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Published by
Pavilion
Richmond House
Richmond Road
Brighton
East Sussex BN2 3RL
UK

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Volume 2 Issue 2 September 2007

The Journal of Mental Health Training, Education and Practice

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All contributions to *The Journal of Mental Health Training, Education and Practice* are welcome. Please contact the editors if you would like to discuss your ideas.

ISSN 1755–6228

The views and opinions expressed by authors are their own. They do not necessarily reflect the views of their employers, the Journal, the Editorial Board or Pavilion.

The Journal of Mental Health Training, Education and Practice is included in: British Education Index; British Nursing Index; Business Source Complete; Education Research Abstracts; Social Care Online

Design: Matt Lancaster, Pavilion

Printed on paper from a sustainable resource by Newnorth, Bedford

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Editorial

Kevin Gournay
Guest editor
Emeritus Professor, Institute of Psychiatry, King's College London

When I sat down to write this editorial, the first questions I asked myself were whether inpatient care was necessary and whether it was sufficiently available. I will begin with a statement of my own position on these matters and set out what may, to some, be an unpopular and outdated view ie. that there will, for the foreseeable future, be a need for acute inpatient care and indeed, there should be more of it available.

I of course, accept that there will always be a need for asylum. However, this does not necessarily need to be provided under the care of doctors and nurses. For centuries we have provided asylum in the form of places of religious retreat or, for the more 'well-heeled', spas and residential health clubs. I also accept that psychiatric inpatient care may be provided safely in houses in the community, such as those famously used by Dr Richard Warner in Boulder, Colorado. Nevertheless, such houses in the community need to be supervised by clinicians on a 24-hour basis. For many years now, in most of the developed world, there has been a drive towards a massive reduction in inpatient beds, using instead 'community approaches' such as assertive outreach, home treatment and crisis intervention. However, the reality of the situation in the UK is that even after many years of community developments, a majority of those people who require intensive community care, either receive none at all, or receive only token interventions. Even then, save a few model services sited around the country, community teams have poor levels of training, and are, by any standards, overworked and carry caseloads that are much too big. There is also what is known as 'the threshold problem', which seems to exist everywhere. Local mental health services often have high thresholds for acceptance by community teams, these thresholds being put in place to deal with the shortage of resources. Therefore, only the most dangerous (to themselves or others) patients are accepted by the team. In turn, people with severe levels of despair and anguish who, however, 'behave themselves' and do not pose a grave risk, are simply considered not ill enough to deserve services.

I am of the opinion that there is no one who does not believe that illnesses such as acute schizophrenia and severe depression are sometimes such that the level of symptoms suffered requires 24-hour skilled care, treatment and observation. Although the public debate about the dangerousness of the mentally ill, or otherwise, will undoubtedly carry on, in my mind there is a population among the mentally ill who pose such risk to themselves and others, that there is simply no alternative but 24-hour clinical care and treatment within reasonable levels of security. Another reason for inpatient care is to provide the detoxification of illicit substances and alcohol, while at the same time stabilising mental health states. I realise that one of the difficulties here is that drugs and alcohol are readily available in some inpatient services. The answer to this particular objection to inpatient care is that we need to do something about providing drug and alcohol-free wards, rather than simply giving up. Although this might come at the cost of additional security and more expenditure, I believe that this is necessary, as in many cases of severe illness, it is essential to be able to accurately titrate the patient's medication and take illicit substances out of the picture. In addition to the usual arguments about why we need more beds, which include very high occupancy rates in many services, one also needs to consider what Professor Len Stein referred to many years ago as the 'transinstitutionalisation phenomena' (Test & Stein, 1978). Stein, arguably one of the most important architects of assertive community treatment, coined this term to describe the adverse consequences of de-institutionalisation, and he accurately forecasted that many mentally ill people would be housed in prison, rather than in psychiatric hospitals. Any visitor to a British penal institution can see that this is now the case. It is true that we have a number of initiatives that 'in reach' into prisons, but my position is quite simple – there are, literally, thousands of mentally ill people in prisons, whose offences are so trivial that imprisonment is completely inappropriate and that these individuals, who often alternate between incarceration and homelessness, would benefit from acute inpatient care.

It is my earnest hope that in the future we (and by 'we' I mean taxpayers) will recognise that community mental health services are grossly under-funded. If, at some point, this situation is corrected and all those mentally ill people in the community who needed decent community care, received it, we would be able to reduce – although not abolish – the need for inpatient care. That day has, of course, not arrived.

I also wish to take this opportunity to raise the issue of inpatient care for people with conditions such as obsessive-compulsive disorder, post traumatic stress disorder and other conditions, which are not currently provided by the NHS. Obviously, people with these conditions should not receive treatment within acute admission wards, but there are many people with such conditions who would benefit from 24-hour care and treatment provided by doctors, nurses, psychologists and others skilled in these particular areas. In the case of obsessive-compulsive disorder, the NICE guidelines on this condition recognise the need for such treatment. However, inpatient treatment is simply not available on the NHS. It is true that there are a few dozen people with OCD being treated in the independent sector under NHS contracts, and another handful of people being treated in specialist centres in the NHS where day care is provided. However, we seem to have abandoned whole populations, including many members of the armed forces, who have been so traumatised in Iraq, Afghanistan and other places, to an extent that that they are in states of unbearable anguish and are unable to function normally. Whether one agrees with wars in these countries or not, I believe that we have a duty to provide decent care and treatment (sometimes on an inpatient basis) for these young men and women who have suffered so much in the service of their country.

This second part of my editorial should leave the reader feeling somewhat more enthused than after reading the first part. The articles in this issue, I believe, demonstrate that there are many things that we can do to improve acute inpatient care.

Although the paper by Paul Rogers, and others on breakaway training, conveys a message regarding what does not work and challenges long-held assumptions, I believe that the work that they describe could eventually lead to improvements in the training and preparation of staff in the management of violence. Indeed, I know that all of the collaborators on this paper are actively involved in developing much-needed innovation in education and training.

The Australian contribution by Nicholls and colleagues is interesting in its portrayal of services in Australia, and I think that we can, by comparing the UK and Australian situations, be justly proud of the NICE guidelines, published in 2005, which if followed, will undoubtedly lead to services that are much safer for staff and patients alike. The other Nichols – Trish Nichols, a social worker, describes a very simple, but effective procedure for dealing with absconders from secure services and this work may well have implications for acute inpatient care. However, what interests me particularly about this piece of work is that social workers have been responsible for this innovation and, arguably, taken much needed responsibility for an important area of inpatient care.

In their paper, Joe Curran and his colleagues have described a therapeutic intervention (behavioural activation) that can be used in any UK service, and which could, arguably, provide many benefits to patients. Behavioural activation is a simple but effective procedure that does not need the skills of specially trained nurses or therapists, nor the clinical psychologists, who are so noticeably absent from inpatient care in the UK. It seems to me that the implementation of behavioural activation across the UK is a very realistic proposition, in contrast to cognitive behaviour therapy for schizophrenia, which according to many of its advocates, requires special training and the input of psychologists, who simply do not exist.

Elizabeth Hughes' and her colleagues' paper is similarly inspirational in its messages regarding inpatient interventions for dual diagnosis – perhaps the greatest single clinical challenge we face in mental health services. This article provides both a scholarly and practical account of the area.

The paper on 'new ways of working' by Ian Baguley and colleagues sets out a wide range of suggestions for what can be done to improve mental health services for inpatients, and reading this left me with considerable hope for the future.

I think that my concluding comments boil down to two main messages. First, I believe that the papers in this journal demonstrate that there is considerable potential

for innovation in our acute mental health services, and that those responsible for education and training have a substantial and positive agenda on which to work. However, the second message, I think, reflects the rather negative views expressed above (for which I make no apology) and that we get what we pay for. Despite statements by politicians, which now go back more than 15 years, stating that mental health is a priority area, we have not seen advances comparable to those in other priority areas, such as cardiology or cancer care. There was a time, 15 years or so ago, when cardio-thoracic surgery and expert cardiological treatments were scarce. Now, some parts of the country actually demonstrate an over-provision of such services and there have been statements to the effect that we have trained too many cardiologists! Similar accounts can be found in respect of cancer services. However, I have no knowledge of any area of mental health care where such improvements have been demonstrated and I therefore consider the statements (about mental health services being a priority) by politicians, and indeed echoed by civil servants and mental health professionals who should know better, as shallow and simply untrue. At the heart of this problem is the fact that very few taxpayers will vote for a political party who aim to increase taxation to fund better mental health services, and it is only when mental health problems, ranging from depression to Alzheimer's disease, affect us personally, that we will wake up to the reality of the impoverishment in this area.

My message to colleagues in nursing, psychiatry and other disciplines is not to assist with the perpetration of the myth that things are getting better – from my point of view, the overall position in mental health services is one of stagnation, rather than growth.

Reference

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Is breakaway training effective? Examining the evidence and the reality

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Abstract
Breakaway training is a mandatory training programme for mental health staff in both NHS and private services. However, the question that remains outstanding from the recent guidance on the management of short-term violence published by the National Institute for Clinical Excellence (NICE) (NICE, 2005a; 2005b) is whether breakaway training is effective?

This paper provides a history of and evidence for breakaway training, and a study examining the content of breakaway training in one English high secure hospital is provided.

Key words
breakaway training; violence; violence reduction; prevention; training

Introduction
Violence reduction and violence management have become key policy and practice workforce priorities for mental health and other areas of workforce delivery across the UK over the last 10 years (Miller *et al*, 2007): Scottish Health Service Management Executive,1996; Royal College of Psychiatrists (RCP), 1998; Nursing and Midwifery Council (NMC), 2001; NHS Security Management Service (NHS SMS), 2003, 2004, 2005; National Audit Office (NAO), 2003; Welsh Assembly Government (WAG), 2004; National Institute for Health and Clinical Excellence (NICE), 2005a, 2005b; National Institute for Mental Health England (NIMHE), 2004; and the Wales Audit Office (WAO), 2005.

One of the key policy cornerstones underpinning violence reduction training for mental health workers is 'breakaway training' (NIMHE, 2004; WAG, 2004; WAO, 2005). However, the effectiveness of such training has yet to be established, and at present, the practice of training staff in breakaway techniques can be at best considered a 'tradition'. As such, this practice requires careful consideration given that it is nearly 30 years ago that breakaway training spread to the NHS and private hospitals from the prison service.

The types of violence faced by staff
In undertaking this review, we attempted to determine the actual types of assaults faced by staff during their day-to-day practice. Despite headline news items by the NHS and associated bodies, we could not find any part of the NHS or any associated body that collected such surveillance data. Neither the NHS, the National Patient Safety Agency, the National Audit Offices, the Health and Safety Executive or the NHS Security Management Service were able to provide any data at all upon the type and frequency of violent attacks upon staff. Basic descriptive data, such as this, is the backbone of epidemiological research, thereby informing the development of interventional programmes – yet it is not available. Quite simply, if we do not know what type of attacks staff are facing then how can we develop training programmes to equip staff in coping with violence? Additionally, despite any lack of meaningful national representative data, it is impossible to determine whether breakaway training actually equips staff with the skills that they may need.

The history of breakaway training

In the UK, the dominant 'model' in terms of physical interventions has historically been from 'control and restraint', an approach developed for the prison service of England and Wales in the 1980s. This training was adopted by the English high secure hospitals in the mid 1980s following an inquiry into the death of a patient. Initially, this training was highly regulated by the prison service, however, the formal links between the health and prison services dissipated in the late 1980s. This led to the development of multiple variations of physical interventions that were then marketed by individuals to the health sector and by services within the health sector to other sectors including social care. The unintended consequence was that an unregulated market developed for the training in physical interventions within the UK National Health Service. Private training companies sprang up that marketed 'breakaway training' to a range of NHS and non-NHS staff. Furthermore, some staff, whether working in the NHS or in private business, began changing the techniques as they saw fit without basing such changes upon any evidence base. Issues regarding the complexity of the techniques, the student's ability to later recall the techniques, the potential for error and harm to occur to the recipient and the professional ethics of such practices were ignored by some providers. (It is important to acknowledge that there are some training providers both NHS and private that deliver high quality training based on robust training needs assessment with regular follow up).

Unfortunately, one apparent legacy of the lack of regulation is the confusion that has been allowed to develop around the exact inventory of techniques within specific 'versions' of breakaway training. Given the number of agencies offering training described as breakaway training and incorporating elements in various modified forms, it is difficult at this point to regard the term 'breakaway' as a unitary entity in a national context (Topping-Morris, 1995). Some organisations have developed manuals and protocols with accredited instructor training, along with internal and external procedures to review programme content (eg. West London Mental Health Trust). However, this situation is far from universal and breakaway training has arguably, in some respects, become a victim of its own success. The rapidity of its dissemination along with 'C&R' meant that there were inadequate mechanisms to prevent the development of a plethora of instructor programmes, and an inherently flawed pyramidal training system was thus allowed to develop by default. In the course of our review, we came across a range of private training programmes that market their training to the NHS. The techniques being taught were sometimes described as 'evidence-based' within individual companies' literature, and some of the techniques were concerning. For example, one company's marketing brochure reports that they train staff how to breakaway from 'earring grabs'. Surely, the issue for the NHS should be whether and why staff are wearing earrings in clinical practice, not how to help staff breakaway from such holds?

Policy guidance

In England and Scotland, there is no national policy that specifies how often breakaway training should be provided. However, evidence suggests that the norm is yearly (NMC, 2001; NES NHS Education for Scotland, 2005).

Welsh policy specifies that staff should be trained and refreshed a minimum of every two years. Surprisingly, 30 years after such training was adopted by the NHS, the issue of how long the skills and knowledge taught within such training are retained, has yet to be established. Therefore, it is difficult to understand the rationale as to why England, Scotland and Wales have chosen a timescale that is at best unspecified, and at worst every two years, is difficult to understand in the absence of any evidence.

Similarly, in England and Scotland there is no national policy that specifies which techniques should be taught. Yet in Wales, the techniques are specified (Welsh Assembly Government, 2004). The 'All Wales NHS violence and aggression training passport and information scheme' specifies that the following techniques should be taught: 'hair grabs – front and back'; 'clothes grabs – single and double grabs', 'wrist grabs – single and double grabs'; and 'strangle holds – front, side and back'. However, the rationale for choosing these techniques over others (eg. punches, kicks, bear hugs, bites) is unknown. Furthermore, it is unknown why hair grabs from the side and strangle holds with the victim pinned to the floor are excluded from the list?

Economics

The NHS has no record of how much training in violence costs. However, a recent attempt by the Wales Audit Office gives an example of the large amounts of money involved.

Based upon reported violent attacks, the Wales Audit Office estimated that the cost to NHS Wales between 2003 and 2004 of violent assaults was £6.3 million. This is an estimate of the training, absence through sickness, legal services and security staff, but does not cover the costs of recruitment and retention (eg. through staff turnover). If we assume that every qualified mental health nurse requires breakaway training once yearly for one day, then the costs of training alone are enormous. Currently, there are in excess of 70,000 qualified mental health nurses per year. If we consider qualified, learning disability nurses, qualified A&E nurses, ambulance personnel and unqualified staff in these areas then we are probably approaching 200,000 days of training per year.

Current evidence base for breakaway training

NICE guidance

NICE (2005a) have published *The Clinical Practice Guidelines for Violence: The short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments*. NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance is based upon systematic reviews, and where appropriate, meta-analysis of best evidence. Where systematic reviews are not available, then alternative forms of evidence are considered, from single randomised controlled trials gradually decreasing in the strength of the evidence to expert opinion. The NICE guidelines on violence considered the evidence for the effectiveness of prevention and training related to violence. It is beyond the scope of this paper to summarise the vast amount of information that underpinned the search strategy for the literature review that informed the NICE guidance; suffice to say that it was vast and comprehensive (NICE, 2006a).

It is important to note, that when NICE guidance steering groups compile guidance, the full information is vast. For this reason NICE release a shortened guideline that includes the main findings from the fuller review. Thus, there are usually two reviews to consider: (1) the released NICE shortened guidance, and (2) the full guidance for each NICE reviewed health area. To put this into context, the released NICE shortened guidance is 83 pages, yet the full guidance is 135 pages (NICE, 2005b). Furthermore, the full NICE guidance has 16 appendices. Appendix 5, which provides an overview of the included studies, is 266 pages alone (NICE, 2006b). The full guidance defines breakaway training as, *'Breakaway: a set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint'* (p7).

Additionally, the full NICE guidance recommended that based upon the evidence available that,

> *'the following constitute the core curriculum of training courses in the UK: taking the patient to the floor; three-person restraint team; sitting and standing the patient; negotiating stairways and doors; restraining holds; roles within team; turning the patient over; breakaways; entry into and exit from seclusion; and blocking punches' (p53).*

However, caution needs to be taken when considering such guidance. It is important to consider the possibility that there may be a problem of 'pooling' data, leading to conclusions that need to be carefully examined. In fact, there were only five UK studies that attempted to evaluate the effectiveness of breakaway training in mental health, of which only one found any difference: that staff felt satisfied and slightly more confident as a result of the training (Southcott *et al*, 2002). In reviewing the studies on which the NICE guidance is based upon, then it becomes clear that there is a dearth of evidence to support such training in the UK.

This clearly leads us to the conclusion that we need to go back to the beginning in studying breakaway training. Before we can determine effectiveness, we must first describe what it actually involves. Only then can we expect to develop more robust studies in the hope that the NICE and policy guidance is able to be more specific in what such training should contain, in what population, and for what level of staff?

