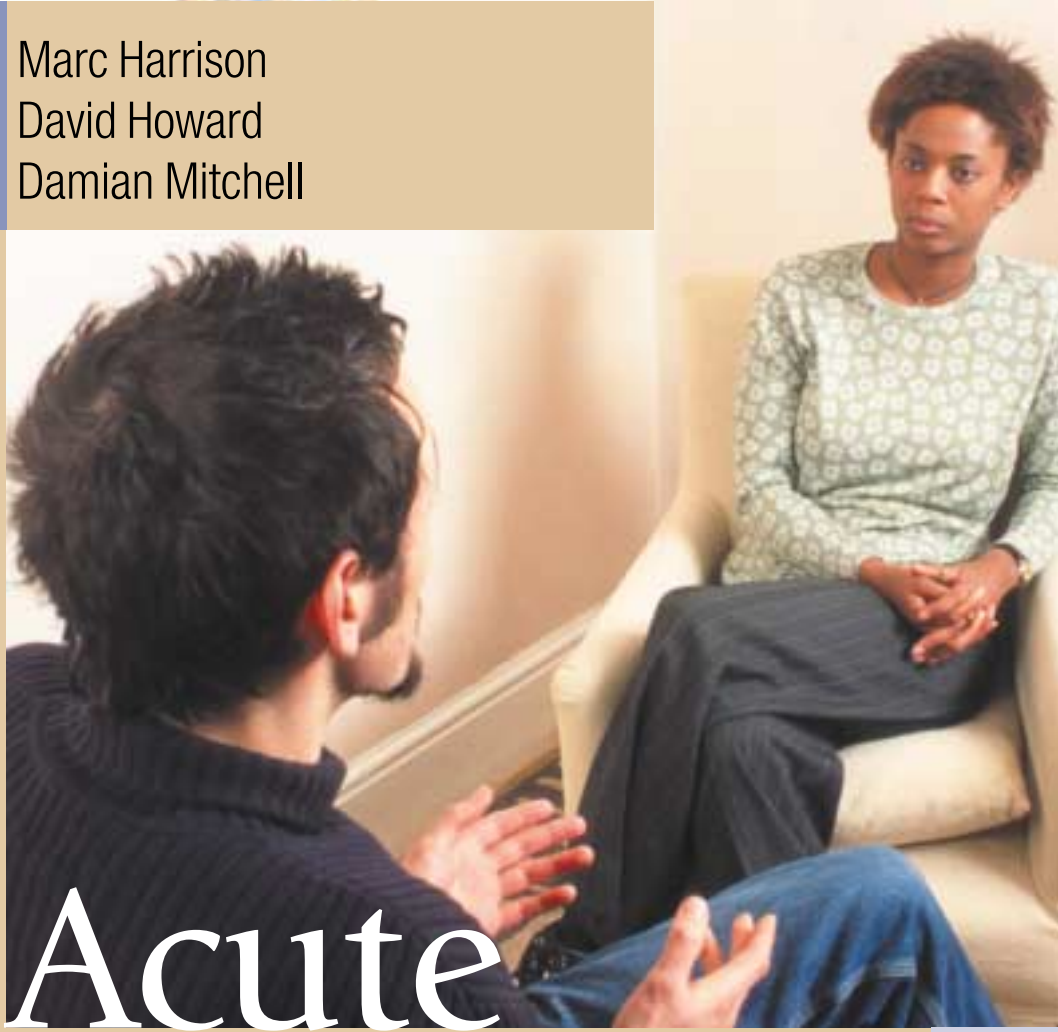
EDITED BY

Marc Harrison
David Howard
Damian Mitchell



Acute Mental Health Nursing

From Acute Concerns to the Capable Practitioner

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Marc Harrison,
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List of Contributors

Ian Baguley qualified as a Mental Health Nurse in 1973 and worked in a range of NHS settings. He started work at University of Manchester 10 years ago and has been involved in developing skills based education courses in areas such as Psychosocial Interventions and Cognitive Behaviour Therapy. He is currently working as National Programme Manager for Mental Health Workforce Development.

