is very little evidence on whether the education and training of nurses has an impact on patient outcomes. It is important to state again that there is no training currently available to nurses on in-patient units that would be the equivalent to the Thorn Initiative.

In summary, we have identified a number of specific gaps in the knowledge, skills and attitudes of mental health nurses that are not being met by current educational provisions. We believe that there is an urgent need to establish the specific role and functions of acute mental health nurses and to develop this as an area of specialisation that will attract and retain highly qualified nurses. Although there are some good examples of post-graduate training for nurses, these are not widely available, and are not specifically designed with the needs of in-patient mental health nurses in mind. Not only are there no courses aimed at this group, there are few conferences when compared with those for community staff, CPNs, forensic nurses and nurse therapists. There are few opportunities for education and training in workplace settings, and staff are dissatisfied with the often distant relationship between the university education providers and the service setting. Finally, the ideal of involving users and carers in the planning, teaching and delivery of professional education has not been realised.

Recommendations for action:
Educational institutions, educational commissioners and service providers must work in partnership to:

- Develop post-registration and post-graduate courses in the nursing of mentally ill patients in the acute phase of illness.
- Develop courses on formal assessment, in the context of the care programme approach, risk assessment and management, involving users and carers in care planning.
- Develop courses on evidence based interventions, including medication management, management of psychiatric emergencies, observation of patients at risk, management of violent behaviour, and cognitive and behavioural interventions such as social skills training, activity scheduling, and coping strategy enhancement.
- Provide work-based courses for all grades, as well as extending opportunities in higher education.
- Plan and monitor effective programmes of education through MH specific commissioning groups within education and training consortia.

Research

In the course of the work we identified areas in which further research is needed.

NHS Research and Development organisations should:

- Allocate resources for a programme of research to improve the evidence base of nursing interventions. Studies to include:
  - the components of a therapeutic culture in acute units
  - the effectiveness of nurses in liaison roles (such as accident and emergency).

5.5 THE QUALITY OF WORK LIFE FOR MENTAL HEALTH NURSES

5.5.1 The nursing profession as a whole has problems in recruiting and retaining staff which are reflected in the staff shortages in mental health. Problems can be masked by the fact that Trusts can meet their legal requirements by using bank and agency staff. We found, for example, that in Inner London, at night, one third of acute in-patient mental health wards were staffed entirely by bank and agency staff. This situation would be unacceptable in any specialty, but is especially problematic in mental health, where nursing care depends primarily on relationships. Unless trends in recruitment and retention to mental health nursing are reversed the patients’ experience of care in acute units seems destined to become even more anomic, less personal and more custodial.

5.5.2 Mental health nursing is, by its very nature, a demanding occupation. A great deal of evidence now supports the conclusion that the levels of stress experienced by nurses working in in-patient settings are unacceptably high. Ultimately, this is due to trying to meet the demands of the job with inadequate resources. At the individual level this can lead to feelings of emotional exhaustion (burnout), depression, injury, and increased susceptibility to physical illness. At the level of the unit, high stress compounds the problem of staff shortages by increasing the rates of sickness and absence. Low staff morale also mitigates against the development of an innovative and therapeutic unit culture.

5.5.3 Although the ideals of multidisciplinary team work permeate all aspects of health care, the reality is that the workforce in in-patient units in many areas is comprised of nurses with support from medical staff. Considerable concern has been
expressed from all quarters regarding the low level of input from clinical psychologists, occupational therapists, pharmacists, and other health professionals who would contribute to a much richer pattern of care. In-patient units that provide appropriate stimulation and structure as part of patients’ individualised care have a more therapeutic atmosphere than wards that lack such facilities. Clinical psychologists, as mentioned above, contribute to patient treatment and care but in addition can provide valuable support for nursing staff.

5.5.4 In addition to the shortage of trained professional staff, there are concerns about the lack of administrative support and about the use of health care assistants. When the burden of administrative tasks fall to nurses, this takes time that could be spent more therapeutically with patients, and is a waste of a scarce resource.

In summary, the picture of mental health nursing in acute settings is often a demoralised group, with ineffective clinical leadership, inadequately prepared in terms of education and training, with patently inadequate support from other professional groups and administrative staff. Left unchecked the current situation would seem destined to deteriorate as problems of recruitment and retention will inevitably lead to further staff shortages. Lack of staff increases the risk of injury or harm to patients and staff, and to an inability to replace custodial care with active therapy and rehabilitation.