Studies after the NICE guidance

A recent published study has examined the effectiveness of breakaway training in a real life role play scenario where medium secure ward-based nursing staff had minimal warning of what was about to occur (Rogers *et al*, 2006).

Three registered mental health nurses randomly attended the wards. Two of whom were breakaway

instructors, and one a ward manager. The participant was asked to select one from five sealed envelopes that contained a description of a breakaway technique that they would be asked to perform. They were then asked to sign a consent form for the audit. Each envelope contained one of the following scenarios: a strangle hold from the front, a strangle hold from the side, a strangle hold with a forearm from behind, a strangle hold while on the floor, and a hair grab. All but the last scenario are considered to be life-threatening events as unconsciousness can occur within seconds if enough force is applied. Each participant was given 10 seconds to think about the scenario before being given the instruction to commence. The scenario would then be enacted. When 10 seconds had elapsed, the scenario was stopped, as it was presumed that if participants were not able to escape after 10 seconds, then in reality they would probably have been either unconscious or possibly dead (if a strangle hold).

The results found that of the 50 nurses asked to participate in the study, 47 agreed (94%). All had had breakaway training. Eleven staff had received the full breakaway training more than once and 24 had at least one update since their original breakaway training course. Unexpectedly, none of the sample had used a breakaway technique in the preceding 12 months. Forty per cent (19/47) were unable to breakaway within the 10 second period. Of the entire sample, 60% of staff did not employ the correct breakaway technique. One of the staff used in the sample who did not employ the correct technique was one of the instructors used to teach breakaway training.

Most alarming, is that during this study, we observed staff trying to remember the correct technique for breaking away from a strangle hold and being unable to, resulting in a struggle. Staff often verbalised that they 'couldn't remember' what to do. This therefore, leads us to the simple question, why can't staff remember what to do following training?

Method

Aims

The aims of this study were to determine the content of breakaway training provided at Broadmoor high secure hospital, to describe the techniques that are taught, and the length of time dedicated to each technique.

Design and procedure

An observer attended a mandatory one-day breakaway training course at Broadmoor high secure hospital for new staff in early 2007. The observer covertly recorded the techniques that were taught, the length of time that each technique was demonstrated, and the length of time that the students had to then practice such techniques. The staff providing the training were unaware of the observer's role.

Ethical issues

The study was undertaken as part of an agreed strategic internal training evaluation within the hospital in order to inform a wider review of current training, and therefore was not subject to the need for ethical approval.

Setting

The high secure services at Broadmoor hospital, a directorate of West London Mental Health Trust has been delivering breakaway training programmes to its employees since 1984 and as a mandatory training requirement to all employees since 1989. Within Broadmoor hospital alone, there is on average 650 personnel trained in breakaways each year; this equates to a total number of staff trained since 1984 as being approximately 11,700. The prevention and management of violence reduction department at Broadmoor hospital has maintained a register of all staff trained as instructors. This shows that the breakaway training programme has been delivered by Broadmoor personnel to the vast majority of instructors throughout the United Kingdom and the Republic of Ireland, at Broadmoor. The register shows that 150 instructors from 35 separate organisations have been trained, and have subsequently gone on to teach the breakaway training package at their establishments.

Results

Training structure

The training day consisted of an introduction to violence and aggression as well as prevention. For the nature of this paper we were concerned with the actual techniques that were taught. The training day comprised of seven and a half hours training. In this time, 21 different techniques were taught covering hair pulls, strangles, clothes grabs, wrist grabs, bear hugs and 'full nelson' (see ***table 1***). The training consisted of two demonstrations by the trainers for each technique followed by student practice.

Table 1: Breakaway techniques taught with demonstration and practice time

Technique	Demo 1 (Duration)	Demo 2 (Duration)	Participant practice	Total (Duration)
1. Hair pull from the front (palm)	4	3	10	17
2. Hair pull from the front (radius)	3	3	10	16
3. Hair pull/ear grab – same side	5	4	9	18
4. Hair pull/ear grab – opposite side	3	3	7	13
5. Hair pull/collar grab from rear (turning in)	3	3	8	14
6. Hair pull/collar grab from rear (turning out)	4	4	8	16
7. Straight arm strangle standing from the front	6	4	7	17
8. Straight arm strangle/trapezium grip from the rear	3	3	7	13
9. Straight arm strangle on floor – knees astride	8	6	7	21
10. Straight arm strangle on floor – from the side	6	4	5	15
11. Straight arm lapel grab	6	4	8	18
12. Bent arm lapel grab	6	5	8	19
13. Wrist grab single handed – same/opposite side	2	2	4	8
14. Wrist grab double handed – thumbs up/down	2	1	3	6
15. Wrist grab (both sides) – thumbs up/down	1	1	2	4
16. Wrist grab taking aggressor to floor – same/opposite side	7	7	10	24
17. Bear hugs	2	1	3	6
18. Full nelsons	2	1	3	6
19, 20 and 21. Close proximity techniques (three separate methods)	7.5	7.5	15	30
	Total 80.5 minutes	**Total 66.5 minutes**	**Total 134 minutes**	**Total 375 minutes**

Demonstration time

The total demonstration time for all techniques was 146.5 minutes (8,790 seconds). Thus, the mean average demonstration time per technique was six minutes and 58.57 seconds (418.57 seconds).

Practice time

The total practice time for all 21 techniques was 134 minutes. Thus, the mean average practice time for students per technique was six minutes and 22.86 seconds (382.86 seconds).

Separate components

Of the 21 techniques there was a total of 104 component parts, as each technique is made up of smaller component parts. For example, for a hair pull from the front, the first component part is a sideways stance. The total supervised practice time for all techniques was 134 minutes (8,040 seconds). Thus, the mean average student practice time per component part was one minute and 25 seconds (84.53 seconds).

Average training time per technique

Overall, therefore the mean average time, which includes two demonstrations and student practice time per technique, was 13 minutes and 22.86 seconds (802.86 seconds).

Discussion

The results of the training review at Broadmoor hospital led to a review of the training that was being offered to staff, and has resulted in a comprehensive restructuring of the training that is provided. It is not plausible to train staff in 21 different techniques, containing 104 component parts in seven and a half hours, and then expect them to be able to recall and apply such techniques any time in the next year with little or no notice.

Breakaway training has become mandatory tradition in mental health. However, this review causes considerable alarm. This paper has reviewed the evidence for breakaway training as currently provided to NHS staff and has found that there is little if no evidence supporting wide scale training programmes. The systematic review undertaken as part of the NICE review only found that staff were satisfied with the training and felt slightly more confident as a result. We do not know how long such effects last and whether confidence in the absence of evidence is an appropriate training outcome. The study undertaken by Rogers *et al* (2006), found that staff who were trained in breakaways were not easily able to recall the techniques in a clinical environment with little notice. In fact, it could be questioned whether the training actually causes harm, as some staff were focusing on trying to recall what to do, instead of breaking away from a dangerous situation. It is possible that breakaway training may actually inhibit a person's natural responses when being strangled, in favour of a taught response, which they cannot recall.

Finally, we need to ask whether the training that we provide staff in dealing with violent assaults actually equips them with the realities of violence within their workplace. The majority of violence within the NHS is most likely from kicks or punches. Yet, we are teaching staff breakaway techniques that are to be employed once someone has 'hold' of a member of staff. This does not mean that some breakaway techniques are not needed, however, we need to determine what else is needed first. For any training program to be effective, it must be based on a robust training needs analysis, which includes incident analysis and discussion with the staff involved. Interventions taught must be relevant to the operational setting in which they will be deployed. The techniques must be proportionate to the threat presenting, and in order to be effective must be simple to learn and recall under pressure, while achieving the desired outcome of harm minimisation. There is an urgent need for researchers and policy makers to address the current situation.

This paper does not aim to disregard breakaway training as an intervention. The objective is to prompt a review of the training curriculums currently offered in order to ensure that the desired outcome of harm minimisation is achieved. It is therefore necessary to redefine the term breakaway training. This term is currently used to describe a catalogue of interventions aimed at escaping from a situation. This will range from techniques aimed, for example, to release the grip of a confused frail elderly patient. A primary objective in this intervention is to ensure the risk of harm to the patient is minimised. The technique deployed in this scenario would not be appropriate if the individual was required to escape from a life threatening situation, for example, being strangled by a fit young man who is expressing intent to kill.

The response deployed by staff in any situation arising in a clinical setting will be dependent on multiple physical, psychological, environmental and situational variables including, for example:

- the threat impact factors, size, strength, intent of assailant etc.
- staff members' confidence
- predictability/regularity of the service users' behaviour
- staff members' previous experiences

- the relationship with the patient
- availability of support from others
- clear organisational policy guidance
- appropriate training.

In order to provide interventions that can be contextualised in a legal and ethical framework, the intervention currently referred to as breakaway needs to be described more accurately in order to assist training providers and services to ensure that the interventions taught are appropriate to the presenting risk, and relevant to the role of the staff member. Legally, staff have a right to a safe working environment and can utilise interventions that are necessary and proportionate to protect themselves and others. Within a care setting, this right under statutory legislation is not altered, however, ethical considerations promote a balance with maintaining the safety of the service users. Breakaway techniques therefore need to be addressed on two levels: low level interventions aimed at disengaging from a situation that does not present a serious risk of harm and higher level interventions that demand a prompt escape from a situation that is likely to result in injury or even death. Providing staff with the physical skills necessary to respond in such circumstances is arguably essential, as without a structured approach, ethical and legal conflict could occur, potentially resulting in a greater harm occurring. However, if such physical skills are being taught, they must be effective in practice. In order to be effective, the skills must be easy to learn, and recall when necessary.

The future

Given that we have allowed breakaway training to become the main form of dealing with violent assaults over the last 30 years without any credible evidence, the urge to 'hang on' to it due to its historical relevance has to be abandoned. It may be possible to refine and modify these courses, however, until we know the reality of NHS and non-NHS violence, it is rather pointless investing all our efforts and resources into a 'tradition'. A considerable research programme lies ahead, which has natural researchable questions and designs (see ***table 2***). The question is whether policy makers and those responsible for ensuring the safety of the workforce are prepared to invest funding in order for this to happen?

Table 2: Research questions and designs for the future

Question	Design
1. What is the reality of violence to staff? Specifically, what type of violence do staff face and how often?	Epidemiological survey
2. What might be done to prevent such violence occurring in the first place? Does it work?	Systematic review of literature
3. For violence that cannot be prevented, what physical skills are available that might help staff?	Survey
4. How effective are such available physical skills in an emergency situation?	Randomised controlled trial
5. What is the best method of teaching staff these physical skills?	Randomised controlled trial
6. How long do such training effects last?	Randomised controlled trial
7. How often is refresher training needed?	Randomised controlled trial
8. How can we demonstrate that such reformation of violence training for staff has benefits to individuals, the NHS and society as a whole?	Economic evaluation, user satisfaction studies

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The alignment of workforce development with service user moves towards integral self-intervention in the management of emotional states that may lead to behavioural disturbance: one Australian perspective

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Abstract
This paper explores the workforce development issues that arose in the course of an Australian repeat pilot study. The aim of the pilot study was to introduce, within a different setting, a planned approach to the assessment of, and interventions in, emotional states of service users that may lead to episodes of behavioural disturbance within psychiatric units. The pilot study necessitated training of staff in the use of an assessment tool. During the course of the study, a novel element was encountered with regard to staff understanding of service user involvement in treatment. This element, presented here as 'integral self-intervention', emerged in conjunction with the development of two wall charts: an acute arousal management process chart for staff, and a patient safety chart for service users. The paper will outline the collaborative process towards the partial realisation of this element of integral self-intervention, and associated workforce development issues.

Key words
integral self-intervention; patient safety; behavioural disturbance; acute arousal

Introduction
This paper addresses the workforce development issues that arose during a repeat pilot study, conducted in Melbourne, Australia in 2005, titled *A prospective observational study of the effectiveness of a rating tool for patients who are experiencing acute agitation*. The study, which received ethics approval from Austin Health's Human Research Ethics Committee, involved the introduction, within two neighbouring psychiatric units of an assessment template and debriefing form. These 'tools' are designed to provide a consistent approach to the early recognition and clinical management of emotional states involved in episodes of behavioural disturbance.

'Behavioural disturbance' is a term that denotes a way of acting that differs from one's usual mode, and may have consequences that one would not otherwise desire. For example, a person may become verbally or physically abusive, aggressive, harming of themselves or others, or being intrusive of others' privacy. The terms, 'acute agitation' and 'acute arousal', have been utilised to refer to the emotional states that may lead to such behavioural disturbance (Castle *et al*, 2005). The original study, conducted on the Bleuler acute inpatient unit at the Royal Melbourne Hospital, resulted in the development of clinical practice guidelines for the 'pharmacological management of acute behavioural disturbance in psychosis' (Castle *et al*, 2005). The development of guidelines for pharmacological management, however, is not the only possible result of such a pilot study. We will show here, that more comprehensive outcomes can be achieved, with implications for workforce development.

Aggressive behaviour in hospitals is not, of course, confined to psychiatric units, and presents a major management issue in other areas, notably accident and

emergency departments (Lee, 2001). This poses associated risks to the service users and others, and necessitates the development of effective protocols and strategies for management of this behaviour, in addition to educational programs for staff. Cooper (1994) studied an education program conducted in an emergency department in Canada to enhance the knowledge and skills of staff in dealing with aggressive incidents. The study found that following training there was increased confidence in dealing with aggressive incidents, with some impressive, positive statistics related to the introduction of the program. The essential thrust of the programme was to link theory and practice vis-à-vis aggressive incidents, though it is not made clear how *'acquired knowledge facilitated integration of concepts and theories of aggression, anger and anxiety in the management of potentially aggressive clients'* (Cooper, 1994 p55).

Increased confidence related to training programmes has also previously been demonstrated by Thackrey (1987), who conducted a US study in a community mental health centre, a psychiatric prison and a psychiatric hospital. In contrast, a more recent study undertaken in Switzerland (Needham *et al*, 2005) found no correlation between a training course and nurses' attitudes to aggression, though the researchers posit several reasons for this non-correlation apropos the study itself. Interestingly, they suggest the possibility of *'an inverse model of causation with behaviour leading to attitude change and not – as assumed in this study – that the training course mediates attitude change'* (Needham *et al*, 2005 p653). This is a classic idea, beautifully described by the philosopher, Alain, who counselled us in the 1920s to sit up straight so we would think better about ourselves, rather than to firstly think better of ourselves so that we could sit up straight (Alain, 1989).

The 'inverse model' was evidenced in relation to the repeat pilot study, described in this paper, with staff coming to understand service user perspectives during the course of the study, rather than first 'learning' about the value of these perspectives and then expecting to work in a collaborative framework at a later date. Currently, in Australia, the roll-out of the 'Collaborative Recovery Training Programme', operating in the latter mode, is faced with the challenge: 'how to transfer training to practice' – as was reported at a recent conference (Deane *et al*, 2007). This mode, which seems logical due to its sequential nature, fails to provide the first hand experience where new possibilities of knowledge can be immediately embraced and applied. Furthermore, the transfer of knowledge to practice is not a single event: it must be ongoing so that sustainability can be achieved.

This fine interplay of learners' acquisition of new knowledge and knowledge application sits at the heart of attempts to integrate theory and practice. As Gilles Deleuze reminds us, *'At one time, practice was considered an application of theory, a consequence; at other times, it had an opposite sense and it was thought to inspire theory, to be indispensable for the creation of future theoretical forms'* (Foucault, 1977 p205). Deleuze continues:

> *'For us, however, the question is seen in a different light. The relationships between theory and practice are far more partial and fragmentary […] from the moment a theory moves into its proper domain, it begins to encounter obstacles, walls, and blockages, which require its relay by another type of discourse'* (Foucault, 1977 pp205–206).

We will attempt to show that it is this 'other type of discourse' that emerged in the repeat pilot study.

The interplay of learners' acquisition of new knowledge (theory) and knowledge application (practice) is evident, when in discussing the management of disturbed behaviour Harrison states that,

> *'It is vital that nurses develop a sound understanding of the factors that can cause and influence such behaviour and that each department has in place clear, accessible policies and procedures for the management of such incidents'* (Harrison, 1999 p186).

Here, Harrison places understanding (knowledge/theory) and practices in the same sentence, with no comment on their relationship.

A relationship is more evident in the original study for the introduction of the assessment template and debriefing form, which provided guidelines for the use of medications in episodes of acute behavioural disturbance. Castle *et al* state,

> *'It is incumbent upon the field to establish workable guidelines for the management of such scenarios so that efficacy and safety are ensured. Such guidelines as currently exist are often idiosyncratic and reflect individual clinicians' experience and preferences'* (Castle *et al*, 2005 p247).

The emphasis in this first study was to train clinicians in the use of the 'tools', towards the development of a guide to pharmacological interventions suitable for particular states of acute arousal. The training then, applied to the pilot study only, the guidelines providing the 'transfer to practice'.

In the repeat pilot study, the pharmacological component of management of behavioural disturbance was viewed as only one aspect of the picture. The training would occur as previously, in the use of the 'tools', but this time a range of nursing interventions would be examined towards the implementation of local guidelines: psychological, behavioural and environmental interventions. What was not expected was the shift in emphasis from the staff need to manage acute arousal, to the service user need to self-manage emotional states.