Joe Curran is a mental health nurse with experience in acute in-patient, forensic and community settings. He currently has a clinical caseload and is involved in education, training, and some research. His work interests include the application of CBT to in-patient environments, practice-based evidence, and behaviour analysis.

Mike Doyle is a qualified RMN who has worked in mental health services for 18 years. He is currently undertaking Post-Doctoral Research at the University of Manchester and also has a Clinical Advisor role in the North West Adult Forensic Mental Health Service that includes work as a specialist therapist in Psychosocial Interventions.

David Duffy is a Nurse Consultant specialising in suicide and self-harm, currently employed by Bolton, Salford and Trafford Mental Health NHS Trust. David has a Doctoral thesis on the subject of suicidality, and from 2001 was lead co-ordinator of the National Suicide Prevention Strategy for England. With Dr Tony Ryan, he is editor of *New Approaches to Preventing Suicide: A Manual For Practitioners* (Jessica Kingsley, forthcoming).

Julie Dulson completed her nurse training in 1997, working in a range of inpatient settings mostly acute, but also rehabilitation and high dependency. She currently works for Mersey Care NHS trust as a practice development facilitator working within the acute inpatient wards. She has recently been seconded half time as practice development facilitator for the acute solutions project at Sainsbury's Centre for Mental Health, based within the acute wards in Mersey care NHS trust.

Alison Faulkner is a mental health service user/survivor now working as an independent researcher, trainer and writer. She has over 16 years' experience in social research, including around 5 years specialising in qualitative methods, and is currently working on the evaluation of a crisis service in Leeds. She is owned by a small black and white cat.

Kevin Gournay is a Chartered Psychologist and Registered Nurse. He has been involved in policy research and development in inpatient care for the last 10 years. He is an expert witness on inpatient suicide and has continued clinicial work throughout his career, latterly using CBT for psychosis as well pursuing his specialist interest in the treatment of severe anxiety disorders.

Richard Gray is a Lecturer and MRC Fellow in Health Services Research at the Institute of Psychiatry, Kings College, London. He qualified as a mental health nurse in 1993 and in 2001 he was awarded his PhD from the Institute of Psychiatry. He has published over 60 papers and book chapters.

Julie Hall has a background in mental health nursing who is currently employed as Care Pathway Manager and Audit Lead for Lincolnshire Partnership NHS Trust where she has led the successful implementation of integrated care pathways and variance reporting systems. Julie is currently supported by an Economic and Social Research Council research scholarship to evaluate the use of integrated care pathways in mental health services.

Marc Harrison has a background in both community and acute mental health nursing. He is currently Head of Curriculum Development and Quality Assurance for HM Prison Service (England and Wales) and is also Honorary Research Fellow at the Institute of Psychiatry. Prior to this he was Senior Research Fellow at the University of Manchester and Senior Project Officer with the WHO 'Nations for Mental Health Programme'.

David Howard began his mental health career at the age of 17 as a nursing cadet and has worked extensively in areas of mental health practice, research and education. He is currently Director of the MSc in Organisational Leadership in Health and Social Care at the University of Nottingham, although he continues his interests in mental health by means of teaching and clinical work.

Ann Jackson, RMN, BA (Hons.), MA, is Senior Practice Development Fellow with the RCN Institute Mental Health Programme. Ann's clinical

background is in acute in-patient nursing. Her main research interests include: feminist and anti-oppressive research methodologies/practice and women's mental health.

Mick James qualified as a mental health nurse in 1984 and has worked in a broad range of clinical settings. As a senior nurse, he had practical experience of implementing the use of HoNOS across a mental health service. Mick has been National HoNOS Advisor at the Royal College of Psychiatrists' Research Unit since 2000 and also continues to work as a senior manager in the NHS.

Julia Jones, BA (Hons.), Ph.D, wrote this chapter whilst Research Fellow with the RCN Institute Mental Health Programme. She has conducted a number of research studies in acute in-patient settings. She is currently a Marie Curie fellow at the University of Verona, Italy.

Damian Mitchell was appointed to the post of Head of Healthcare Training for the Prison Service (England and Wales) in July 2002, a post that moved across to NHSU in March 2004. Damian is also Subject Lead within the School of Interprofessional Health and Social Care, NHSU, for Mental Health, Criminal Justice and Offender Services.