Recommendations for action:

NHS Trusts and Health Authorities must:
- Ensure that therapeutic care is delivered in acute in-patient units by improving the skills base of health care professionals and by promoting multi-disciplinary team work.
- Audit staffing levels, review skill mix, administrative support and training of staff on acute units.
- Ensure unqualified staff receive appropriate induction training that covers aspects of safe, supportive and humane care, as well as information about the Mental Health Act.

6. SUMMARY AND CONCLUSIONS

6.1 The shift in emphasis from hospital to community has led to a number of changes in the population of in-patient units. Today, service users tend to be more acutely ill and have more complex psychiatric and social needs than they did in the past. Yet, mental health nurses are not receiving appropriate leadership or adequate training to cope with these increased demands, nor are they given sufficient resources in terms of staff, including support from other professional groups, such as doctors, clinical psychologists, occupational therapists and administrative personnel to develop the therapeutic aspects of in-patient care.

6.2 The safety of patients in hospital is a source of grave concern. Elements of basic nursing care, such as risk assessment, empathic therapeutic relationships, observation and control and restraint are not standardised or seen as essential components of clinical practice. Women are especially vulnerable to violence and sexual abuse in hospital. Many in-patient facilities do not afford women and other vulnerable groups, such as young people, sufficient protection from harm. Privacy and dignity are also scarce resources in in-patient units. The lack of sensitivity to
cultural differences, shown by individual staff and in the organisation of services, has a profound effect on the experiences of minority group members.

6.3 Mental health nursing has not yet come to grips with two important elements of current health policy—evidence-based health care and the involvement of users and carers in the planning, development and evaluation of services. Implementing both of these policies demands that nurses have the appropriate academic preparation, clinical supervision, and continuous professional development opportunities. Although there are some exemplary courses in advanced skills in mental health nursing in the UK, these are not aimed at nurses in acute settings nor are they available to the majority of the profession.
7. RECOMMENDATIONS

Our study revealed that mental health nursing needs to respond to the challenge of providing therapeutically safe and supportive care in acute in-patient settings. The Committee therefore recommends to the Health Ministers in England and Wales that action is taken by the NHS Executive, Health Authorities, NHS Trusts and educational providers as follows:

NHS Executive:

• Professional and Statutory Bodies and The National Institute for Clinical Excellence (NICE) to develop multi-disciplinary evidence-based guidelines on observation, seclusion and the management of aggression and violence.

Chief Nursing Officers:

• Promote the recognition of acute mental health nursing as an area requiring specialist expertise to be set in a career structure that will attract and retain expert nurses in the clinical setting.
• Develop a clinical leadership programme for mental health nurses

Educational institutions, educational commissioners and service providers must work in partnership to:

• Develop post-registration and post-graduate courses in the nursing of mentally ill patients in the acute phase of illness.
• Develop courses on formal assessment, in the context of the care programme approach, risk assessment and management, involving users and carers in care planning.
• Develop courses on evidence-based interventions, including medication management, management of psychiatric emergencies, observation of patients at risk, management of violent behaviour, and cognitive and behavioural interventions such as social skills training, activity scheduling, and coping strategy enhancement.
• Provide work-based courses for all grades of staff, as well as extending opportunities in higher education.
• Plan and monitor effective programmes of education through MH specific commissioning groups within education and training consortia.

Research funding bodies, such as the NHS Research and Development Programme to:

• Allocate resources for programmes of research to improve the evidence base of nursing interventions. Studies to include:
  - the components of a therapeutic culture in acute units
  - the effectiveness of nurses in liaison roles (such as accident and emergency).
NHS Trusts and Health Authorities:

The Practice of Mental Health Nursing
- Implement formal methods of patient assessment in the context of the care programme approach.
- Ensure that mental health users and carers are involved in planning and evaluating their care.
- Exploit the potential for liaison nurses in A&E.
- Ensure effective ward clinical leadership that addresses problems in nursing practice, in particular medication management.
- Promote opportunities for nurse consultants with specialist skills nursing acute in-patients.

The Safety of Patients and Staff
- Ensure that staff are adequately trained in risk assessment and management.
- Implement and audit policies on safe and supportive observation.
- Audit and correct environmental dangers.
- Audit and review the management of violence and aggression including the practice of seclusion and use of control and restraint.

Cultural differences: Race, Ethnicity and Religion
- Involve members of minority and ethnic users and carers in planning, teaching and evaluating training programmes.
- Collect and analyse data on nurses’ characteristics, including ethnic background and grade to assess the extent of local discrimination.
- Implement the NHS Executive programme of action for minority staff which has goals for the recruitment, selection and development of minority staff, and for ensuring that NHS workplaces are free from racial harassment and discrimination.