Setting

The repeat pilot study, which comprised the introduction of the rating template and debriefing form, was conducted within two neighbouring psychiatric inpatient units of the same service: a secure (protracted stay) unit and an acute (shorter stay) unit. Typically, inpatients of the secure unit experience more severe forms of mental illness marked by unremitting psychotic symptomatology, than those of the acute unit. Inpatients of both units may manifest serious behavioural disturbance, where they may present a danger to themselves and/or to others. Moreover, they may exhibit behaviours that are socially unacceptable by current community standards. In both units, active treatment and individual programs are promoted, which are aimed at returning service users to community living where possible, but which are also appropriate to the needs of those who may require a stay for an extensive period of time.

The responsibility for providing a safe environment for service users, and providing continued risk assessment, continues to place great demands on staff. Pratt (2001) contends that staff increasingly feel that they are being held responsible when violent or self-harming acts occur. Thus, there is a twofold requirement of staff: a requirement to provide a safe environment and a requirement to account for things when they go wrong. This compounded effect may go some way to explaining why some would hold a zero tolerance view with regard to aggressive behaviours. This position is quite contentious and certainly not universally held. Nicholls & Mitchell-Dawson (2002 p294), for example, argue that a zero tolerance approach may lead to a situation where, *'consumers of mental health services will be increasingly feared and treated as a potential threat'*. They add, *'It is this very attitude nurses are trying to dispel in the community at large'*. Another problem with a zero tolerance stance can be the limiting of opportunities for a collaborative, or partnership approach in the management of behavioural disturbance.

Partnerships between all service providers as well as with service users and carers are integral in assisting service users to identify goals and strategies to achieve their identified outcomes, including living in the least restrictive environment – in line with a primary objective of the Australian, Victorian Mental Health Act, 1986. It is not too difficult to see that too many restrictions would prevent people from entering into a collaborative process to facilitate an integral engagement with their own emotional and behavioural states. In other words, this means engaging in a process that may not seem to be logically consistent with recovery: to collaborate with others towards responsibility for self. This notion of a collaborative alliance towards self-intervention finds its corollary in the literature of self-determination. This related notion has been well explored in relation to a variety of mental health conditions (Sheldon *et al*, 2003). The extent to which self-intervention can be applied to service users who are experiencing severe and sometimes unremitting psychotic symptoms is the real challenge here.

Integral self-intervention

In visiting the principle of self-intervention of service users experiencing severe psychotic symptoms, the opposing reality of actual coercion, within psychiatric settings, needs to be admitted. Often, coercive strategies are utilised to address behavioural disturbance. The range of these coercive strategies is well described by Ryan and Bowers (2005), interestingly with one strategy called 'negotiation' and with rationales including 'enabling'. With this in mind, it is useful to consider just what 'coercion' means. The original meaning of the word coerce, from Latin, is *'to restrain'*: these days it is *'to constrain'*, and *'to forcibly impel to obedience'* (Brown, 1993). The force, we see, is now quite subtle, with one being enabled to obey through negotiation.

At first glance, this might seem like a contradiction, but in fact, the word 'obey' contains its own contradictions. As well as denoting submission, it contains the sense of following, or agreeing with. For example, we can say that the angles of a triangle 'obey' certain rules of geometry. We can see how both meanings of obey are manifested in the coercion of service users: both meanings come to light in the strategies outlined by Ryan and Bowers, who clearly show the intent behind certain coercive practices as enabling rather than disempowering, with negotiation quite rightly being named for what it is. It is important to note here, however, that the subtle distinction contained in the word 'obey' needs to be fully comprehended by health professionals in order that respectful interventions are employed. There is (at least) a two-way interest in obedience.

This duality of inherent meaning in the word 'obey' is the prompt for the term, 'integral self-intervention'. This term contains the all-encompassing word, 'integral', including all its meanings, which derive from its base: 'to touch' (Brown, 1993). The definition, then, of 'integral self-intervention', is the taking of responsibility for one's behaviour through personal choice. Whether one feels one has a choice in hospital is a key question here. Carpenter *et al* (2004) reported reduced perception, of both service users and staff, of service user choice in hospital settings, compared with community settings. The question now arises whether those diagnosed with a mental illness and involuntarily detained in an inpatient setting, are capable of self-intervening in their emotional states. All of the service users who participated in the research were involuntary patients detained under Section 8 or Section 12 of the Victorian Mental Health Act, 1986.

The Victorian Mental Health Act, 1986 describes the conditions whereby a person can be detained as an involuntary patient. It specifically states, *'the person has refused or is unable to consent to the necessary treatment for the mental illness'*. (Victorian Mental Health Act, 1986, Section 8 (1) D). There is no suggestion here that behavioural disturbance is a necessary factor in mental illness. In fact, quite the contrary: the Mental Health Act specifies that particular behaviours and beliefs may not be considered, in themselves, indicative of mental illness (Victorian Mental Health Act, 1986, Section 8 (2)).

We cannot, therefore, automatically assume that aggressive behaviour (or any other particular behaviour) is a necessary feature of mental illness. Noak & Hopley (2000) might dispute this statement, and indeed, cite evidence to show that, *'mental disorder has a direct association with violence'* (p377). Their argument, however, tends to waver and is qualified with statements like, *'although **not all** mentally disordered people are violent, there is a clear association between violence and **some** forms of mental disorder'* (our bolding). The best we can say for certain is that the aggressive behaviour may 'accompany' the mental illness. Just as aggressive behaviour may accompany other states considered outside the realm of mental illness. Sanctioned aggression, for example in certain sporting activities, is considered by some to be socially acceptable. The Mental Health Act clearly states the conditions for a mental illness, *'being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'* (Victorian Mental Health Act, 1986, Section 8 (1A)). To reiterate then, disturbed behaviour, on its own, is not a criterion of mental illness.

Under the right circumstances, then, everyone can take some control of his or her behaviour, including those diagnosed with mental illness. Naturally, the circumstances may not be right, all of the time, for someone with 'a significant disturbance of thought, mood, perception or memory'. But for those times when the circumstances are right, every opportunity must be afforded the service user to achieve their own controls. In order to demonstrate this point, we refer to Castle *et al* (2005 p247), who remind us, *'mild arousal does not generally require parenteral medication'*. In fact, it may respond well to oral medication. The taking of oral medication indicates that service users may not be so affected by their aroused state(s) that they are not able to agree to take drugs orally. The question is raised then of what other approaches/interventions service users would agree to. The study described in this paper sought to establish an early and sustained approach that includes the agreement and involvement of service users in the self-management of their emotional states.

Pilot study

The study was conducted over a five-month period in 2004/2005. Participants were those inpatients who were able to provide informed consent (42 participants in total with 187 uses of the tools) at the debriefing stage of an episode of acute arousal. Nursing staff were responsible for

assessing the emotional states of inpatients, dispensing prescribed medications and initiating psychological and/or behavioural interventions. Empirical data consisted of: frequency of ventilation/redirection, timeout, incidents of seclusion, and restraint.

An overall quality improvement structure is evidenced in the staff training in the use of the tools and in the focus group. Action measures are evident in the process itself and the creative outcomes: wall charts and innovative workforce development. It is important also to add the thoughtful overlay, evident in the ongoing reframing by researchers, service users and nursing staff of just what it means to be confident to take responsibility for one's behavioural responses. The collaborative process commenced with individual and group discussions among clinical staff, service users, and the consumer consultant (also a service user, but not an inpatient) whose function in the organisation is to advocate on behalf of service users. The word 'consumer' is commonly employed in Australia for service user or patient – albeit that the term smacks of the market (Connor & Wilson, 2006 p472). The discussions included an explanation of the tools to be used in the pilot study, as well as an explanation of expectations regarding staff and service user involvement.

The pilot study included measurements, completed by nursing staff, of the level of acute arousal as it was identified. This was in line with the process developed by Castle *et al* (2005). The tools utilised were the Bleuler Acute Arousal Programme: Rating Template and the Bleuler Acute Arousal Programme: 24–48 h Post-intervention Patient Debriefing Form (Castle *et al*, 2005). The template was completed by nursing staff for all episodes of behavioural disturbance requiring 'PRN' treatment, including, but not limited to the use of medications. It includes a number of scales, one of which, the Fremantle Hospital Acute Arousal Scale, was developed by staff on the psychiatric intensive care unit at Fremantle Hospital in Western Australia, and is a simple five-point scale. Other scales utilised included the Excitable Subscale of the Positive and Negative Symptom Scale (PANSS) (Kay *et al*, 1988), and the Clinical Global Impression Scale (CGI) (Guy, 1976).

In terms of the debriefing that occurred as part of the pilot study, the Bleuler Acute Arousal Programme: 24–48 h Post-intervention Patient Debriefing Form was utilised. A researcher who was not part of the clinical team conducted this debriefing. It was at this stage that written consent was sought from service users to use the data. The form consists of questions requiring the service user to recall the event, to comment on reasons and necessity, interventions used and feelings. In the repeat pilot study service users were also asked their advice on what they would like to see happen if, at a future time, they found themselves in a similar situation of acute arousal.

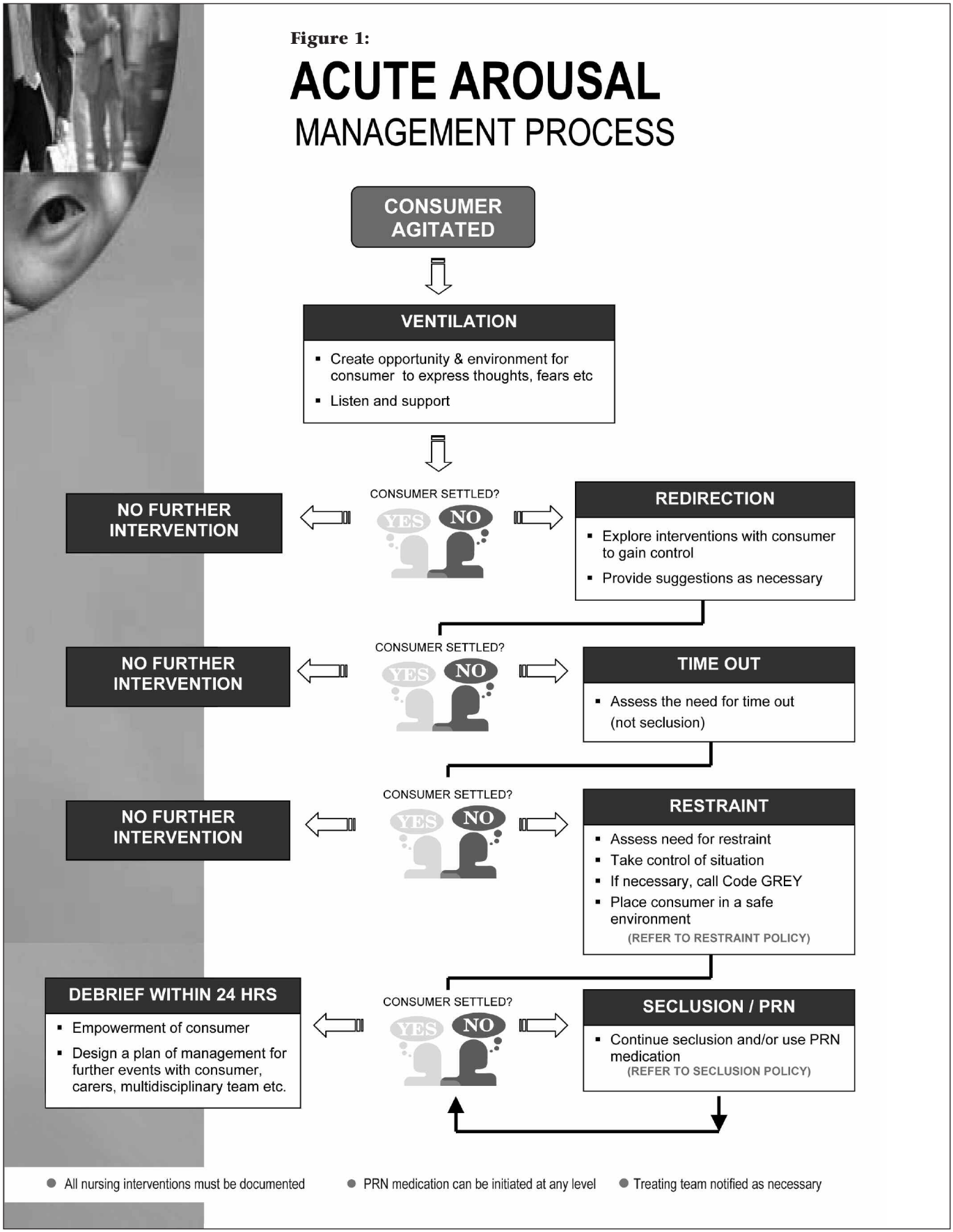
All nursing staff were given in-service training in both the procedures and documentation. They were trained in the use of the Bleuler Acute Arousal Programme: Rating Template, with the study team conducting regular follow-up training as required. Part of the process included discussions with the treating team regarding early intervention strategies to help manage episodes of acute arousal as they might arise in particular service users. These strategies were then discussed with those service users in order to identify previous treatment strategies that had worked for them in the management of their emotional states. These treatment strategies included medication, time out and diversion activities.

Co-operative outcomes

The empirical findings of the pilot study are not a feature of this paper, however, it is noted that during the conduct of the study, service users reported valuing the opportunity to debrief after each episode of acute arousal, and to have input into future management. Rates of complaints from service users, as well as rates of seclusion, were reduced during the period of the study, and these trends were maintained afterwards. Specifically, of the 187 uses of the tools over the five-month period of the study, 145 inpatients responded to ventilation/redirection, 28 responded to time out, and 14 required seclusion. There were no incidents of restraint.

Following the period of the pilot study a nursing staff focus group was conducted to ascertain perceived benefits of participation in the pilot study and appraisal of a staff draft flow chart (eventually configured as ***figure 1:*** **Acute arousal management process**, overleaf) that was developed as a direct result of the pilot study. This chart comprised core principles of the stages of arousal with a decision tree of suggested interventions. Differing from the pharmacological guidelines developed following the original pilot study, this chart was rather a plan for psychological and behavioural interventions, which became embedded in practice.

Figure 1:


ACUTE AROUSAL
MANAGEMENT PROCESS
CONSUMER AGITATED
VENTILATION
Create opportunity & environment for consumer to express thoughts, fears etc
Listen and support
CONSUMER SETTLED?
YES
NO
NO FURTHER INTERVENTION
REDIRECTION
Explore interventions with consumer to gain control
Provide suggestions as necessary
CONSUMER SETTLED?
YES
NO
NO FURTHER INTERVENTION
TIME OUT
Assess the need for time out (not seclusion)
CONSUMER SETTLED?
YES
NO
NO FURTHER INTERVENTION
RESTRAINT
Assess need for restraint
Take control of situation
If necessary, call Code GREY
Place consumer in a safe environment
(REFER TO RESTRAINT POLICY)
CONSUMER SETTLED?
YES
NO
DEBRIEF WITHIN 24 HRS
Empowerment of consumer
Design a plan of management for further events with consumer, carers, multidisciplinary team etc.
SECLUSION / PRN
Continue seclusion and/or use PRN medication
(REFER TO SECLUSION POLICY)
All nursing interventions must be documented
PRN medication can be initiated at any level
Treating team notified as necessary

Discussions of the acute arousal management process chart prompted one experienced staff member to suggest that an abridged version may empower service users. This idea was endorsed by all group members who agreed that displaying such a chart in the inpatient areas would assist service users in understanding options staff may take, if someone was becoming agitated. However, following discussions with a consumer advocacy group, the eventual form of the chart (***figure 2***, overleaf) differed from that suggested in the staff focus group: the chart was not finally a version or modification of the staff flowchart, but was something that alerted service users to their own safety needs and the safety needs of others. It alerted service users to what they should do if they, or others around them, became anxious or agitated, and the support they could expect from staff. The name of the chart, 'patient safety', was chosen, and approved by the consumer advocacy group, in order to best meet the needs of the service users, who know themselves as patients rather than consumers: they are able to instantly see that the chart was developed for them. This necessity for sensitivity in the use of language is also noted by Connor and Wilson (2006).

While the emphasis of the chart is on the safety of the service users, however, it is important to note that the chart is still very much a staff initiative, which is evident in the language of the chart – 'you and we'. This fact need not detract from the significance of the chart in relation to the safety needs of service users as they have a right to expect that staff will always respect their safety needs, including those times when their vulnerability is expressed through highly aroused states that may lead to behavioural disturbance. There is no suggestion here of a 'staff know best' attitude. Rather, it is a matter of the responsibility of staff to ensure a safe environment for everyone. There is a suggestion, however, that staff needed to move in uncertain terrain in accepting the idea of a patient safety chart to sit alongside the acute arousal management process chart. This uncertainty, and the acceptance of staff of service user views, is an instance of a developing ethos in care. It is workforce development at its most integral level.

Conclusion

The focus of this paper has been to highlight the workforce development issues that sit alongside collaborative strategies towards service user self-intervention. The workforce development occurs within a spirit of partnership with service users in their desire and willingness to manage their own emotional states more effectively. It is in the staff appreciation of this willingness that practices can change and be sustained. The practices will then, in turn, inform the knowledge of staff.