Rachel Perkins is a Consultant Clinical Psychologist and Clinical Director of Adult Mental Health Services at South West London and St. George's Mental Health NHS Trust. She is also a user of mental health services, vice-chair of the Manic Depression Fellowship, a Specialist Advisor at the Health and Social Care Advisory Service and a member of the Disability Rights Commission's Mental Health Action Group.

Julie Repper is Senior Research Fellow at Sheffield University and Lead Research Nurse for Sheffield Care Trust. Her research interests include social inclusion, recovery and user and carer involvement. She is currently exploring best practice in the assessment of carers' needs and has recently published, with Dr Rachel Perkins, a book entitled *Social Inclusion and Recovery: A Model for Mental Health Practice*.

Paul Rogers worked as a clinician in secure services for 14 years prior to commencing his research career. His current research includes suicidal thinking and mental disorders in prisoners, and the examination of predictive tools for criminal reconviction. Paul has published over 50 peer reviewed and professional papers and was the recipient of the Professor Annie Altchul Publication Prize in Mental Health in 2001.

Tony Ryan has worked as Service Development Manager and Senior Research Fellow since 2000, initially at the North West Mental Health Development Centre and now for the Health and Social Care Advisory Service (HASCAS), as well as working at the University of Manchester. Tony has also spent 10 years working in the NHS as a mental health nurse in a variety of roles.

Gail W. Stuart is Dean and a tenured Professor in the College of Nursing, and a Professor in the College of Medicine at the Medical University of South Carolina. She is currently President of the American College of Mental Health Administration and a fellow in the American Academy of Nursing. She is a prolific writer possibly best known in nursing for her textbook: *Principles and Practice of Psychiatric Nursing*, now in its 7th edition.

Martin Ward is an independent mental health nursing consultant and director of MW Professional Development Limited. He has 35 years' experience in mental health care, as a nurse, teacher, researcher, politician and writer. He was formerly Director of Mental Health for the Royal College of Nursing, and has a large portfolio of publications and a history of international teaching and supervision.

Foreword

When I first started my career in nursing during the 1960s, there were something over 130,000 in-patient places for people with mental health problems, largely sited in the large Victorian asylums. We now know that literally tens of thousands of patients spent their lives incarcerated, when there was probably no reason why they should not have lived reasonably productive lives in the community. Visionaries such as Jim Birley, George Brown, John Wing, Julian Leff and others, were the driving forces behind deinstitutionalisation in the UK, a process that has now been paralleled worldwide. Without any doubt, deinstitutionalisation has brought major benefits, and the lives of countless people have been improved because they are now able to receive treatment in their own homes and communities, rather than being banished to a distant 'bin'. However, we also have to admit that deinstitutionalisation and the setting up of community mental health teams have been far from free of problems. It needs to be said that the expectations of community care have not been realised and I believe (and I know this is an unpopular view with many of my colleagues), that when Frank Dobson said in 1997, community care has failed, he was substantially correct. I had the great pleasure of providing Frank Dobson with advice at this time, and I know that he recognised that community care had failed, not because of the shortcomings of the dedicated people who are the doctors, nurses, psychologists, social workers and others working in our mental health services, but because of starvation of necessary funding, which had been a problem for more than 20 years. With a few exceptions across the world (Australia being a notable example), there had been no bridging funding made available to start up community mental health teams and no real investment in training the necessary numbers of mental health staff for this work and providing them with the means to deliver psychosocial interventions and other evidence-based treatments. Another set of reasons for the relative failure of community care is connected with a range of complex issues concerning public acceptance of the mentally ill. As a consequence of society's views of mental illness and of under-resourcing we now have the spectre of what Len Stein (the architect, with his collaborator Marianne Test, of assertive community treatment) called transinstitutionalisation; i.e., housing mentally ill people in prisons rather than in humane residential care settings.