Education, Training and Research
- Ensure that therapeutic care is delivered in acute in-patient units by improving the skills base of health care professionals and by promoting multi-disciplinary team work.
- Audit staffing levels, review skill mix, administrative support and training of staff on acute units.
- Ensure unqualified staff receive appropriate induction training that covers aspects of safe, supportive and humane care, as well as information about the Mental Health Act.
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INTRODUCTION

The enquiry into homicides and suicides by people with a mental illness has revealed that up to 4% of the nation's suicides occur while the patient is in receipt of in-patient care\(^1\). In addition, there are many patients who do not die as a result of self harm, but nevertheless suffer, and in some cases, are left with permanent disabilities. Although UK statistics on self-harm are similar to those found in other international studies\(^30\), the consensus is that many of these incidents are potentially preventable. A recent audit of 29 cases where patients either committed suicide or suffered serious self harm,\(^14\) revealed a number of recurring themes in the care they had received. These included:

- adequate risk assessment not carried out
- lack of a joint medical and nursing plan to deal with obvious risk
- risk identified, but no action taken to increase observation
- observation put into effect, but incorrectly or negligently applied
- patients jumped through windows which were not appropriately glazed or reinforced
- obvious environmental dangers not attended to e.g. door to roof left open, patients allowed free access to scaffolding on side of building

A survey of 12 Inner London Trusts\(^6\) revealed that, while every Trust had a policy for the observation of patients, there was great variation in the content and quality of these documents. While we recognise that the existence of good quality policies and procedures does not always prevent tragic outcomes, (as the audit cited above has shown), we set out to gather information about the policies and procedures that exist in England and Wales, in order to identify some of the commonly agreed principles of good practice in this area. In addition, we sought to increase our understanding of how they are applied in practice. The main limitation of the current study is that we rely on respondents self-report, rather than on an independent test of the implementation of observation policies and procedures.

Study Design

The aim of the study was to collect policies and procedures on observation and questionnaire data from a representative sample of Trusts in England and Wales. To obtain a representative sample of hospitals, we obtained a list of acute Trusts from each Regional Office in England and from the Welsh Office in Cardiff. We then stratified the samples into three groups based on their position on the urban/rural continuum. This method has been used in other epidemiological studies, and has been shown to provide representative cross sections of hospitals\(^44\). We randomly selected three Trusts from each Region of England (8 Regions at the time the study was carried out) and three from Wales based on this stratification. The total sample was therefore composed of 27 Trusts.

The research team developed a draft questionnaire based on previous research and on information gathered from the study of Inner London mental health trusts\(^6\). This was circulated to a group of mental health nurses working in various settings. A refined version of the questionnaire was then piloted in three Trusts, prior to being used in the main study. The Nurse Executive Director (or a deputy) was then contacted and asked to gather information from ward managers and other clinicians responsible with the day to day delivery of in-patient care in order to complete the questionnaire. They were also
asked to send hospital policies and procedures with regard to observation to the study team.

Results
We had responses from 21 of the 27 trusts i.e. a response rate of 78% and the main findings were:

• 3 of the trusts had no written policies on observation.
• 14 of the 21 trusts had no risk assessment policy.
• 46% of trusts keep no central records of observation.
• 37% keep no records of observation at all.
• There was no consistency in the terms used. For example, there were no fewer than 12 different terms used to describe the highest level of observation (for example, constant, continuous, high, level 1, level 3, level 1 maximum, red, special, total).
• The same terms were assigned different meanings in different places, for example, ‘close’ in one trust meant continuous one to one (within eyesight) observation, while in another trust ‘close’ meant intermittent 15 minute checks.
• Trusts vary greatly in the number of levels of observation. For example, one trust had 6 levels of observation, while we found that 5 trusts had only two levels of observation, all defined differently.
• Of the 21 responses we received, we could find no two trusts with the same definition of levels.
• There seems to be a wide variation in the responsibility for prescribing levels of observation.
• There is considerable variation in policy regarding who should or should not be assigned to observe patients. For example, in some Trusts student nurses can be delegated this task, and in some Trusts relatives and carers may be assigned the task of observation. Some trust policies stipulate that observation must be performed by a registered nurse.
• In some Trusts bank and agency staff who are not familiar with the ward or the patient are assigned to this task.