We can say, like Deleuze, that there is another type of discourse at play here – not a discourse of theoretical certainty, but rather a discourse that is 'partial' and 'fragmentary'. It is partial, in that we have not finally assured the service user voice. It is fragmentary, in that we needed to proceed in diverse ways – a movement that did not end with the completion of the pilot study, but has continued to the construction of this paper. In point, the term 'integral self-intervention' was coined here in an attempt to capture the link between service user desire for self-management of unpleasant emotional states that may lead to behavioural disturbance, and the need of staff to transform their practices as they begin to recognise and understand this desire. The image of 'touch' inhering in the word 'integral' is played out in the emotional images of 'being in touch with oneself' and 'being in touch with others'. The partnership is with others, and it is with oneself.

In order to develop the workforce then, strategies are required that ensure that needs of service users are recognised and respected in this spirit of partnership. These needs are expressed in the diverse perspectives of both service users and staff. An appreciation of these diverse perspectives is an integral aspect of service provision and workforce development, in the recognition that service users have a desire and an ability to influence their behaviour in a socially appropriate manner. Involving service users with staff in a co-operative project cannot, then, be a paternalistic endeavour. It requires a sensitive appreciation of service user moves towards integral self-intervention. Staff must always be prepared to challenge their pre-conceived ideas of what may be best for service users. In order to challenge any preconceived ideas they need to openly express and share these ideas and embrace different views.

This attitude was evidenced in the difference between the two wall charts, as well as the way in which they were constructed. The patient safety chart is qualitatively different from the acute arousal management process chart. Workforce development does not end with this attitude, however. Incorporating service user perspectives in the recognition and management of emotional states

Figure 2:

PATIENT Safety

WE CARE ABOUT YOUR SAFETY ON THIS UNIT

Some people may be feeling disturbed or agitated.
This may cause other people to feel upset or unsafe.

What you should do:

- If you feel you are getting angry, agitated or anxious, speak to your contact nurse as soon as possible.
- Discuss with your nurse ways to manage your feelings:
  - extra medication may help you settle
  - find a place away from distractions where you can feel safe as you gain control of your emotions.

When unpleasant incidents happen around you:

- Please be reassured that staff are in control of the situation.
- Avoid getting involved.
- Move away from the situation.
- Go somewhere quiet where you can relax.
- Do something like reading a book/magazine or having a chat with another person.
- Speak with your contact nurse about your feelings.

What you can expect from us:

- We will provide you with a safe environment.
- Your contact nurse will go through your individual treatment plan with you, and offer support to manage your feelings that will help you feel more in control.

You have a right to feel safe.

that may lead to behavioural disturbance is the first stage in the acceptance by staff of service user moves towards integral self-intervention. What was clearly identified during the process described in this paper, is the need for sensitivity and understanding of the complexity of the circumstances in which we find ourselves, either as service users or staff. An appreciation of this complexity is important when considering strategies to enhance broader understandings within the workforce.

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Acknowledgements

Service users and staff of Austin Health who participated in this project are acknowledged for their commitment. The pilot study research team comprised: Jeffrey Daniel, David Castle, Peter Bosanac, Mervyn Love, Daniel Nicholls, Sundram Pillai and Max Tan. Appreciation is expressed to Oksana Cymbalak for chart design, and to Robyn Dwyer who facilitated the staff focus group.

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Absconding from secure units: a review and description of an 'absconding pack' – implications for wider use

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Abstract

In the present climate of risk assessment and management, the risk posed by the mentally disordered offender might be considered central to the role of mental health professionals working with this population. To discipline risk is a challenge that involves making something uncertain somehow quantifiable, so that decisions about the short–longer-term future of another individual can be made and justified (Rose, 1998). Although unauthorised patient absence from secure hospitals in the UK is an infrequent phenomenon, there are often prominent repercussions, perpetuated by negative media coverage, often resulting in responses from the highest political level. This article will attempt to highlight known statistics on absconsion from secure hospitals, including frequency and consequences, and impact of negative media coverage and various reviews, inquiries and proposed recommendations, which have resulted in the proposed reforms of the Mental Health Act 1983. Finally, the article will outline the work conducted by the social work department at Chadwick Lodge and Eaglestone View (medium secure hospitals) in the development of an 'absconsion pack'. This development provides an example of safe practice through its use of collaborative inter-professional and multidisciplinary team working, resulting in a procedure that should reduce the risks in the event of an absconsion from a medium secure hospital. The wider implications of this work will be discussed.

Key words

absconsion; secure hospitals; multidisciplinary team working; risk management; absconsion pack

Introduction

Published research reveals that there were seven escapes from the high secure hospitals between 1976 and 1988 (Huws & Shubsachs, 1993), and a further 12 breaches of physical security between 1989 and 1994 (Moore, 2000). Fourteen escapes from one particular high secure hospital between 1985 and 1996 occurred from sites other than the part of the hospital surrounded by the six metre well (Brook *et al*, 1999). Furthermore, Brook *et al* (1999) documented the very low rate of absconding from the thousands of rehabilitation trips undertaken by patients from Ashworth Hospital over an 11-year period, and the 'minimal' risk to the public during the incidents.

Numerous well-reported enquiries into homicides committed by mentally disordered offenders (Richie & Lingham, 1994; Gabbott & Hill, 1994; Asthal *et al*, 1998) and the murders of Lynn and Megan Russell in 1996, have undoubtedly fuelled public fears about dangerous people in their midst. Additionally, fears about the behaviour of absconders at liberty are not entirely without foundation. Two serious offences (rape and manslaughter were committed by patients who had absconded from an English high secure hospital between 1976 and 1988 (Huws & Shubsachs, 1993). However, the relative risk of harm to others following absconsion by a high hospital patient was found, in the same study, to be extremely small. When the absconder has been detained because he or she has violent, dangerous or criminal propensities, this often attracts media, public and political attention (Brook *et al*, 1999). Reports about incidents by the media can have a marked impact on public opinion, which in turn, may influence decision-making regarding rehabilitation and other policy at the highest level (*Guardian*, 1994).

Current policy development in secure care has been greatly influenced by the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital and subsequent report, the *Fallon Inquiry* (Fallon *et al*, 1999).

The Fallon Inquiry was particularly critical of social workers at the hospital, which suggested that they had lost appropriate focus and clarity of role. A review group was established to look at the provision and function of social work services in high secure hospitals and issues that may also be relevant to the development of social work services in medium secure units. Specific factors for consideration addressed the future function of social work services with the high secure hospitals including their relationship to local authority social service departments, relationship to local probation services, and the responsibilities of local authorities and probation services in planning leave of absence or discharge arrangements for patients (Lewis, 1999).

Social Services Inspectorate inspections of the social work services in the high secure hospitals and *The Lewis Report* combined to influence the publication of the *National Standards for the Provision of Social Care Services in the High Security Hospitals* in August 2001 (DoH, 2001). This report outlined the primary and secondary functions of the social work service. The primary functions highlighted the need to balance issues of public protection and the rights of the individual patients, including personal, familial, social, cultural and environmental issues. It also addresses planning the patient's discharge and aftercare with the council that has the primary responsibility, to ensure successful reintegration in the community, as well as public protection and to address the needs of children, victims and other groups who are part of the patient's social network in the community. The secondary function emphasised the importance of multidisciplinary team working within the hospital, which should provide an organisational structure and environment that would best meet the overall aims and objectives of the hospital.

A further report, (Tilt *et al*, 2000) provided an independent review of both physical and relational security at the high secure hospitals, as recommended by the *Fallon Inquiry*. The report addressed a central dilemma or tension for working within a high secure psychiatric hospital, namely that the high security hospitals have clear twin security and therapeutic objectives. The security objectives include the protection of the public, by seeking that patients do not attempt to escape or abscond, and the provision of a safe environment for staff and patients within the hospital (Tilt *et al*, 2000).

The recommendations of *The Tilt Report* had two main emphases being *'an increase in therapy and activity for patients, and an upgrading of physical and procedural security to safeguard the public, staff and patients'* (Tilt *et al*, 2000). Procedural security includes the systems and operational procedures, by which patients are managed, and safe security maintained. With regards to medium secure units, one recommendation called for *'a nationally led review of medium secure provision'*, which will address the capability of such units, such as their ability to contain patients within the unit, rather than successfully rehabilitate them for a return to living in the community.

The social and political context for mental health services is located within the recent growth in public concerns about risk and expectations that professionals will infallibly legislate and act to protect the public from harm, which culminated in the proposed reforms of the Mental Health Act 1983.

Under new legislation, there will be a single set of criteria and processes that will apply to all mental disorders, but within this overarching framework there will be specific recognition of the fact that, for some people, their plan of care and treatment will be primarily designed to manage and reduce high risk behaviours that pose a significant risk to others. Furthermore, the process will also balance the rights of the patient who is undergoing compulsory care and treatment, with the right of the public to be protected from serious harm, which will further enhance compliancy with the Human Rights Act 1998.

The new legislation will also include a new statutory duty covering the disclosure of information about patients suffering from mental disorder between health and social service agencies and other agencies (for example, housing and criminal justice agencies), where it can be justified. This will include cases where there is a significant risk of serious harm to others from the patient. Such information will, of course, be kept confidential by the receiving agencies, except in those limited and specified circumstances where its release is justified, for example, where specific individuals are thought to be at risk of harm from the person concerned and would need to be alerted for their own safety. It is only by effective inter-agency working that the right risk management packages for individuals will be put in place and risk managed in the most effective way. There will also be a duty on health and social service agencies to ensure that appropriate

arrangements for storing and exchanging confidential patient information with other agencies are in place.

As highlighted in *Building Bridges* (DoH, 1995), professional collaboration was required for the operation of the Care Programme Approach (CPA), which applies to all people with serious mental health problems who are accepted as service users of specialist mental health services. The CPA stands to promote best practice by ensuring a multidisciplinary approach, systematic planning, recording and reviewing of service users' care and support, working in partnership with service users and their carers in creating and reviewing care plans, and therefore taking into account any element of risk to service users, carers, professionals and the wider community.

Managing risk is about making good quality clinical decisions to support and sustain a course of action that, properly supported, can lead to positive benefits and gains for individual service users. Furthermore, safe practice indicates that professionals and organisations should have robust systems that allow for valid, reliable and retrospectively defensible risk assessment and management for every service user.

The absconsion pack

Background

Chadwick Lodge (men's services) and Eaglestone View (women's services) are adjacent medium secure hospitals in Milton Keynes and both are divisions of the Priory Group. They provide treatment and rehabilitation for patients, (predominantly mentally disordered offenders), who have been detained under the Mental Health Act 1983. All patients are provided with a holistic approach to treatment and rehabilitation through clinical teams, each consisting of a responsible medical officer (consultant psychiatric), associated specialist, psychologist, occupational therapist, forensic social worker, ward manager, qualified nurses and health care assistants (HCAs). The social work team at the hospital is committed to evaluating policies and procedures on an ongoing basis and consistently identifies and highlights any issues, which may impact on operational procedures, including areas of risk.

In 2006 a patient absconded while on local escorted leave and made his way home to a family member. Immediately following the absconsion there was a four hour delay while the police officers collated the relevant information, which eventually assisted in locating, apprehending and returning the patient safely to the hospital. As part of a 'learning the lessons' approach the social work team identified the need for a procedure to be set in place to facilitate inter-professional working and so deal more effectively with such incidents. Trisha Nichols (Director of Patient Services), Head of Social Work, initiated a meeting with Broadmoor Hospital to discuss issues relating to the absconsion of detained patients. In addition, following the incident, there were a number of discussions with Thames Valley Police. These discussions and further detailed consideration involving staff and patients in the unit resulted in the design and implementation of an absconsion pack.

The objectives of the absconsion pack were two-fold, namely the hospital objectives and the social work objectives. The hospital objectives were to:

- promote multidisciplinary team working decisions
- promote proactive risk assessments/management of all patients
- maintain clearer communication between all the different disciplines
- improve the response time taken to provide the necessary patient information to the police
- enhance collaborative inter-professional working to ensure public protection is adhered to at all times
- maintain agreed local working procedures with the police
- manage the risk to patients and public safety more effectively.

The social work objectives were to:

- work in partnership with patients through encouraging patient involvement
- bi-annually update the information contained within individual absconsion packs in conjunction with the clinical team following CPA meetings
- annually review the absconsion pack through reflection and evaluation, considering how the process has worked and any areas open to improvement
- balance the potential risks to patients and public safety
- represent best practice
- enhance multidisciplinary team working
- enhance collaborative and proactive inter-professional working
- adhere to the GSCC (General Social Care Council) Code of Practice (2002) throughout the entire process.

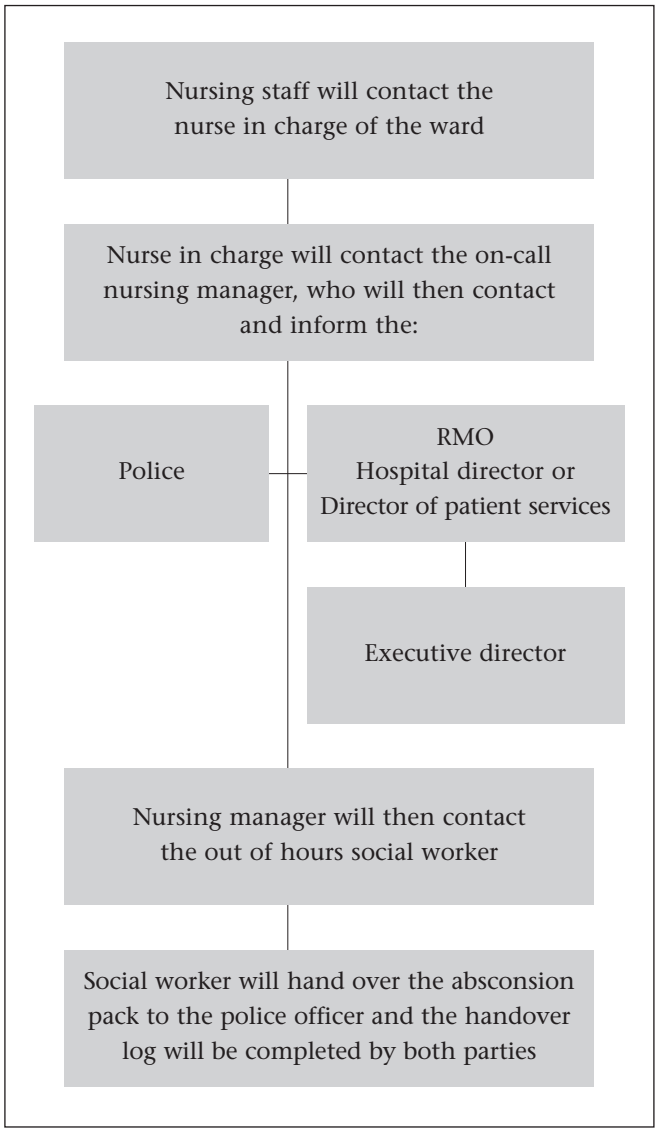
The purpose of the absconsion pack was discussed at a patients' forum meeting (this included patient representatives from each ward) and this was followed up by discussions between the social workers and their individual patients. All patients were issued with a declaration to read, which highlighted the procedure and addressed issues of confidentiality, and the safe storage of collated information. This further addressed concerned patients who felt highly stigmatised by negative media coverage. Patients were then asked to sign a disclaimer, which stated whether they wished to receive an additional photograph (see below) and highlighted that they would assume responsibility for this.

Photographs were taken using a digital camera, which were printed and laminated by the social work department. All photographs were then deleted from the camera. The patient background details and risk assessments were completed by the social workers in conjunction with the clinical team and the completed information sheets were laminated (to ensure they were robust and weatherproof). The laminated photograph and information sheets were then placed in the absconsion pack zipped folder, sealed using security tabs and placed in a locked cabinet, for which there are only two nominated key holders. Finally, an absconsion log sheet was created for each house. In the event of an absconsion, this records the date, patient's name, name of the person handing over the absconsion pack to the police, and the receiving police officer's details. For all new patients to the hospital the absconsion pack procedure is introduced during the initial patient assessment by the allocated social worker.

There are three information sheets in total. The first sheet contains 'patient background details', including name, date of birth, known aliases, height, weight, distinguishing features (hair, eyes, tattoos, body piercing and scars), details on known behaviours, details of responsible professionals, index offence and where it was committed, last known addresses, nearest relative, mental order category and whether the patient is a child sex offender. The second and third sheets jointly contain the 'risk assessment' including categories of physical health, current treatment, patient status (media/political profile), behaviour, identification of high risk groups, patient attitude, recent events that may have had a negative impact, leaves of absence (last 12 months), relationships, other factors (including child protection and victim issues) and patient's financial situation.

A written policy has been developed that is readily accessible for reference by all staff members. ***Figure 1*** illustrates the procedures from the time immediately following a patient absconding, to the handover of the absconsion pack to police. In addition to the professionals identified in ***figure 1***, other agencies that need to be notified are the Health Care Commission, Home Office, the funding authority, and the probation service (where applicable). Throughout this process there is, of course, an ongoing dialogue with the patient's family.

Figure 1: The procedure in the event of an absconsion



In addition, and in order to promote good practice, a series of workshops for all grades of staff is offered by the social work department. Ongoing training is offered during induction training for all new employees.

Current compliance with the procedure is 99% for the men's services and 98% for the women's services. The reasons highlighted for non-compliance were:

- clinical team assessed the patient as being of 'no risk' of absconding
- refusal without an explanation.

However, three per cent of patients agreed to the pack, but not the taking of photographs. In these cases, the information sheets have been completed and placed in the absconsion pack zipped folder.