It is within this wider context that this book is being published. Its publication is extremely timely given that we have at last realised that the emphasis on community approaches has led to the neglect of the acute care area. This book is a valuable addition to the growing literature on acute care and should provide great encouragement to the frontline staff in this area. More positively, we are beginning to see some real new financial investment in mental health services and while some say this is too little too late, I am optimistic that this new money will make a real difference. One other development which should lead to improvement is the setting up of the National Institute for Mental Health which has an emphasis on improving standards in a uniform and systematic fashion. Thus, new textbooks, such as this, will provide the means of disseminating up-to-date knowledge to services across the country.

The chapters in this book should provide the reader, who may be an undergraduate or an experienced mental health worker, with current perspectives on a range of important topics. I was particularly pleased to accept the offer of contributing a chapter, as when I saw the chapter outline, what struck me was the emphasis on providing humane mental health care, within the context of a sound evidence base. Now that I have been able to read the whole text, I am even more pleased to see that the chapter focus is on topics that will make a real difference to people's lives. These important issues are: psychosocial interventions, medication management, risk assessment and management, and the use of various assessment methods. While the issues of what constitutes evidence, and how that evidence is obtained, preoccupies many academics, these chapters go to the heart of what is important to patient care, and the reader will obtain an overarching, and practical-based, view of each area. In addition, the chapters on integrated care pathways, the analysis of the UK and US systems, and two excellent chapters which focus on social inclusion and patient perspectives will provide much food for thought.

Finally, I was delighted to see a chapter on observation, which sets forth the view that the observation of the most ill patients in our residential settings should be provided within the context of a therapeutic relationship. By bringing together this range of excellent material the editors have also been able to produce a book which addresses the most thorny problems which face most frontline staff for much of their working day. Most importantly, the reader of this book will be availed of a wide range of information which, if put into practice, will improve the quality of services that we provide to one of the most needy groups in our society.

Kevin Gournay CBE
Institute of Psychiatry, King's College London
March 2003

An introduction to acute mental health care: from acute concerns to the capable practitioner

David Howard

This book was written in response to the demands being made on the reshaped mental health services for acute adult in-patient care. Effective integration of in-patient environments are essential for the delivery of the National Service Framework for Mental Health (DoH, 1999), the fundamental document underpinning the Mental Health Policy Implementation Guide for Adult Acute Inpatient Care Provision (DoH, 2002).

This is in direct contrast to the previous 25 years, however, where the majority of mental health policy in the UK focused on developing community-based services (DoH, 2002). While considerable improvements were made, both in the provision of care in the community and in encouraging innovative practices, this was often at the expense of investment in acute in-patient care, despite substantial demands made upon in-patient services caused by:

- a reduction in the numbers of in-patient beds;
- more challenging symptoms of the patients who were admitted (because community staff supported less severely ill patients within the community);
- an increased number of admissions complicated by drug abuse (Higgins et al., 1999; Watson, 2001).

The NHS Plan (DoH, 2000) took the first step in redressing this imbalance. It pledged the government to investing in developing and improving in-patient mental health services and, in April 2001, this commitment was followed up by making £30 million available for upgrading ward environments. However, it was not just the buildings that had been neglected over the previous 25 years. Staff working within in-patient settings had seen investment diverted into high-profile community-based services while at the same time, they were having to meet increased demands on in-patient

services with reduced numbers of available in-patient beds while simultaneously coping with more demanding symptom profiles of patients. This was compounded by an apparent devaluing of in-patient care, inconsistent services arising from local funding agendas and trust re-organisations, difficulties in recruiting and retaining in-patient staff and increased levels of sickness – particularly sickness associated with stressful work environments (Hurst, 2000). Furthermore, numerous reports have identified severe shortcomings in mental health care delivery (NIMHE, 2002) and, in turn, this has resulted in the adoption of 'defensive' working practices, the upshot of which in many areas resulted in a doubling of time senior ward staff spent completing paperwork (Higgins et al., 1999).

So within this context, why would anyone want to work within acute in-patient care? Although the situation described above sounds very negative, it must be remembered that it is precisely because of these circumstances that the attention of policy makers turned to the provision of in-patient care. While changes in mental health legislation has set targets for good practice, the means of achieving these targets relies upon the skills and commitment of practitioners within in-patient services.