Discussion

These findings suggest that there is little consensus about the principles, practice and procedure of observation across the country. It seems clear that there is a need for further discussion regarding all aspects of this very important procedure, with a view to developing national guidelines for the observation of patients in acute settings.
There is concern about the problem of violence in in-patient settings. Members of the Mental Health Act Commission, our sub-group, and the sounding board conferences have expressed concern about the standards of policies and procedures and implementation of various methods to control aggressive or violent behaviour. The impression is that there is considerable variation in the management of violence and aggression, and that training in the techniques of control and restraint (C&R) varies in standard across the UK. The mental health sub-group has been made aware of a number of incidents where harm has come to staff and patients during the use of control and restraint techniques, including a recent tragic case where a young man died while being restrained in an in-patient setting.

The Institute of Psychiatry Section of Psychiatric Nursing carried out a survey to, first, describe the types of control and restraint training provided in England and Wales, including the variety of techniques taught, and the variety of training providers who offer such courses. Second, we sought to ascertain whether the practice of control and restraint matched trust policies, and to describe the subjective experiences of nurses involved in the application of control and restraint techniques.

Design

The questionnaire was developed by a team at the Institute of Psychiatry Section of Psychiatric Nursing, which comprised a C&R instructor, clinicians and academics, and a Mental Health Act commissioner. A draft questionnaire was reviewed by experts including a Mental Health Adviser at the UKCC, the Mental Health Adviser of the Royal College of Nursing, members of the Mental Health Act Commission, Nursing Officers at the Department of Health, and a selection of staff involved in C & R training across England and Wales. The final version of the questionnaire was mailed to a random sample of staff in all regional secure units and intensive care units in England and Wales. We also collected policy and procedure documents from each participating trust.

Results

Of the 294 responses received to date, 46% were from females and 54% from males. The highest number of responses (n = 104, 37%) were from staff nurses. 80% of the sample had a professional nursing qualification. Only 39% of respondents received C & R training in the first 3 months after starting work on their ward. 13% of respondents waited more than 2 years for training. 41% of respondents did not know to which organisation their instructor belonged. Training varied in duration from 5 - 21 days. The technique most frequently taught was verbal de-escalation, followed by restraint using a 3 person team, and the third most frequently taught technique was for taking the patient to the ground. Our survey revealed that 27% of respondents received an injury while training. Questions about the last incident in which the respondent was involved in C & R showed that in 19% of cases staff were injured, and in 11% of cases patients were injured (n = 33). After the incident only 61% of respondents were de-briefed, and 76% were given documentation for audit procedures. About half of respondents (55%) had post incident discussion review with the patient. A significant number of respondents (41%) offered suggestions for alternatives to the use of C & R.

Discussion
The key findings: Staff are not always trained promptly and there is no clear policy about refresher courses. Staff often do not know who trained their trainers, or who employs them, which can cause problems of accountability. The meaning of “control and restraint” varies widely and there is great variation in the duration of training. The content of courses may have inadequate coverage of the theoretical, preventative and defensive aspects of managing violence and aggression and nurses’ responsibility for patient safety and dignity may not be given sufficient emphasis. Consequently, staff may lack confidence in their ability to use control and restraint techniques, which increases the risk of injury to both patients and staff. Post-incident debriefing, which should happen in all cases, does not in about a quarter of cases.
This event was set up by SNMAC to obtain views on in-patient care from a wide variety of individuals. A list of attendees at this event is shown below. Groups focusing on the 6 core themes identified in the preliminary study were asked to define the problems encountered in each area, and to identify ways forward. Rapporteurs from each group fed back the results of the day's work to a plenary session. The sounding board event produced a number of suggestions that greatly influenced the writing of this report and several invitees have kept in contact with members of the project team and have provided ongoing advice and feedback. Some of the themes that emerged are summarised below.

**Admission and bed usage**

There is a shortage of beds nationally, but it is most acute in inner cities, particularly London. Users report that they are “forced into a crisis” before they are admitted due to a lack of adequate community treatment. The mix of patients can be inappropriate, with psychotic, or intoxicated patients in the same unit as elderly frail patients. Some members of the group believe that a process of de-skilling of mental health nurses has taken place, whereas other believe that they have the skills but are not empowered to use them. The RMN training alone does not prepare nurses for the kind of work they have to do today and the lack of leadership in mental health acute nursing is widely acknowledged. Some ways forward mentioned were the need for a more systematic approach to the lack of beds which is often treated in isolation from the system of which it is a part. Beds could be better used, but we need to know more about why patients are admitted, and the function of in-patient services. Better criteria for admission to in-patient units should be devised. Alternatives to admission, such as residential care, respite care, intensive home care and step down facilities need to be developed. The training of RMNs needs to be reviewed and new recruitment and retention strategies need to be devised.