Figure 2 sets out the financial implications for the hospital, including the initial set up and ongoing costs. Savings are anticipated in the reduced number of staff involved following an absconsion, and also for the police in a reduction of time taken to share the details with other police forces, who may need to be notified.

Figure 2: Financial implications of setting up the project

- One full time staff x 5 working days = £410.96
- 350 sheets of paper used = £49.95
- **400 laminate pouches = £140.00**
- Amount used 308 x 0.35 per pouch = £107.80
- 100 large flat security wallets x £10.00 = £1000
- Security seals £12.25
- Camera and printer already in place
- Total cost = £1,568.70
- Individual cost per patient £20.37
- **Ongoing costs per patient**
- Now incorporated into the initial social work assessment.
- Time = collation of information and photograph one hour = 10.95
- Materials = £ 11.85 minimal ongoing costs

Following implementation in January 2007, the absconsion pack was presented to the Thames Valley Police, who identified the absconsion pack as an example of 'good practice'. The social work department achieved the Priory 'Team of the Year' award for the work completed on the absconsion pack.

In February 2007, a patient absconded and the absconsion pack procedure was implemented. Police were in receipt of all details within 30 minutes, and their feedback was that it was a 'textbook exercise', which provided a very valuable and successful early evaluation.

It is anticipated that the absconsion pack will be introduced in all secure hospitals within the Priory Group. To date, other facilities have also shown an interest and currently there are discussions on how it can be adapted to any secure service, with the Priory Group. In addition, various outside organisations have shown an interest and the social work department are looking into opportunities to share the information.

The absconsion pack is intended to be used in the care of all patients at Chadwick Lodge and Eaglestone View. It is seen as the catalyst to enhance collaborative working and proactive risk assessments/management, both within the hospital and with other agencies and, therefore, to promote safer working practice, which addresses some of the concerns raised by *The Fallon Inquiry* and recommendations from *The Tilt Report*. Furthermore, the primary and secondary functions required from the social work service within a secure hospital, as outlined in the *National Standards for the Provision of Social Care Services in the High Secure Hospitals* have been executed through the extensive collation of information detailed in the information sheets, multidisciplinary team working and discussions with patients. The collaboration of patients in the implementation of the absconsion pack illustrates proactive consideration of the new proposed reforms of the Mental Health Act 1983 and adherence to the GSCC Code of Practice.

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Acknowledgements

Thanks to the support of all the social work team, and Marilyn George for their dedication to ensure this new project met the requirements in law to protect our patients care and that of the general public at all times.

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Implementing behavioural activation in inpatient psychiatric wards

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Abstract
Behavioural activation is a contemporary behavioural treatment for depression that has the potential advantages of being more readily adopted in psychiatric inpatient environments than more complex psychological treatment approaches and requiring less intensive training than these approaches. In this article the theoretical and empirical foundations of behavioural activation are described along with an outline of the therapeutic process and key interventions used. Consideration is then given to factors influencing the implementation of BA in psychiatric inpatient environments.

Key words
Behavioural activation; acute inpatient environment; depression; psychological treatment approach

Introduction and policy context
There are a range of policy drivers to both improve the therapeutic care delivered in inpatient settings and increase access to psychological therapies for all users of mental health services. The National Service Framework for Mental Health (DoH, 1999) acknowledged a need for standards for hospital care. Areas highlighted included the physical environment, and the need to restore the therapeutic status of acute admission wards. In the Department of Health Guidance *Choosing Talking Therapies* (DoH, 2001) service users are advised that, *'You should be given the option of talking therapy regardless of your diagnosis'* (p4), and that *'people with complex and long-term mental health problems, and those whose troubles may appear less severe, have an equal need to talk'* (p4). These principles are repeated by the National Institute for Mental Health in England (NIMHE) who highlight the need for service users to be able to make choices about the care they receive including having access to psychological therapies (NIMHE, 2006). NIMHE particularly identify the needs of clients in inpatient facilities saying, *'They should get choices in the types of therapeutic activities they can take part in while on the ward'* (p4), suggesting that inpatients should have a choice of individual and group psychological therapies, exercise and participation in creative arts. The Department of Health identify intensive cognitive and behavioural psychological approaches, recreational activities, regular exercise, and life skills training as core interventions in the treatment of service users while inpatients on psychiatric intensive care units in acute services (DoH, 2002a).

Mental Health Nurses (MHN) have been identified as a key part of the workforce that possess the foundation skills common to all psychological therapies (DoH, 2006), using these regularly to form and sustain relationships with service users. This review of MHN identified inpatient care as needing particular development, with lack of therapeutic activities and limited time in direct contact with staff being frequently cited by service users as concerns (DoH, 2002b). Adult acute inpatient care should include the provision of meaningful activity determined within an individual care plan negotiated with the service user, and that the ward should be managed and organised *'to foster a milieu and culture of engagement and to maximise the time that staff spend therapeutically engaged with service users'* (DoH, 2002b p13). It also emphasises that these activities should be available to the service user in the evening, at weekends, and both on and off the ward.

Mental health service providers have a statutory duty to provide care recommended by the National Institute for Clinical Excellence (NICE). Current guidance on the treatment of depression in primary and secondary care (NICE, 2004) describes the types of treatment that should be offered to service users. Cognitive behavioural therapies are recommended in the treatment of mild, moderate and severe depression and for those people

with recurrent, chronic and treatment resistant depression. These guidelines make no distinction on the setting for intervention other than to say that those people requiring inpatient care will have the most severe depression and may be at a high risk of suicide or self-harm. As such, clients in inpatient services should have equal access to psychological therapies to those receiving community services based solely on their clinical need. The expansion of the availability of psychological therapies is a current government priority for mental health care (Appleby, 2007).

Behavioural activation (BA) is a contemporary behavioural treatment for depression that has the potential advantages of being more readily adopted in psychiatric inpatient environments than more complex psychological treatment approaches and requiring less intensive training than these approaches (Jacobson *et al*, 1996; Martell *et al*, 2001; Hopko *et al*, 2003; Dimidjian *et al*, 2006). There is some evidence that BA may be more effective than cognitive therapy for more severely depressed outpatients (Dimidjian *et al*, 2006).

Behavioural activation

Despite early interest in the application of behavioural approaches to the treatment of depression (Lewinsohn *et al*, 1973; Ferster, 1973), the most used and most researched cognitive behavioural treatment for depression became the cognitive therapy described by Beck and colleagues (Beck *et al*, 1979). In cognitive therapy three main treatment components are utilised – activity scheduling, identification and challenging of automatic thoughts, and work to examine the impact of dysfunctional assumptions. Jacobson and colleagues (Jacobson *et al*, 1996) carried out a component analysis of cognitive therapy, in which 150 depressed participants were randomised to receive either activity scheduling alone, activity scheduling plus an automatic thoughts intervention, or the full cognitive therapy treatment package. The results demonstrated no clinically or statistical significant difference between the groups indicating, for some people at least, the full cognitive therapy package is not necessary. More recently a larger RCT (Dimidjian *et al*, 2006) carried out a comparison of behavioural activation, cognitive therapy or antidepressant medication in 241 clients with major depressive disorder. The results of this trial again showed no clinically or statistically significant differences between behavioural activation and cognitive therapy for moderately depressed clients. For more severely depressed clients, behavioural activation and antidepressant medication were equally efficacious, and both superior to cognitive therapy.

Hopko *et al* (2003) designed a behaviourally based therapy, brief behavioural activation treatment for depression (BATD), and compared it with supportive psychotherapy in an inpatient psychiatric population. BATD involves the systematic exposure to positive activities, through the use of a graded hierarchy of activities, with the aim of alleviating depressive affect. Twenty-five depressed psychiatric inpatients were randomised to either BATD (n=10) or SP (n=15), with the results showing a mean decrease in the BDI of 16.0 in the BATD group compared with a change of 6.8 in the SP group ($p < 0.5$). Hopko and colleagues go on to suggest that this intervention is ideally suited for inpatient settings given that it requires limited time and training for its implementation.

Cuijpers, van Straten and Warmerdam (2007) recently completed a systematic review and meta-analysis of randomised controlled trials that evaluated the effect of activity scheduling procedures in adults experiencing a depressive disorder (or elevated depressive symptomatology) compared to a control condition or another treatment (psychological or pharmacological). Sixteen studies, involving a total of 780 subjects across all conditions, were included in the meta-analysis. The results of this showed that post-treatment comparisons with control conditions produced a mean effect size for activity scheduling of 0.87 (95% CI: 0.60 to 1.15), indicating that activity scheduling is an effective treatment for depression in adults. Comparisons to other treatments (18 contrasts in total) resulted in a pooled effect size showing the difference between activity scheduling and other psychological treatments of 0.13 (95% CI: -0.05 to 0.30), indicating this difference is not significant. In 10 studies, activity scheduling was directly compared to cognitive therapy, with the pooled effect size demonstrating the difference between treatments of 0.02 (95% CI: -0.21 to 0.25), which is not significant, with a similar pattern at follow-up intervals. Several methodological limitations apply, such as the low number of studies, but the overall direction of results was

the same. The equivalence of activity scheduling and cognitive therapy is discussed in terms of common factors research.

Two papers report the effects of a treatment group for depressed outpatients, one in a community mental health setting (Porter *et al*, 2004), and one in a specialist psychotherapy service (Curran & Houghton, 2007).

These results have stimulated interest in the behavioural components of treatment for depression, with specific therapist manuals (Lejuez, 2001; Martell *et al*, 2001), and client self-help materials available (Addis & Martell, 2004; Veale & Willson, 2007).

Theoretical background

The current behavioural activation approach adopts and develops the behaviour analytic account of depression outlined by Ferster (1973), that views many of the symptoms of depression as a consequence of specific features of a person's interaction with their environment. Of particular interest is not only the type of behaviour that the depressed person is displaying, but also the consequences of this behaviour. For Ferster, some of the behavioural symptoms of depression (eg. crying, complaining, withdrawal) could be viewed as serving the function of avoidance, and subsequently maintained by the temporary relief they may bring about. This view of 'symptoms' as potentially serving a useful purpose to the individual experiencing them exemplifies behavioural approaches' attention to the functions of behaviour rather than an exclusive focus on the presence of symptoms as indicative of some supposed underlying pathology.

It is crucial here to have some understanding of key behavioural terms that form the foundation of the behaviour analytic view of depression. These terms are **positive reinforcement, negative reinforcement, punishment, response cost and frustrative non-reward** (see ***box 1*** for further explanation). These processes are termed 'contingencies of reinforcement' and refer, colloquially, to the patterns of reward and punishment that are present in everyone's everyday life. It is important to note here that 'rewards and punishments' are not only provided by external sources. In the behavioural literature the term 'environment' can be used to denote specific aspects of a person's internal experience, including thoughts and feelings.

Box 1: Key behavioural terms (adapted from Skinner, 1969)

Positive reinforcement: The consequence of an action is that something (usually positive) is added to the person's environment, leading to the action being more likely to occur in the future.

Negative reinforcement: The consequence of an action is that something (usually unpleasant) is removed from the person's environment resulting in the behaviour being more likely to occur in the future.

Punishment: The consequence of an action is that something (usually unpleasant) is added to the person's environment, resulting in the action being less likely to occur in the future.

Response cost: The consequence of an action is that something (usually pleasant) is removed from the person's environment, resulting in the action being less likely to occur in the future.

Frustrative non-reward: A reward that usually follows an action is not available, resulting in a reduction in the occurrence of that action.

Applied to the clinical area, two of the most relevant contingencies of reinforcement that are likely to lead to the symptoms of depression are low levels of positive reinforcement (particularly for non-depressed behaviour), and high levels of negative reinforcement. Here it can be seen that the person is not engaging in many activities that they get something meaningful back from, and that they are spending a lot of time removing unpleasant experiences, usually through various forms of avoidance. Given their success in terminating aversive experiences or sensations, the use of avoidance strategies makes sense. Unfortunately many of the avoidance strategies employed by clients attempting to manage their mood may lead to longer-term unhelpful consequences, ranging from a lack of contact with any sources of positive reinforcement in the case of behavioural withdrawal, to the physical consequences of prolonged drug or alcohol use.

With these two processes in mind, the goals of behavioural activation are to help the client engage in

more positively reinforcing activity, and to reduce patterns of avoidance that are limiting their ability to engage with activities that they are likely to find meaningful or rewarding.

In cognitive behavioural therapies cognition is generally given a central role in the origin and maintenance of psychological distress. In BA, in marked contrast, the thinking patterns seen in depression are seen as further symptoms of depression, rather than something that must be changed in order for the disorder to be resolved. Indeed, in behaviour analytic approaches, thinking and other descriptions of the process such as ruminating are seen as further examples of behaviour. Consistent with behaviour analysts' emphasis on the functions of a behaviour (colloquially – the purpose it serves), rather than its form (or what it looks like), thinking is examined from a functional perspective – 'How is thinking this way helping you?' or 'What is the effect of thinking this way on what you do?' This has major implications for the treatment process, so that the primary focus of therapy becomes about helping people engage with a meaningful, rewarding life rather than about symptom elimination, thought replacement or challenging assumptions before being able to start living.

In a recent literature review Longmore and Worrell (2007) examined the evidence for some of the central tenets of cognitive therapy, finding that there was little evidence that cognitive interventions significantly increase the effectiveness of therapy and little empirical support for the role of cognitive change as causal in the symptomatic improvements achieved in CBT. They also noted that there was limited evidence that the changes seen in cognitive therapy can be wholly attributed to the earlier phases of therapy when the behavioural components are delivered. These authors conclude that cognitive interventions are not a necessary component of therapy.

Clinical delivery of BA

In the Jacobson and Dimidjian studies, BA was delivered in 24 clinical sessions over 16 weeks. When implementing this form of therapy, care must therefore be taken not to oversimplify the intervention, and to ensure that the client is given adequate time to develop an understanding of the use of the specific techniques. Here we provide a brief description of the content of the general approach to behavioural activation (Martell *et al*, 2001; Addis & Martell, 2004), with specific consideration to its implementation in the psychiatric inpatient setting below.

Assessment

In addition to more general assessment procedures, there are two central assessment processes in BA. The first of these is activity and mood monitoring, where clients are asked to keep a diary of the main activity of each hour across a whole week along with a brief description of their mood at that time. It is often helpful if a mood rating of between 0 and 10 is also provided. The activity and mood monitoring process can be used to identify a wide range of features of the client's experience over a given time period, including their general activity level, the breadth or restriction of activity, the range of feeling experienced, the intensity of any emotions and most importantly whether there is any link between activity and mood.

The second key assessment process is a form of functional analysis. Here events and experiences are examined to obtain information on their antecedents, behaviours, and consequences. In a functional analysis (eg. Sturmey, 2007) the main features of a client's experience at a particular point in time are examined to highlight key behavioural patterns and contingencies of reinforcement that may be maintaining their problem. In BA, this is translated into an acronym 'TRAP'; trigger, response, avoidance pattern.

Formulation

The BA formulation is developed after the initial assessment and once the patterns of reinforcement have been identified. In practice this takes at least three clinical sessions to develop, and is constantly evolving as more details of the client's situation develops.

An important point here is that while the general approach is towards increasing the availability of positively reinforcing activities, the activities that will function as positive reinforcers for each individual client will be varied. For this reason, the identification of specific goals and alternative coping strategies should be identified in collaboration with the client, and efforts made by the therapist to support the client in their implementation of change techniques. This has important implications for the work done in implementing the approach in inpatient settings, where tailoring activities to individual client need may have important resource implications.

Treatment process

The BA treatment process, as noted above, aims to increase the number of positively reinforcing events in a client's life and to reduce the avoidance patterns that generally get in the way of this. With this in mind, the initial stages of treatment focus on developing alternative behavioural patterns to the withdrawal and avoidance typically seen in depression. Initially, clients are asked merely to make one change in behaviour based on their activity and mood monitoring charts. As awareness of avoidance patterns develops, specific situations are targeted in which the client can identify and practice alternative coping techniques. The identification of alternative coping techniques is aided through the use of an additional acronym that relates directly to those used to identify avoidance patterns (the 'TRAP). Here the self assessment procedure is 'Trigger, Response, Alternative Coping – or TRAC, leading to the clinically useful reminder 'Get out of the TRAPs and get back on TRAC'. In the clinical experience of the authors this activity is of great utility in clinical work.

Grading activities is important, so where a client identifies a larger goal they would like to work towards, specific smaller steps that work towards this goal can be identified and planned. The use of a graded hierarchy of difficulty (as used by Hopko *et al*, 2003) or a Subjective Units of Discomfort Scale (or SUDS) (Addis & Martell, 2004) can aid in the identification and planning of the steps.

When selecting activity, it is helpful to select those that will be naturally reinforcing, that is those that do not rely on external sources of reinforcement, such as praise from others, or tokens (although see Hopko *et al*, 2003, in which a token economy procedure was used). The use of arbitrary reinforcers may be appropriate if identifying naturally reinforcing activities is difficult, or the client's symptomatology (eg. anhedonia) suggests that they are not likely to experience much reward or pleasure. It is important to bear in mind that some of the client's previous meaningful activities may not be available to an inpatient; it is then necessary to establish what it was about the activity that was satisfying for the client.