The government's (long overdue) intention is to raise the profile of in-patient care and to recognise the specialist knowledge and skills of staff working in this area (DoH, 2002). Indeed, within the context of contemporary service delivery, achieving this intention is not an option. For those working within in-patient areas these factors present a rare opportunity to improve and develop in-patient services for the benefit of all stakeholders. This is therefore an exciting time to be working in this area and this period is likely to be seen as a watershed in care delivery in subsequent years. However, to meet these challenges, and to implement changes safely, requires that practitioners are informed and knowledgeable of contemporary practice. It is to support these staff, by supplying a resource of evidence to enable them to achieve these objectives, that this book was written.

A key report into contemporary mental health in-patient care was that of the Standing Nursing and Midwifery Advisory Committee (1999), *Mental Health Nursing "Addressing Acute Concerns"*. Although this was followed by two major publications – *The Capable Practitioner: A Framework and List of the Practitioner Capabilities Required to Implement the National Service Framework for Mental Health* (SCMH, 2001) and *The Mental Health Policy Implementation Guide* (DoH, 2002) – the majority of their recommendations for changes to practice within in-patient care in adult mental health can be traced to the six core areas originally identified by the SNMAC (1999) report. Consequently, the chapters within this book have been clustered around these areas.

- Assessment
- Involving users and carers

- Care management
- Management of risk
- Cognitive, behavioural and family interventions
- Medication management

Assessment

To begin, Joe Curran and Paul Rogers provide an overview of the purpose and practice of assessment in their chapter 'Acute psychiatric in-patient assessment'. By using a funnelling approach (from Hawkins, 1986) they introduce three levels of assessment beginning at the broad level, where open questions are used to gather information about the patient's background. Using this information as its base, the assessment gradually focuses down to specific questions designed to gain insight into specific issues linked to the patient's presentation.

It is at this point that specific, validated, instruments to record symptoms or indicators are introduced. A selection of empirically tested tools is outlined and the difficulties of obtaining accurate measurements are discussed. Finally, the chapter concludes by examining how the factors identified during the assessment can be incorporated within a plan of care.

Mick James and Damian Mitchell continue the section on assessment in their chapter 'Measuring health and social functioning using HoNOS'. A number of recommended outcome indicators make use of Health of the Nation Outcome Scales (HoNOS) and it is the application of these within an acute in-patient unit that is the focus of this chapter. There are numerous measures of outcome in mental health care and the debate surrounding the effective use of outcome data to inform clinical practice and service evaluation extends well beyond the use of HoNOS. However, the brevity and comprehensive overview of functioning provided by the instrument provides a relatively easy way of embedding outcome evaluation as part-and-parcel of routine clinical practice. The importance of linking outcome measurement with service practices and systems (e.g., care programme approach, clinical governance and audit, risk assessment and risk management) are debated. In addition, it is suggested that HoNOS data can complement more specific health outcome enquiries relating to groups of service users or specific service delivery models.

Involving users and carers

In their chapter 'Social inclusion and acute care' Julie Repper and Rachel Perkins identify concepts of social inclusion and social exclusion and how they apply to acute psychiatric care. In particular, the ramifications of being treated for a mental illness on the patient's employment and relationships

are discussed, and tentative strategies to counter these are identified. However, implementing these strategies within an acute ward environment, particularly when trying to maintain the involvement of family and friends, can be very difficult. So, to put this into perspective, the chapter concludes by encouraging staff to develop self-awareness by thinking what the ward environment is like for patients, relatives and friends.

Self-awareness is continued in the following chapter, 'Strategies for surviving acute care', in which Alison Faulkner gives a very candid account of experiences of receiving acute in-patient care. Some very moving examples of less than ideal practices are documented; however, the aim of this chapter is not to dwell on these, but to highlight aspects of good practice and explore how they can be developed. This is essential reading for care providers and will help to develop awareness of local practices. This chapter, while critical of some aspects of in-patient care, is not written in a negative fashion and there is much to be learned from the author's positive attitude and enthusiasm.