**Safety Issues**

Most violence in in-patient units is between patients. Safety would be enhanced by national standards, standards for policy development and review, more opportunities for gender segregation, more intensive care units and more attention to the problems of substance abuse, control and discipline. National policies on training for violence and aggression, seclusion and control and restraint are required and support systems need to be put in place to help staff deal with critical incidents. Attention also needs to be paid to issues of staff numbers, skill mix and employment of agency staff to allow time for clinical supervision, and training in clinical interventions.

**Ethnicity**

Action on racism is required at a national level, but locally services need to be adapted to the needs of the local population and users need to involved at all stages. More needs to be done to recruit staff from black and ethnic backgrounds. Transcultural psychiatry and ethnically sensitive nursing need to be an important strand in training. Clinical governance may provide an opportunity to monitor attitudes and skills in this area.

**Education and training**
Whereas CPNs are recognised as specialists, there is no specialist training for nurses in acute care. There was some debate about whether we should return to the 3 year RMN training, and whether basic training should be seen as sufficient to prepare staff for work in an acute setting. The competencies of the in-patient mental health nurse need to be defined and incorporated into training packages. There should be more emphasis on specific skills in training and systems need to develop in order for nurses to use their skills. Existing training does not cover practical ways of working with other services how to find out what users want.

**Clinical Interventions**

There is a hierarchy of needs which puts safety before relationships, followed by case management and specific skilled interventions must be institutionalised. We must focus on clinical expertise, revisit clinical nurse role, and develop clinical leaders. Cognitive Behaviour Therapy (CBT) can be useful but nurses need training in relationship-building as well as CBT which can be reductionist.

**Human resources**

Recruitment problems are common in all mental health disciplines but there is a 50% vacancy rate among nurses in London. This is at least partly due to the blaming culture that has developed, and the lack of staff support. More flexible working would help. The role of the mental health nurse in acute settings need to be clarified and more highly valued. Clinical supervision needs to be properly structured and resourced. The number of permanent staff in post should be identified as a quality indicator for services and externally monitored to encourage organisations to address issues of staff burnout and turnover.
APPENDIX 4

POLICY FRAMEWORK FOR WALES

In Wales the policy for the development of mental health services is based upon the principles outlined in “Mental Illness Services – A Strategy for Wales” (May 1989) and the updated Guidance on the Care of People in the Community with a Mental Illness (March 1996). This advocates a community based, multi-agency, model of care, supported, as appropriate, by local hospital or residential services. The policy is complemented by the Protocol for Investment in Health Gain (Mental Health) 1993 and the Report of the All Wales Advisory Group on Forensic Psychiatry 1992. The Mental Health Act 1983, the Mental Health Act Commission Code of Practice (revised 1993) and the Mental Health (Patients in the Community) Act 1995 set the main legal framework within which services in Wales are being delivered. In addition, the mental health nursing services have worked towards the targets set in “Caring for the Future: The Nursing Agenda – Mental Health Nursing Action Plan” published in April 1996.
APPENDIX 5

MEMBERSHIP OF STANDING NURSING MIDWIFERY ADVISORY COMMITTEE

Mrs Sandra Betterton Nurse Advisor to Cambridge and Huntingdon Health Commission
Mr Philip Boulter* Co-ordinator of Nursing/Manager Outreach Services - Lifecare NHS Trust
Miss Kate Caldwell* Director of Midwifery Services - Royal Devon and Exeter Hospital
Professor Jill Macleod Clark (Vice-Chairman) Director of the Nightingale Institute
Mrs Ann Close * Nursing Director - Dudley Group of Hospitals
Dr Annette Dearmun Principal Lecturer Practitioner, Oxford Brookes University, Oxford
Ms Denise Hagel Director of Nursing, Essex Rivers NHS Trust
Mr Dave McNicholas Senior ITU Nurse, Sunderland
Ms Susan Richards General Practice Nursing Sister - Penzance
Mr John Small Clinical Nurse Manager
Mr Harry Teaney* [Wales appointment] Public Health and Contracts Advisor: Clwyd HA
Ms Meryl Thomas Director Midwifery, Education and Practice ENB
Mr Tony Bell* (Chairman) Director of Nursing and Joint Commissioning, Liverpool
Ms Sue Norman Chief Executive/Registrar of the UKCC
Mr John Archer* (Vice-Chairman MH Sub-Group) Director of Nursing and
Service Development Tameside and Glossop.
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APPENDIX 6

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