A recent report on the implementation of BA (Curran & Houghton, 2007) has added an assessment of the client's values to the therapy process, based on approaches within another contemporary cognitive behavioural therapy, acceptance and commitment therapy (Hayes *et al*, 1999). While values assessment is not a feature of the original BA approach our experience suggests that its inclusion in BA helps to develop a wider context for the identification and selection of activity that will be meaningful and rewarding.

As the client and therapist continue working together in a graded way towards helping the client engage in more meaningful and rewarding activity, other additional techniques can be introduced where they assist the goals of therapy. Examples of these techniques include problem solving, social skills training, exercise, sleep, and hygiene procedures.

Case illustration

Behavioural activation is currently being implemented as part of a depression treatment protocol in acute inpatient wards in the authors' workplace setting. Evaluation of the project is underway. The illustrative case study (***box 2***) describes the process of treatment for a psychiatric inpatient.

Implementation issues

Clinical

The authors' (particularly PL) experience of the implementation of BA in a psychiatric inpatient setting has identified a number of practical issues that facilitated or acted as potential barriers to implementation. For the sake of clarity, these are summarised below with reference to the individual client presented, but continue to apply to wider adoption of the approach across settings and clients.

- There was a lack of consistency in use of approach within the team. Some staff would firmly encourage the client to undertake the agreed activities, while others would not persevere if he was reluctant to comply, stating they felt they were 'bullying' him. This was resolved through regular supervision and open debate about the role of nursing staff in encouraging clients to engage in therapeutic activity.
- Care-planning the approach, and making colleagues aware of the care plan was essential in order to maximise consistency.
- The client's inability to identify treatment targets, particularly in the early stages; this placed the onus on staff to identify targets initially.
- The approach was discussed and reviewed in MDT meetings each week; the consultant psychiatrist was enthusiastic about the approach (although initially a little sceptical), and quite prepared to allow time for its effects to be seen.

Box 2: Case illustration

Dave, a 62-year old man, was admitted to the acute psychiatric inpatient ward by his care co-ordinator because of severe self-neglect secondary to chronic depression with psychotic features. Earlier in his life, the client had enjoyed a busy life working and being actively involved with a classic car club, and had many friends. Although the onset of his problems was unclear, it seemed he had had a car crash and stopped driving altogether, losing touch with his friends and giving up work. Having never married, he lived with his widowed mother, and when she died the client's mental health went into further decline. On admission to hospital, the client was very withdrawn, unkempt and unable to develop conversation beyond expressing anxieties about his bowels (he had diverticular disease), and stating that his head was made of wood and he did not have long to live; he would state that getting out of bed, for instance, would hasten his demise. He expressed no hope for the future. He spent the vast majority of his time in his bed area, and had no interest in attending to his personal hygiene, dressing or eating. He was very uncomfortable in the presence of fellow clients on the ward, and would therefore avoid the ward dining room at mealtimes. There was little spontaneous interaction with staff, unless it was to draw attention to his health fears. Very little progress was made for some months, with little change from the presentation on admission. Medication included an antidepressant (citalopram) and an antipsychotic (risperidone). Following foundation training in CBT, a staff nurse decided to offer CBT to this client, under the supervision of the clinical lead for inpatient CBT (PL). Given the severity of his depression, poor insight, cognitive impairment and his complete lack of meaningful activity, even in activities of daily living, a behavioural activation (BA) approach was selected. A simple, structured activity schedule was designed in collaboration with the client, who was given a simple treatment rationale and consented to the treatment. Initial graded activity focused on activities of daily living, such as getting up by a certain time each morning, getting washed, getting dressed, having breakfast, and so on. Over time, the activities were increased in complexity and frequency, and pleasurable activities based on his individual preferences were introduced – for example, reading articles in classic car magazines and discussing them with ward staff. The physical scope of activities was also increased over time, to encourage excursions off the ward and into more 'normal' environments in the outside world. The treatment took place over many weeks; at the time of writing the client is still in hospital, but plans are being made for his discharge home. He now spontaneously attends to his activities of daily living, is objectively brighter in mood, engages in spontaneous conversations, socialises with fellow clients and expresses far less health anxiety.

- Some nursing staff were sceptical about the efficacy of the approach, claiming the client's improvement was due to medication (in fact, over the course of the BA treatment his antipsychotic medication was reduced considerably and antidepressant use unchanged).
- In practice, a combination of graded activity and graded exposure took place, addressing both the depression and the social and health anxieties, indicating wider adoption of approach behaviours.
- Regular clinical supervision to all staff involved was provided throughout the treatment. Emphasis was placed on patience, a graded approach, offering positive reinforcements for desired activities, sharing work with ward colleagues, positive reinforcement (praise and increased job satisfaction) for staff as the client progressed.

Client selection

With regard to the selection of clients for inpatient BA, we would develop the suggestions of Thase and Wright (1991) (when talking about implementing CBT) that BA is an appropriate treatment for non-psychotic unipolar major depression, particularly for clients who have refused, cannot tolerate or have not responded to antidepressant medication.

Organisational

Delivering inpatient psychological therapies requires a different approach than the traditional one-hour, once a week that is seen as typical of adult outpatient psychotherapy, with variable and often unpredictable lengths of admission and lack of diagnostic specificity a feature of inpatient environments (Durrant *et al*, 2007).

Given the fact that clients hospitalised for depression may have more severe symptoms, but the length of contact with staff delivering therapy may be notably shorter, consideration needs to be given to making therapy more frequent, but at a slower pace (Thase & Wright, 1991). In their inpatient work Hopko *et al* (2003), for example, delivered therapy in three 20-minute appointments each week.

Clear consideration must be given to the range and type of activities that clients hospitalised for depression may need to be engaged in if they are to maximise the possibility of positive reinforcement. The NICE guidelines on the management of depression suggest that activities should be provided that are conducive to recovery from depression (p39). The precise nature of the activities that will be conducive to this recovery will vary according to each individual, their values and their goals. Therefore, a range of activities should be possible, and which activities the client engages in should be based on a careful understanding of their individual situation. The use of generic group-based ward activities is of relatively limited value in the context of an individualised formulation and treatment plan.

In the authors' setting, BA is being implemented on adult acute psychiatric inpatient wards as part of a project that aims to increase the availability of evidenced-based psychological therapies in those environments. Implementation has required specific personnel to champion the project, to become trained in the approach and to provide specialist supervision to staff involved in the clinical delivery of BA. In the adult outpatient setting, the implementation BA is being developed through mental health professionals working alongside specialist cognitive behavioural psychotherapists.

The importance of involvement of the multidisciplinary team cannot be over-emphasised (Thase & Wright, 1991). Specific professionals who have skills and experience in facilitating the provision of meaningful activity engagement (eg. occupational therapists) can be involved especially in the early stages of treatment where clients' ability to leave the unit may be curtailed for risk management purposes. The multidisciplinary emphasis should include those with whom the client may have contact following discharge from hospital, so that a comprehensive discharge plan can be developed, and continuity of therapy can be facilitated. In the authors' experience, providing staff are sufficiently trained and supervised, the implementation of BA can be done by a range of mental health professionals who have skills in therapeutic engagement with clients experiencing depression. This, of course, needs to be substantiated by evidence, and is the subject of future empirical work.

Conclusion

The provision of psychological therapies in psychiatric inpatient wards is a focus of current mental health policy. BA has the potential to be a suitable psychological therapy for inpatient psychiatric environments, as it is relatively less complex than other forms of psychological treatment and may therefore be better suited for clients experiencing more severe depression. Additional benefits, such as less intensive training required, have been proposed, although clear consideration needs to be given to the provision of and access to meaningful activity that can be implemented consistently in a graded collaborative way.

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The challenges of developing dual diagnosis capabilities for acute inpatient staff

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Abstract

Dual diagnosis poses particular challenges for inpatient mental health services. Workers have low levels of training, clinical experience and support to deliver integrated care that combines mental health and substance use interventions. In addition, inpatient workers have to balance being therapeutic with ensuring that illicit substance use does not occur on the wards. This often leads to confrontation and poor engagement.

In order to improve the capabilities of the workers to deliver more effective interventions for this group of service users, dual diagnosis training should be a high priority for acute inpatient services. However, there are a number of challenges in the implementation of this including lack of resources to fund training and specialist roles, lack of time to attend training (and supervision), and lack of time to implement learning in routine care.

This paper will describe the policy drivers for the improvement of dual diagnosis care in acute psychiatric inpatient services, and how two initiatives in London are overcoming some of the obstacles and showing some promising initial outcomes. This paper will make recommendations for future research and developments.

Key words

dual diagnosis; acute inpatient; staff training; mental health; substance use

Background

Despite the increasing awareness of the issues of combined mental health and substance use problems (dual diagnosis) it remains a serious challenge for service provision. *The National Service Framework – Five years on* report (DoH, 2005) highlights dual diagnosis as a high priority for mental health service development. The outcomes for people with dual diagnosis are likely to be poorer than for those with a single diagnosis and the risks of harm to self and or others are substantial. In *Avoidable Deaths* (University of Manchester, 2006), it is reported that 27% of suicides and 36% of homicides were committed by those with mental illness who also had drug and alcohol problems. The suicide rate for those with substance use has increased in the last five years from 23% to 27%; and two-thirds of these occurred while the person was an inpatient. Half of homicides were committed by those with a mental illness who also had a drug or alcohol misuse history; 20% were alcohol dependent and 10% were drug dependent.

In the UK, the government policy guidance document (DoH, 2002) has advocated 'mainstreaming' as a model for service provision. This proposes that people with serious and enduring mental health problems (such as schizophrenia) should have both their mental health and substance misuse problems addressed within mental health services (with some input from specialist substance use services as required. Likewise, someone with a primary substance use problem (with a common or mild to moderate mental health problem such as anxiety) should be cared for in substance use services with input from mental health services as required.

However, if mainstreaming is to be effective, then the workforce issues need to be urgently addressed. Mental health and substance use workers lack the capabilities to offer this service user group comprehensive care in one service. This is due to a lack of pre-registration training in dual diagnosis issues, lack of availability of post-qualifying training in dual diagnosis (O'Gara *et al*, 2005) and the rigid service boundaries that exist that may be prohibiting workers from providing integrated care (Johnson, 1997). In addition, workers don't have a clear

idea of other services roles and referral criteria. This leads to inappropriate referrals and service users falling between the services (Hughes, 2006a). Disengagement with services has been associated with increased likelihood of suicide, self-harm, violence and offending (Wright *et al*, 2000).

Dual diagnosis training research

In terms of dual diagnosis training, there have been three UK research studies that have sought to examine the effectiveness of providing basic training to community mental health workers with the aim of improving attitudes and skills of the workers and in turn having some positive effect on service user outcomes. The COMPASS project in Birmingham (Graham *et al*, 2006) was established to provide training, consultation and practice development for services around dual diagnosis. They undertook a quasi-experimental study of training and supervision for assertive outreach teams. This comprised six half-day training sessions, weekly input at team meetings, joint assessments, and supervision. They found some positive benefits for the service users including better engagement and more motivation to change substance use. The workers reported more confidence in working with this group.

In south London, community mental health workers were randomised to receive five-day training, plus monthly supervision over an 18 month period (Johnson *et al*, 2007). Service users with dual diagnosis on their caseloads were recruited and data was collected on their mental health and substance use. After 18 months, the training group workers showed significantly higher levels of self-rated confidence and increased knowledge compared to the control group (who had no additional training). There was no major impact on service users apart from a significant improvement in psychiatric symptoms in the service users who had worked with trained case managers.

In north London (the CODA project) whole community mental health teams were randomised to receive five-day training (same as the COMO project) or two members of the team completed a 12-day validated dual diagnosis course at the Institute of Psychiatry, King's College London (Hughes, 2007). There were no significant differences in outcomes between the two training methods at 18 months follow-up. However, the whole team group showed significant increases in attitudes and self-rated confidence from baseline to follow-up. There was no difference in service user outcomes.

Implications for inpatient psychiatric workers

These three studies taken together demonstrate that it is difficult to achieve clinically significant outcomes based on relatively brief training courses. In addition, all these studies have focused on community based teams. However, dual diagnosis issues are particularly pertinent and in some ways more challenging for workers in acute psychiatric units. Phillips and Johnson (2003) conducted a prevalence study of substance use by inpatient service users in inner London psychiatric units. They found that 49% of people with a psychotic illness also had a substance misuse problem. Most (83%) admitted that they had used drugs at some point during the current admission, and 47% had obtained substances from another inpatient. Others (19%) reported obtaining substances from friends or relatives who had visited the unit. The conclusion of this research is that substance use is now commonplace in psychiatric units, and that services need to consider carefully how this is managed.

The Chief Nursing Officer's review of mental health nursing (DoH, 2006a) calls for all mental health nurses to receive training to manage substance misuse issues in mental health settings. In addition, recommendation 12, regarding inpatient facilities, calls for the development of specialist roles within inpatient nurses including substance misuse to provide expertise, support and advice.

In October 2006, the Department of Health launched guidance on the management of dual diagnosis in inpatient and day hospital settings (DoH, 2006b). This sets out guidance on a number of pertinent issues regarding substance misuse including searching, legal issues, confidentiality, and detoxification, and makes reference to appropriate guidance and policy documents. There is a section on staff training and it calls for specific programmes of training that (ideally) should be multidisciplinary and multi-agency, and should include assessment, treatment and care planning. It also advocates provision of opportunities for inpatient staff to spend time in specialist services in order to gain skills, but also to foster links. The guidance is less specific about how inpatient services develop their service beyond

training, but do mention that clinical supervision is essential for staff to work through various issues related to working with dual diagnosis, including risk, and race and cultural issues.

Training and implementation in acute inpatient units

Training is important, but there must also be some consideration as to how people integrate what they have learnt into routine care within the inpatient unit. This is very challenging for busy ward staff, who are often under resourced, and who have to balance therapeutic interventions with safety and security. This can often lead to adopting a confrontational stance with service users. This in turn leads to increased resistance on the part of the service user to enter into a meaningful discussion about their substance use, how it affects them, and what (if anything) they would like to do about it. Despite this assertion that acute inpatient workers have the most challenging role in working with dual diagnosis, they are the least experienced, trained and supported in this endeavour.

Two London-wide initiatives have sought to increase mental health worker capabilities for dual diagnosis. The first was the Pan-London Dual Diagnosis Training Project (Brewin, 2004). This involved the dissemination of the five-day training developed for the COMO and CODA studies, previously reported. The method of dissemination involved training dual diagnosis workers across London trusts to deliver the course in their local services. To date, there has been approximately 80 people who have completed the train-the-trainers course (although only half are still actively training), and approximately 1,000 mental health workers have participated in the five-day course. About a third of these have been inpatient staff. Initial analysis of the Pan-London Dual Diagnosis Training Project (Brewin, 2004) demonstrated that over 80% of the trainees had never had any training related to dual diagnosis and over 70% had never had any clinical experience in substance use services; almost half of the trainees worked in acute psychiatric inpatient settings.

The Acute Care Collaborative (London Development Centre, 2006) was a project established by the Care Services Improvement Partnership (CSIP) London Regional Development Centre, from September 2004 to September 2005. It set out to raise the standards of care for people with dual diagnosis in acute inpatient care by helping wards undertake a series of small projects. After a consultation process with service users and workers, the overall plan was to establish ward-based project teams to implement developments for dual diagnosis. It recruited 10 London trusts and 34 ward teams.

The interventions included:

- protected engagement time (where the ward would be effectively closed for business for a period of time, which freed up the staff to actively engage with service users in 1:1 activities)
- pan-London five-day dual diagnosis training for key staff, who would then disseminate their learning to the rest of the team
- provision of ward-based activities.

The acute care collaborative demonstrated improvements in almost all of the standards originally identified from baseline to follow-up after one year. It also demonstrated that small but clinically meaningful changes not only benefit the care that service users receive, but also improves morale of the workers as well.

Case studies

This paper will now focus in more depth on two services that have been involved in exemplary work related to dual diagnosis in acute inpatient care. Both services had already commenced innovative work, and joined the Pan-London Training Project and the Acute Care Collaborative Programmes as a way of building on what had already started.

In Camden and Islington, there has been an inpatient dual diagnosis initiative (as part of a trust-wide dual diagnosis programme led by Dr Tara O'Neill, Dual Diagnosis Co-ordinator), which has been running since 2002. Claire Lynch (Lecturer–Practitioner) has been a key person in the development of this. The acute care initiative has been multi-faceted and liaison workers from substance misuse working in acute inpatient services to perform assessments, and pick up referrals, as well as offer advice and support related to substance misuse issues. The other strand of the initiative has been providing training for a large proportion of inpatient staff with the five-day training course as part of the Pan-London Dual Diagnosis

Training Project. This was evaluated as part of an MSc research project (Lynch, 2004 unpublished) and this demonstrated increased attitudes and self-reported confidence post training when compared to baseline data (before training). However, the challenge was the integration of what was learnt and gained in the classroom into routine care. A series of supervision sessions were set up monthly at all the inpatient sites led by Claire Lynch. However, attendance at these was poor, and reasons for non-attendance included being too busy on the ward, staff days off, and shift patterns conflicting with supervision. There was little evidence that people were able to change their practice with training alone. Therefore, it was decided to focus intensively on one unit, and in addition to training, this intervention involved weekly supervision and the setting up of a dual diagnosis service user group co-facilitated by the supervisor and a member of the team. This unit was also a site for the Acute Care Collaborative. This meant that the worker would gain skills in shadowing the supervisor with the view that once they were skilled and confident the supervisor could withdraw and move on to another unit. This unit has benefited greatly from this intensive approach, and anecdotal evidence is suggesting that since the team have adopted a less confrontational response to substance use, and uses a more focused, motivational-interviewing style therapeutic approach, the number of violent incidents has reduced. This effect would need to be verified by conducting more formal data collection, but this is a promising outcome.