Care management

Drawing from experiences in the United Kingdom and the United States of America, Martin Ward and Gail Stuart examine how case management has been used to monitor quality and promote cost-effective care. 'Case management: perspectives of the UK and US systems' describes the components of case management and argues for its inclusion within UK mental health services, particularly to support people with enduring mental illnesses, where it would help to integrate health and social care services. This is followed by discussion of case management in the United States and examples are given of nurses acting as case managers. The low uptake of case management within the United Kingdom is discussed and ways that may lead to greater uptake are also highlighted.

This issue is developed in the next chapter, 'Integrated care pathways: the "acute" context'. Here, the progress of care pathways within the mental health system in the United Kingdom is examined. Julie Hall argues that the introduction of care pathways in mental health is an attempt to counter the fragmented care systems between different care providers to improve the overall quality of mental health services. Care pathways are described, and the link between this approach and their integration into the care management approach in the US is made. This is closely followed by a comparison of the motives of each system; the US system aiming to control costs while the care pathways attempt to ensure research-based evidence reaches clinical practice. And it is this latter point that demonstrates the benefits to users of the service, the professionals working within it and the

organisations providing it. Following this discussion, the application of care pathways within an acute in-patient setting is demonstrated using documentation that has kindly been supplied by Dr Karen Moody of the State Hospital, Carstairs, to allow readers to make an in-depth evaluation of the process.

Management of risk

In 'Risk assessment and management in acute mental health care', David Duffy, Mike Doyle and Tony Ryan examine risk from the perspectives of risk of self-harm and risk of violence. During the first part of this chapter, different methods of assessing the risk of self-harm are considered. Predicting who is likely to self-harm is notoriously difficult and the implications of false negative predictions when the patient succeeds in self-harming, and the staffing costs of false positive predictions, are discussed. They continue by examining how patients at risk of self-harm are managed and debate the issues of accurate screening, care versus control and the attitudes of care staff. Developing on the inconsistencies highlighted by SNMAC (1999), this section concludes with a discussion on the use of observation policies.

The second part of this chapter considers assessing the risk of violence. Factors associated with violent episodes are identified and, with this in mind, the importance of a multidisciplinary approach to assessment is justified. Within a therapeutic programme to effectively manage risk of violence, the authors consider the rights of the individual within the context of the rights, health and safety of others. Strategies and resources to help in the management of a potentially violent patient follow.

Julia Jones and Ann Jackson develop on these issues in 'Observation'. In this chapter, observation is defined as a therapeutic activity, as opposed to a means of collecting data. The patients who are most likely to require observing are those likely to self-harm and the chapter quickly focuses on this group. The trouble with observation, though, is that it is very intrusive and this forms the crux of the first part of this chapter where the difficulties of maintaining the dignity of a patient who is being observed are contrasted with those incurred when maintaining their safety.

It is safety issues that underpin the next part of the chapter where implications of the disparity throughout the UK, regarding observation policy, are considered. Great progress to resolve these issues was made with the introduction of the four-category system of observation in the SNMAC (1999) report. However, major inconsistencies remain, as the CRAG/SCOTMEG system that is used throughout Scotland only has three categories of observation. Despite their differences, though, both make similar

recommendations regarding good practice guidelines and the preparation and support of staff.

Finally, the chapter contrasts policy with the experiences of nurses giving, and patients receiving, observation and discusses how insight into their experiences might be incorporated into current practice.

Cognitive, behavioural and family interventions

This section begins with 'Cognitive behaviour therapy in in-patient care'. Here Kevin Gournay sets in context the use of cognitive behaviour therapy (CBT) with an historical overview of its use within in-patient areas. Its evolution is contrasted with contemporary practice by demonstrating how many CBT activities are already incorporated within the work of mental health staff. To respond to the SNMAC report, it is shown how, through measurement and experimentation, CBT can be developed as an evidence-based framework for practice. Finally, specific CBT techniques, and their applications within practice, are discussed.

Ian Baguley and Julie Dulson continue this section in their chapter 'Psychosocial interventions'. Underpinning the psychosocial intervention (PSI) framework is the stress vulnerability model (Zubin and Spring, 1977), and this is applied to the stress invoked by admission to an acute in-patient area, particularly one where aggressive behaviour is common. The PSI framework is structured around an ongoing process of assessment, formulation, intervention and evaluation and aims to understand problems from the patient's point of view. Ian and Julie show how PSI can aid early identification of relapse, which, in turn, can trigger the early involvement of supporting services, limiting the extent of the problems. Finally, the chapter ends by describing some methods of assessment and education that can be used in areas of in-patient care.

Medication management

Richard Gray begins the chapter 'Medication management' by observing that staff spend a significant amount of time helping individuals suffering from psychotic illnesses to manage their medication. Unfortunately, once discharged from hospital, many patients do not continue to take their medication reliably, and this often leads to a recurrence of symptoms and re-admission – the 'revolving door syndrome', which can be frustrating for all concerned. To help to address this, practitioners need to be able to provide information to patients regarding the way in which medication

works, and to be understanding of the effects of the medication from the patient's perspective.

Initially, the modes of action of different anti-psychotic medications are explained and their use in the treatment of psychosis is justified. However, the beneficial effects of the medication can sometimes be counterbalanced by undesirable side-effects and, in turn, this helps to clarify why many patients choose not to comply with taking medication. Richard continues by considering the implications of these issues, both for the individual and for the mental health services. From this base, the chapter progresses to identify factors that may enhance compliance. These are each examined critically, using empirically based evaluations, and the chapter concludes by identifying how the issues raised within this chapter can be incorporated within clinical practice.

Finally

This book provides a core framework from which to develop practice within acute in-patient areas. The chapters were specifically written to address the issues that were identified by SNMAC (1999) and NIMHE (2002) to enable practitioners to base the care they give on a sound, empirical framework. It is our hope for this book to primarily be used as a resource by practitioners by providing the evidence to support day-to-day practice issues, and to empower practitioners to implement the changes needed to improve care and practice within acute mental health in-patient areas. It can be seen from the information within these chapters that the role of in-patient staff can develop to provide specialist as well as generic services, and practitioners need to look beyond traditional ways of working, and fully utilise the CPA framework to enable continuity of care. This may simply occur by promoting more effective communication with community-based staff. However, staff may also choose to use the information within this book creatively, to justify extending in-patient services by including areas of care such as outreach work and extended day hospital services.

In the wider context, however, this book is an invaluable resource for managers to employ within staff development. We based this book on the structure of the SNMAC (1999) report knowing that this would enable practitioners to develop and meet many of the recommendations for improving practice identified within *The Capable Practitioner* (SCMH, 2001) and, in turn, many of the requirements of the National Occupational Standards for Mental Health (NIMHE, 2003). Thus this book is a contemporary resource to raise the profile of mental health in-patient care, providing an evidence base to support the expert knowledge and professional skills of staff working within this specialist setting.

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ONE

Acute psychiatric in-patient assessment

Joe Curran and Paul Rogers

Introduction

This chapter provides an overview of the assessment process in acute in-patient settings. Often an overlooked area, assessment is a crucial aspect of care as unidentified need, or an inaccurate assessment, may lead to ineffective interventions which can result in longer admission and a greater economic burden for overstretched services. This chapter then offers general details on the main methods of collecting salient information required within acute settings.

There are a number of models available that propose to help clinicians to identify relevant areas of assessment, such as the Hierarchy of Needs (Maslow, 1954; Mathes, 1981) and the Tidal Model (Barker, 2002). However, their true value remains a focus of ongoing debate due to their reliance on conceptual ideologies. As such, they will not be examined in this chapter. Instead, broader principles of assessment will be explored without relying on models offering assumptive views of the patient. Once this value-free assessment is complete, clinicians may then wish to utilise nursing, psychological, medical or social models of intervention.

Background

Effective skills of assessment are fundamental to the practitioner working within an acute in-patient environment. The *Mental Health Policy Implementation Guide* (DoH, 2002: 11), specifies the importance of

> … service user centred assessment of needs and risks … carried out using established methods and procedures for measuring symptoms, risk and social functioning.