In the inpatient wards in Lewisham (part of South London and Maudsley Trust), Cheryl Kipping (Consultant Nurse Dual Diagnosis) and colleagues have also been developing initiatives to promote greater responsiveness to the needs of people with a dual diagnosis. The work began in 2003 when the inpatient services were reconfigured. A new 'triage' ward was opened into which all acute psychiatric admissions are admitted. Service users stay for a maximum of seven days after which they are either discharged back into the community, or transferred to one of three locality wards. Around 50% of service users follow each route. Opening the ward provided an ideal opportunity to enhance the care and treatment of people with a dual diagnosis. It was thought that if substance use was identified early in admission, then more appropriate care could follow.

Initial objectives were to ensure that substance misuse issues were identified on, or soon after, admission through the introduction of appropriate assessment procedures (evidence indicates that substance use in people with mental health problems is often under detected [Barnaby *et al*, 2003], to develop care plans to address substance misuse issues where these were identified, to establish clear discharge plans underpinned by robust care pathways, and to minimise the incidence of substance use on the ward.

To achieve these objectives several strategies were put into place:

- enlisting the support of the ward manager and consultant psychiatrists, without whom it would have been impossible to bring about change
- staff training – some initial training was provided to the ward team prior to the ward opening and some staff attended the five-day pan-London dual diagnosis training
- a dual diagnosis development group was set up.

The dual diagnosis group comprised five nurses, the ward manager and the consultant nurse, who met on a three-monthly basis. It identified training needs, developed action plans and reviewed progress. Opportunities for informal training and case discussion were also incorporated. This group had responsibility for passing on information informally and through business meetings to their colleagues, and encouraging the implementation of agreed strategies. One member of this group, who had previous substance misuse experience, was given protected time to develop the work. Group members were encouraged to visit local substance misuse services with a view to developing their awareness of the range of provision available, building positive relationships with these services and working with them to produce more streamlined referral procedures and improved information sharing. The group was also responsible for the compilation of a resources folder with material of relevance to both service users and staff.

The consultant nurse provided regular sessions to the ward. This involved providing expert input to clinical reviews to promote implementation of good practice in the clinical management of people with a dual diagnosis, conducting joint sessions with ward staff to promote skills development, providing advice and information on the

assessment, management and future care of service users, and participating in training delivery. She also provided some support and advice to other wards in the unit and attended strategic meetings to promote consideration of dual diagnosis issues eg. acute care forums and police liaison meetings.

To add impetus to the work, the ward signed up to the London Development Centre Acute Care Collaborative (London Development Centre, 2006). Audits conducted as part of the collaborative suggested that significant gains had been made. Substance use was addressed in 100% of assessments, these assessments had been completed within the first 24 hours in 80% of cases. Substance use was identified in 100% of care plans (where appropriate) and substance use interventions were documented in 60% of cases.

Staff also reported that there was an increased awareness of substance use issues, more positive attitudes towards people using substances, more discussion of substance use issues in handovers, and evidence of substance misuse issues being addressed with service users in daily case note entries. Prescribing practices were also improved.

Despite these encouraging gains, maintaining changes to practice and spreading good practice to other wards in the unit was, and continues to be, a challenge. In 2005 funding was secured for a full time dual diagnosis practitioner to be based within the inpatient unit to continue development of this work.

The overall aim of the post is to consolidate the developments on triage and spread good practice to other wards. The post holder provides training, delivering the five-day, pan-London training as a grounding from which staff can develop their practice, and local training to address specific needs. He provides expert advice on the clinical management of substance misuse/dual diagnosis to ward rounds and individual practitioners, for example advising on detoxification and stabilisation regimes. He engages in some direct clinical work, providing expert assessment and structured interventions. Ideally, this work is conducted jointly with ward staff so that opportunities are available for them to develop their skills. The post holder also contributes to discharge planning and can provide interim support to service users after discharge to promote their engagement with community services. He contributes to ward programmes eg. physical health care groups, ensuring that issues pertinent to dual diagnosis are addressed. Mentorship is also provided to support and encourage staff who have a special interest in dual diagnosis.

There are significant challenges in developing this work, and achieving implementation of learning from the training requires practice, support and supervision. In a busy ward environment it can be difficult to prioritise joint working, skills development and supervision. Staff would often prefer the dual diagnosis practitioner to carry out the assessment and interventions, and it can be easier for him to do this rather than persisting in engaging others to work jointly, so that they develop the requisite skills. Staff turnover can inhibit attaining a critical mass of staff working to a similar philosophy. As a consequence, desired working practices do not become routine practice. Budgetary restrictions make it difficult to release staff for training and other development opportunities.

However, the practice of many staff has been enhanced and two in particular have developed their skills/capabilities to a high level. Both have prioritised dual diagnosis within their own work, sought out further learning opportunities and subsequently taken on dual diagnosis practitioner roles within the borough.

Future directions

A capabilities framework for dual diagnosis has been developed in conjunction with the CSIP National Dual Diagnosis Programme (Hughes, 2006b) and describes the levels of capabilities to deliver mainstreamed care at three increasing levels of skill for all workers who come into contact with people with dual diagnosis. The first level (core) encompasses skills that everyone should be able to demonstrate, no matter how small their role is in working with this client group. This would include police, third sector agencies, primary care, accident and emergency staff etc. Inpatient staff would require level 2 skills (generalist), which involves being able to make an assessment, offer some level of interventions, and also be able to refer on to more specialist services as required. Key individuals within the ward team with a remit to provide advice, support and training about dual diagnosis would require level 3 (specialist), which has an emphasis on the dissemination of skills to others through role-modelling, training and supervision. A national training resource for dual diagnosis has been developed (CCAWI, 2007) and mapped to the capabilities framework (level 2) and its

foundation is the Ten Essential Shared Capabilities for Mental Health (a user-focused, values-based collaborative model of working with mental health issues for all the workforce) (DoH, 2004). The content is based on the five-day training course from the pan-London project, and is a well-tried and evaluated package. This training resource can be modified by individual trainers to meet the needs of specific inpatient workers, by altering the focus from community-based models, and emphasising areas such as detoxification, legal and confidential issues, and discharge-planning. A training needs assessment should be undertaken before training is developed to ensure that the content matches the specific requirements of that particular service.

Summary

Dual diagnosis training research has so far focused on community mental health teams, yet dual diagnosis poses significant challenges for inpatient staff who are often the least experienced, trained and supported group in mental health services. Workers in acute care have to balance a therapeutic role with a policing role in terms of illicit substances, and this can lead to violence, absconding and other untoward incidents. This means that people with dual diagnosis are viewed negatively by inpatient staff. There is a need for more research into the impact of training and practice development for acute inpatient staff. A couple of models of providing this input are anecdotally showing promise. These approaches involve training, but also emphasise the importance of learning in practice with the use of regular, easy to access supervision, and working alongside 'experts' in their routine practice. The important message to commissioners, managers and practitioners is that acute psychiatry is a priority area for dual diagnosis development, and training alone may have a limited effect on overall clinical capabilities. What is needed is a long-term, comprehensive programme of staff development that involves training, but also provides opportunity for work-based learning, supervision and clinical placements in other services. Both the Camden and Islington and South London and Maudsley projects demonstrate the importance of having key individuals with dual diagnosis expertise appointed specifically to lead and develop this work. Without the creativity, enthusiasm and commitment of these individuals, it is likely that these types of initiatives will fail.

Recommendations

- Dual diagnosis capabilities development is a high priority for inpatient services.
- This should involve training, but also ongoing practice development and supervision built in afterwards.
- There needs to be some creativity in the methods of learning for inpatient staff given the constraints of money for training, and the constraints of the shift patterns. This may involve using handover times, and team meetings.
- There is a clear need for specialist input (whatever form that takes) into the clinical areas that can provide role-modelling, joint-working, informal training, supervision, group work for service users, and resource for the staff regarding outside agencies. This needs to be long-term input.
- It appears that it may be useful to focus limited resources intensively where they are most needed – start with one clinical area, then move on when they have developed the capabilities to manage the issues themselves.
- It is important that the inpatient teams should develop links with outside agencies to ensure appropriate referrals are made, and that outside agencies engage with service users in a timely way.

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New ways of working in acute inpatient care: a case for change

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Abstract
This position paper focuses on the current tensions and challenges of aligning inpatient care with innovations in mental health services. It argues that a cultural shift is required within inpatient services. Obstacles to change including traditional perceptions of the role and responsibilities of the psychiatrist are discussed. The paper urges all staff working in acute care to reflect on the service that they provide, and to consider how the adoption of new ways of working might revolutionise the organisational culture. This cultural shift offers inpatient staff the opportunity to fully utilise their expertise. New ways of working may be perceived as a threat to existing roles and responsibilities or as an exciting opportunity for professional development with increased job satisfaction. Above all, the move to new ways of working, which is gathering pace throughout the UK, could offer service users[1] a quality of care that meets their needs and expectations.

Key words
acute inpatient unit; service user expectations; workplace culture; whole system working; NWW for psychiatrists; multidisciplinary team responsibilities

Introduction
This position paper aims to describe the current tensions and challenges of providing inpatient care in line with contemporary mental health services.

The acute inpatient ward is regarded as a key component of mental health care in the UK; indeed around two-thirds of available (NHS mental health) financial resources go to support acute inpatient services, and they remain the principle method for dealing with disabling mental health crisis.

Over the past 30 or so years, there has been a shift from the inpatient ward as a place of treatment, towards a more community based approach leading to a decrease in the numbers of available beds (Thornicroft & Tansella, 2002). Consequently, the threshold for admission has risen dramatically and inpatient services in many places operate as a crisis service leaving little time for therapeutic interventions (Allen & Jones, 2002).

Service users themselves report being bored and, not uncommonly, threatened while in inpatient facilities, and unhappy with the quality of care they receive; clearly there needs to be a shift in the way that those who work on acute inpatient wards go about their work if the needs of service users and their families and carers are to be met (MIND, 2004).

The New Ways of Working in Mental Health component of the National Workforce Programme provides an important focus for redirecting activities in acute inpatient wards and an opportunity to engage with others who are striving to change an often difficult and intractable system (DoH, 2004).

Background
In 2000 the government identified mental health as one of three national priorities, along with cancer care and coronary heart disease. This setting of new priorities happened at a time when the UK government was making explicit its plans to increase the amount of funding for the NHS to match that of its EU counterparts; it would equate to 9% of gross domestic product (GDP) (Kings Fund, 2005).

What this has meant for mental health is interesting: 12.2% of the total budget for the NHS is reserved for mental health (Audit Commission, 2006b). This represents an increase of 25% (£983m) from £3,770m in 2001/2002 to £4,679m in 2005/2006 (Mental Health Strategies, 2006) for adult mental health services. If the

[1] People who receive and use services are often referred to as patients, clients or service users. The term service user is used throughout this paper for consistency.

budgets for other age groups and capital spend are added, then the total budget for mental health (including learning disabilities) is £7,200m (Audit Commission, 2006a; Mental Health Strategies, 2006).

Although these sums describe the allocation intended for mental health, they do not represent actual spend, nor the amount required to meet need in any particular area. However, it is clear that budgets for mental health services have increased substantially over the past decade.

Of course, such large increases in budget are not without 'strings' and mental health services (and commissioners) were required to increase spending in key priority areas, for example assertive outreach teams, crisis resolution and home treatment teams, early intervention in psychosis teams, graduate workers in primary care mental health and community development workers (CDWs). Investment in these priority areas alone increased substantially from £78m to almost £300m over the five years leading up to 2005/06.

This increase in support for more community focused services, as opposed to hospital-based services, is entirely consistent with research and policy, and reflects acknowledged good practice in mental health (Thornicroft & Tansella, 2002). However, while there continues to be a significant shift to more community-based services, most financial resources in mental health continue to be used to support inpatient services (Mental Health Strategies, 2006).

Nevertheless, the resources to provide overall services continue to improve year on year. Despite these increases in funding and the development of new community service models, inpatient services play (and will continue to play) a significant role in the care and treatment for people with a mental health problem. The key question is whether these services have changed and adapted to the needs of service users and carers at the same rate as community services?

Despite this increase in funding, and the increasing trend towards commissioning services outside the statutory sector, most NHS mental health service provider organisations continue to provide the bulk of service provision. As such, acute inpatient facilities continue to be seen as their priority. Maintaining public order and managing risk by admitting the acutely disturbed continue to be seen as primary functions of a mental health service (Mental Health Strategies, 2006). At the same time, experiences of the acute inpatient unit are the single largest source of formal complaints and seemingly, a series of surveys and reviews confirm the unsatisfactory nature of those events (MIND, 2004).

Collaboration between the Department of Health (DoH), the National Institute for Mental Health (England) (NIMHE)/Care Services Improvement Partnership (CSIP) and other bodies, led to the establishment of the acute inpatient programme that resulted in the setting up of local inpatient fora (DoH, 2002). This has resulted in the development of a set of standards for acute mental health inpatient facilities by the Healthcare Commission, which are now in use as an assessment framework, underpinning reviews of acute inpatient services (2007). There are good reasons to believe that this process will stimulate some change and improvement, but the perceived role of the 'psychiatric ward', professional and informal practices it supports, and the workplace culture that maintains them all have deep roots in earlier expressions of mental health policy. The asylum model of the past socially isolated service users and segregated the staff in remote locations divorced from the community and its services, encouraging institutionalised practices (Nolan, 1993; Thornicroft & Tansella, 2002).

Continuing expressions of dissatisfaction with the acute inpatient units reflect the difficulties encountered in attempting to change these, which may be why these services have not changed and adapted to the needs of service users at the same rate as community services.

Expectations of a contemporary acute inpatient facility

The commonly held view that more traditional services for people with mental health problems include admission to hospital at times of crisis is overly simplistic. The role of the acute inpatient unit is much more complex and demands a high degree of skill and teamwork. The people admitted today are usually more severely ill than people who were hospitalised in the past (Rethink, 2007).

It is true that the reduction in the numbers of beds has led to a rise in the threshold for admission (Brooker *et al*, 2007). Under these circumstances, the skills required when making an accurate diagnosis and assessment of the personal, social, cultural and medical circumstances that

that have led to admission and which will be needed to facilitate discharge, are both sophisticated and complex.

The formulation of a plan of care and interventions based on a series of systematic assessments requires input from a team of people (including the service user and their family/carer) who are well trained and effectively led (Clarke, 2004).

The nature of an acute crisis will often involve an assessment of risk, usually to the service user themselves but occasionally to others, and again this requires contributions from a range of people across different specialities and professional groups, therefore admission to hospital should be regarded as just one component of the whole complex system of care (Sainsbury Centre for Mental Health, 2005).

Once assessments have been completed and a plan of action agreed with the service user and all those involved, decisions need to be made about who will carry out the different actions, where the actions will be carried out and how the process will be managed. An important part of this decision making process should focus on the point at which the service user will be discharged from inpatient care, thus allowing treatment and support to be continued in their own home (Royal College of Psychiatrists, 2006b).

This last point is central, and will often involve a careful consideration of risk and the person's social circumstances, as well as an evaluation of the factors that led to admission. Comparisons of severity may be made with people who are awaiting admission. This process necessitates closer integration of inpatient and community services with early follow up after discharge (Meehan *et al*, 2006).

Although still a somewhat simplistic description, this process should ensure that people enter hospital only when necessary, are discharged as quickly as possible, and have a service that is based on the best available evidence that meets their needs.

Experiences of a contemporary acute inpatient facility

Surveys of service users' experiences of acute inpatient care describe a more worrying situation (MIND, 2004): 53% of respondents felt that the ward surroundings had not helped their recovery and 31% that it had made their condition worse. Only 20% of respondents felt that they were treated with dignity and respect by staff, and overall the service users' unhappiness with their experience in hospital focused on boredom, staff attitudes, understaffing and temporary staffing (bank staff and locums) and the physical environment.

This view was reinforced in the 2005 Chief Nursing Officer's Review of Mental Health Nursing, where a systematic review of the literature on service users and carers views on mental health nursing in the UK found that the use of agency staff, high staff turnover and high sickness rates all contributed to a lack of continuity of care and little or infrequent contact with key staff, although there is a downward trend in the employment of locum staff (Bee *et al*, 2005).

Those qualities that service users value the most in mental health nurses, who provide the vast majority of acute inpatient staff, are exactly those qualities that the service users report as missing in their interactions with staff in acute inpatient settings. More specifically, service users want staff who work in a collaborative way, are flexible, treat them with respect and value them as people, exactly those qualities described in the 10 Essential Shared Capabilities (NIMHE, 2004; Baguley *et al*, 2007).

It seems clear that if acute inpatient services are to meet the needs of those people who use their services, then change to at least some parts of the system is vital.

Many services continue to carry out case reviews in the form of ward rounds, a pervasive approach that maintains an outmoded workplace culture focused upon 'treatment' and risk management rather than recovery. Ward rounds continue despite reports from service users that they find them intimidating, demeaning and often humiliating, and increasing understanding that they are wasteful in the use of time of all concerned, including service users and carers as well as nursing staff (Foster *et al*, 1991; NIMHE, 2007).

Recently, the Royal College of Psychiatrists (2006b) stated that a full multidisciplinary ward round should occur at least once a week to fulfil the accreditation standards for acute mental health wards. This requirement, together with the responsibility that consultants feel for outpatients and service users in the community, influences their relationships with service users and with other professional groups, and makes meaningful change difficult to achieve (Williams & Cormac, 2007).

A contemporary acute mental health services model

One of the major investments in mental health services has been the introduction of crisis intervention and home treatment teams. This has been led in large part by recognition of the high rates of brief admission driven by needs that could have been met differently. The success of this strategy can be seen in the particularly rapidly falling rates of admission in trusts where crisis resolution and home treatment teams have been established (Glover *et al*, 2006). What it also forces is reappraisal of the role and function of the acute inpatient unit. These can no longer operate in isolation, divorced from psychosocial aspects of care. The bio-psychosocial model underpins care delivery in community settings, and acute inpatient units need to match this focus instead of centring on a medical perspective and risk management (Allen & Jones, 2002; Clarke, 2004).

The recent CRHT survey (Onyett *et al*, 2006) draws further attention to the need for mental health services to find ways of operating as a complex whole rather than separate silos. This needs to include the development of stronger links between inpatient services and others involved in providing care, such as social workers and the voluntary sector. It must also be recognised that service users' needs for socially relevant aspects of care do not stop just because they have been admitted, indeed in most cases they intensify. For example, there may be issues around family and social networks that may need to be addressed in order to facilitate discharge and improve a person's employment opportunities. It is possibly naïve to expect to take someone out of their social, cultural and personal context for a period, offer them treatment and then return them without this process having a negative impact on their social networks, family life or personal functioning.

The traditional approach to acute inpatient care is one that has been dominated by the medical model (McCulloch *et al*, 2005). Thornicroft & Tansella (2002) describe the progressive closure of asylum beds in favour of acute inpatient units, often located in general hospital premises. This has tended to emphasise the view that admission is primarily for medical treatment or the containment of risk, and that the social determinants of a need for structured 24-hour support are of secondary importance. They highlight the need to shift the focus of care from the hospital, so that this service is perceived as only one element of a broad range of provisions serving a whole community or population. The use of crisis houses has met with success in some areas, but it is a concept that has been ignored by most. As a result, the culture of contemporary acute inpatient units has developed accordingly, with a seemingly strong dependence upon the psychiatrist as expert in matters medical, and 'responsible' for risk management. The common concerns of ward rounds and dependency upon medical opinion for discharge or other significant decisions about management are understandable consequences (Onyett *et al*, 2006).

The development of strengthened community mental health services, particularly in the form of crisis response, home treatment teams and assertive outreach teams, emphasises the fact that disabling psychological distress, of whatever form, is not in itself grounds for admission. Falling admission rates, and the reduction in bed numbers, reflect increasing skills and services available to support those people in distress more appropriately in their own homes. Most importantly, service users, families and carers prefer these services (Onyett *et al*, 2006; Johnson, 2004).

When admission does become necessary it is commonly for complex social reasons that have made residence in the community temporarily untenable. This requires a complex, multidisciplinary response involving contributions from agencies such as social services that can engage with confused, anxious or threatened relatives, housing agencies, employers and others. As Bridgett and Polak (2003) point out, the admission of a person in acute mental distress can be as much a social as a medical necessity.

These problems are generally beyond the reach of conventional acute inpatient culture and emphasise the need to view admission as part of a continuing journey or pathway that is largely conducted in community settings. Thus, a view of admission as a primarily medical matter becomes outmoded, and so does a view of the consultant psychiatrist as the one holding overall power and responsibility for its conduct (Middleton, 2007).

Since 2003 we have seen developments in the reframing of the relations between professional groups that make up the mental health workforce, resulting in significantly, the publication of *New Ways of Working for Psychiatrists* (DoH, 2004). Although this is proving helpful in identifying priorities for change among the working practices of community-based psychiatrists, there is little understanding of the challenges faced by the psychiatrist

on the inpatient unit. A number of services have endorsed the separation of functional roles between community-based general adult psychiatrists and those focusing upon inpatient services, and more show signs of following this route. This is one model of NWW, which has been found to be effective (Caracciolo & Mohamed, 2007), but is not necessarily appropriate everywhere. However, this type of change in practice alone is not going to address the difficulties of culture and convention that continue to distort acute inpatient services away from holistic, service user centred care, towards the treatment of symptoms and containment of risk (Middleton, 2007).

Key questions are whether services are using the skills and competencies of their staff to best effect (for the service users as opposed to the service). If not, what could be done to change things, and what are the challenges?

New ways of working

The vision and the service imperatives encompassed in the Mental Health National Service Framework (DoH, 1999) and the NHS Plan (DoH, 2000), in the National Service Framework for Older People (NSF) (DoH, 2001), the National Service Framework for Children (DoH, 2004a) and the white paper Our Health, Our Care, Our Say (DoH, 2006), all reflect the need for staff to review their current practice and services to review their modes of delivery.

New Ways of Working (NWW) is about supporting and enabling consultant psychiatrists (among others) to deliver effective and person-centred care across services for children, adults and older people with mental health problems. This is about big culture change – it is not just tinkering round the edges of service improvement (DoH, 2004b).

NWW is not about saving money, releasing resources for other things, nor about undermining the role of the psychiatrist. It is about recognising that we will have increasing difficulty in filling posts – given the high rate of people eligible to retire, fewer school leavers available to enter medical training, despite big increases in training places, and the continued and growing demand for mental health services.

In essence, NWW is about using the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on service users with the most complex needs, acting as a consultant to multidisciplinary teams, and promoting distributed responsibility and leadership across teams to achieve a cultural shift in services.

It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce, offering high quality service. *New Ways of Working for Everyone* and *The Creating Capable Teams Approach* (DoH, 2007b) take this concept further in terms of what NWW means for all professions.

In the context of an inpatient service, this raises particular issues. All acute wards contain at least a small number of formally detained service users for whom, at present the consultant psychiatrist holds specific statutory responsibilities. The National Health Service (NHS) measures hospital activity in terms of 'finished consultant episodes' (DoH, 2007a). Among coroners, there remains a convention of regarding the doctor as the prime witness in the event of an unusual death. These external, formal givens interact with a number of informal influences that powerfully support and maintain a culture in which many conspire to regard the conduct of an admission as a process ultimately guided and overseen by a responsible medical officer. Important decisions cannot be made without the consultant's assent, discharge has to be authorised by a doctor, and of course, the consultant in turn is caused to assume a position of power and authority. However, the new ways of working initiative has important implications for other professionals because the assumption that the responsibility for giving information to the coroner is changing. New ways of working means that the evidence is likely to be provided by other professionals holding autonomous responsibility for the case (Royal College of Psychiatrists, 2006a).

Recruitment and retention of inpatient staff and new ways of working

It is acknowledged that staffing problems exist within acute inpatient services. This has been attributed to complex factors including inadequate clinical supervision and leadership, excessive paperwork and perceptions of a 'blame culture' in the NHS. All of these factors have affected the morale and motivation of inpatient staff. The inadequacy of educational and training opportunities, which provide inpatient nurses with the knowledge and skills to work effectively in these settings have been highlighted (DoH, 1999).

NWW offers all inpatient staff the opportunity to develop their interests and skills for the benefit of service users. If consultants' caseloads reduce, they will be able to

form relationships with service users who require their specific competencies. This will mean that ward nursing regimes could shift from containment towards the therapeutic role that service users desire, with the consultant adopting a truly consultative role. This shift in emphasis in the consultant's role produces a need for a concomitant change in the rest of the multidisciplinary team. As the consultant moves from a position of overall responsibility for inpatients that are perhaps seen only once a week to a more intensive relationship with smaller groups, this provides the other members of the team with the opportunity to develop and utilise their particular interests and skills to best effect. Thus, they are not confined to the specific remit for which they were originally educated and can become experts in their own field with the doctor taking on a strictly consultative role (DoH, 2005b).

In order for this cultural shift to occur, all staff who work in acute inpatient care must have access to education and training. To be meaningful, this would mean carrying out a systematic training needs analysis with existing staff, to identify existing expertise. This would need to be directly linked to an analysis of the needs of service users to identify gaps in skills and competencies. The creating capable teams approach (CCT) (DoH, 2007b) is designed to help multidisciplinary teams to make a more detailed and systematic review of their function, based on the needs and express wishes of service users and carers and the current and future skills of staff, resulting in a team workforce action plan.

Staff, of all disciplines, who work with acute inpatients, have a great desire to help and support people in their care and use the skills that they have to best effect. There is evidence that complex skills, for example cognitive behaviour therapy (CBT) and psychosocial interventions (PSI) can be used effectively in an inpatient setting (Baguley & Baguley 2002; Gournay 2004; Baguley & Dulson, 2004).

Perhaps most importantly, this cultural shift requires that all disciplines embrace a bio-psychosocial model of mental health in understanding the development and maintenance of an individual's problem. This facilitates the integration of both psychological and social interventions. In this respect, the contribution of social workers to the work of the team is vitally important. Inpatient services have been culturally dominated by the medical model, and social work knowledge, skills and values are intrinsic to the reform and progress of inpatient services. Psychiatrists' training increasingly emphasises a consideration of social issues, but the full integration of health and social care factors requires a significant shift in the inpatient culture. The effective reintegration of service users into the community requires that health and social care disciplines adopt a holistic perspective. The role of psychiatrists is central to this and it is necessary for social workers to adopt a more high profile leadership and consultative position within multidisciplinary teams (DoH, 2005b).

Discussion

Acute inpatient services have an important role to play in the care of people with mental health problems. The reduction in the number of available beds has led to a 'raising of the threshold' for admission and, in turn, led to increasing pressure on all staff groups. More importantly, this has also led to service users feeling frightened, undervalued and unsupported (Muijen, 2002).

It is evident that a whole system shift in the culture is required within inpatient services if they are to keep pace with other service developments. Without this change, service users will continue to receive fragmented provision in which the traditional inpatient service is divorced from that in the community. The delivery of effective person-centred care requires support for system change from all acute inpatient staff. It is not enough for psychiatrists to embrace change in the ways in which they practice and manage their work. Role changes must also extend to other disciplines and this involves a move away from traditional models of tasks and responsibilities.

Nurses conduct their own risk assessments and formulate care plans. These are concerned with the day-to-day care of service users and may include, for example, whether the person should bathe unsupervised. Other decisions about observation leave or discharge from hospital is usually regarded as the consultant's responsibility or, on occasion, the junior doctors. Consequently, consultants are perceived by other disciplines and by service users as those who make the important decisions, usually during the ward round, and as holding the balance of power (Alexander, 2006). This restricts the development of NWW and reinforces the status quo between consultants and other disciplines.

It also allows other disciplines to avoid taking responsibilities, which might involve increased contact with service users in order to elicit information other than behavioural observations.

Cross-disciplinary issues and resultant role changes must be addressed so that the often complex needs of service users are managed appropriately, enabling discharge as quickly as possible from hospital. The service user should receive care/therapy from the most appropriate worker based on the ability of the worker's expertise, knowledge and ability to engage with the person. This may involve blurring of professional boundaries, which needs to be managed effectively through teamwork and clinical supervision in NWW (DoH, 2005b). The threshold of risk for admission and discharge is often influenced by the availability of beds. If the complex decisions involved are largely placed upon consultant psychiatrists' shoulders, they cannot utilise their skills, knowledge and experience to best effect (Williams & Cormac, 2007). Furthermore, service users may be restricted unnecessarily and discharges delayed causing a bottleneck in the acute services system as a whole.

The negative reports from service users about nursing attitudes and shortages in acute inpatient care may be viewed from a hierarchical perspective in which nurses feel disempowered by the inpatient system. The nursing duty of care embraces safety and therapy. However, within traditional services, nurses are preoccupied with risk assessment and containment. A large element of the nursing role involves servicing consultants' ward rounds and implementing the decisions that are made (Alexander, 2006). The NWW approach provides opportunities for nurses and others to be equal members of multidisciplinary teams. For this to occur they, and other members of these teams, must be prepared to accept that responsibilities are distributed among those who provide input into decision-making and do not rest with the consultant psychiatrist alone.

Arguably, hospital care should be designated as a speciality with specific training needs. Nevertheless, acute care should be perceived as part of the spectrum of mental health provision incorporating self-management, primary care and community services. A whole systems approach to training might provide service users with a bio-psychosocial approach and promote a better understanding between hospital and community staff who work in diverse settings.

Working on the wards may be less attractive to some NHS employees, than modern high-status community services, which may provide more opportunities in terms of higher grades and salaries (Muijen, 2002). Less disparity between the pay of psychiatrists and other disciplines might have an impact on the perception that the highest paid members of the team should also be the most accountable.

Decisions about service users being discharged or going on leave are often confounded by events outside of the control of those working in acute inpatient care. Lack of suitable living accommodation is probably the most obvious cause of extended stays in hospital, but there are others, for example a lack of community support at the level needed, financial problems or problems with more informal (but vitally important) support networks concerning families and carers (Glasby & Lester, 2004).

The literature on hospital discharge indicates that health and social care professionals encounter difficulties in working together effectively. This failure may arise from conflicting perceptions of good practice. On the one hand, the hospital system focuses on a rapid turnover of service users. On the other, the social model aims to help people, who may be facing major life changes, make long-term decisions, which emphasise choice and empowerment. These could be conceptualised as a resource management model that might be described as user-centred; successful discharge requires an integration of both perspectives. This requires a substantial cultural shift in the acute hospital sector and the development of a more holistic approach towards the care of the person. However, the role of professionals exists within an organisational framework that is influenced by structural barriers to progress in joint working such as access to pooled budgets (Glasby, 2004). The complete integration of health and social issues demands a significant shift in the guiding principles and day-to-day practice of services. It is acknowledged that psychiatrists have a major role to play in breaking the cycle of exclusion experienced by service users (DoH, 2005b). In 2004, MIND expressed concern that social care services for mental health service users were under funded and dwarfed by clinical care and priorities. The contribution and leadership of social workers to inpatient multidisciplinary teams and hospital services is vital. Aspects of social theory and care are now embedded in the daily work of community NHS employees, but acute inpatient services still have much to learn from social work expertise (Young, 2007).

Despite these confounding factors, there are changes that can be made to acute inpatient services that involve not just psychiatrists letting go of responsibility, but other disciplines taking it. A first positive step would be to implement the care programme approach (CPA) in a meaningful way; this would involve each person receiving training in CPA, clarity around the role of the care co-ordinator and a willingness to engage in the process (NIMHE, 2007). The evidence shows that service users who are involved in their own care planning are more satisfied with the services they receive, but that currently many service users and carers are not significantly involved. Commissioners and practitioners have their own views about service provision, care and treatment. Service user empowerment demands adequate financial resources and positive input from professional groups. This means that professionals may have to relinquish some of their power in collaborative working (SCMH, 2007). The CPA process should support people to find out more information before agreeing about how their assessed needs should be met, and direct payments may be an important tool in the promotion of social inclusion and recovery (DoH, 2006).

Another important driver in cultural change is the adoption of the 10 Essential Shared Capabilities (NIMHE, 2004). These are particularly relevant to new ways of working in acute care. The emphasis on the importance of working in partnership and respecting diversity not only in relation to service users and carers, but also with colleagues has important implications for multidisciplinary teams. Making a difference refers to the capability of offering excellent, evidence-based, values-centred health and social care interventions to meet the needs and wishes of service users, their families and carers. The promotion of safety and positive risk-taking involves handling the conflicts engendered by the need for empowerment, and the requirement to confront possible risks to service users and others. Providing service user-centred care involves taking the perspective of service users and carers in setting care objectives. This capability places demands on professionals to find ways of delivering these aims and of clarifying the responsibilities of those who will provide the help that is required.

The capabilities that all staff should be expected to possess make it incumbent upon those working in acute care to take responsibility for their own practice and to work collaboratively. The effective implementation of the 10 Essential Shared Capabilities could cause a cultural shift towards choice, person-centred care and health promotion. They have important implications for the education and training of all staff who work in mental health services. These capabilities also involve accountability for one's own practice, and a requirement to share and accept responsibility for decisions that have traditionally been borne by consultant psychiatrists.

If a cultural shift is to occur, then it is equally clear that services need to be organised in such a way that mental health workers are allowed to use the expertise they have to best effect (Baguley *et al*, 2000). Organisational issues at the highest level often militate against change; the requirements of the Mental Health Act, the beliefs and behaviour of coroners, and the methodology for counting consultant activity through the NHS and Department of Health all conspire to make change more challenging.

We have to acknowledge that meaningful change is difficult to achieve, particularly in a large organisation like the NHS and across such a diverse range of professional groups. If we really do have the needs of service users and their families and carers as the main focus for our activities, then change we must: go on you know you want to – it's not as difficult as you think!

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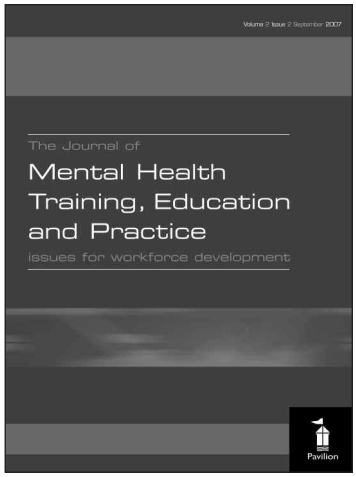

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