In addition, the importance of mental health workers possessing the skills to conduct a comprehensive assessment of mental health problems is among the key competencies identified in *The Capable Practitioner* (SCMH, 2001). In a broader context, the Workforce Action Team (2001) describe work done on a functional map that identifies key purposes of mental health services. Key Area C, in particular, states that practitioners should

> … work with individuals to assess mental health needs, diagnose mental illness, and plan, implement and review programmes of care in the broader context of their lives. (p. 72)

In summary, a comprehensive assessment is patient focused and is conducted by competent practitioners as a fundamental part of the delivery of mental health services.

Assessment goals

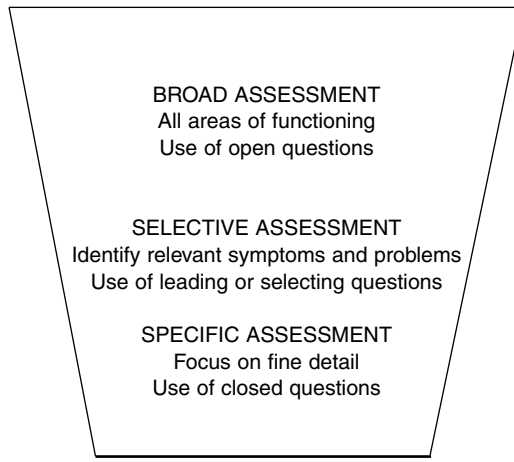
A comprehensive assessment results in:

- a detailed and precise description of the problems the patient is experiencing;
- a clear description of the patient's current symptoms;
- a comprehensive risk assessment;
- a description of the patient's social, occupational and domestic circumstances;
- the support available to the patient;
- family/carer perspectives;
- an overall management care plan;
- a treatment care plan;
- methods of evaluation.

The role of the assessor

The assessment of in-patients involves a number of mental health professionals. In some instances each profession generates its own reports independently, storing these in their own sections within the patient's case-notes. In other circumstances a single assessment process may be conducted, where all involved in the patient's care share the same assessment and recording procedures. Whichever method is adopted, clear communication of the findings, and of the subsequent plan, of care is essential.

Figure 1.1 The funnelling approach to assessment (based on Hawkins, 1986)



Assessment framework

I keep six honest serving men
(They taught me all I know):
Their names are What and Why and When,
And How and Where and Who.

(Rudyard Kipling, 1865–1936)

Hawkins (1986) developed an approach to assessment that is described as 'funnelling' (Figure 1.1). Here, the clinician begins the assessment, taking a broad view of the person and their experiences by assessing a wide variety of areas (e.g., 'What problems does the patient have? Where do these problems occur? When do they occur? With whom do they occur?'). Open-ended questions are used to gather a wide range of information, which on the surface may seem irrelevant; however, it ensures that the assessor is as little influenced as possible by their own, or others', preconceptions about the patient. Funnelling thereafter occurs to identify the fine detail of the problems (e.g., 'When is the problem worse or better?'). Once this has been achieved a complete understanding of the patient's problem can be written as problem statements which become the focus of subsequent treatment or interventions.

The fundamental principle underlying any assessment has the patient and their current experiences at its core. However, a purely symptomatic approach to assessment will not include important contextual factors that may influence the patient's functioning. For this reason it is necessary to

assess and understand the nature of the patient's environment prior to (and after) hospitalisation, and to consider the resources available to the patient whilst they are in hospital. The acute in-patient environment is not representative of the patient's world. It is a place that the patient goes for the convenience of mental health services. These services are not perfect, therefore it is crucial to understand what they can and cannot achieve within it, otherwise the assessment will become idealistic. Consequently, to fully assess a patient's needs and develop a plan of care, the assessor needs to consider the environment within which the assessment occurs and within which treatment will be delivered. As such, the following areas are of relevance:

- the strengths and limitations of the physical environment;
- the strengths and limitations of the ward team;
- the strengths and limitations of others involved in the patient's care;
- the strengths and limitations of home treatment teams;
- joint working arrangements;
- ward atmosphere;
- resources;
- discharge arrangements.

What to assess

The English *National Service Framework for Mental Health* (DoH, 1999: 22) notes:

> Assessment should cover psychiatric, psychological and social functioning, risk to the individual and others, including previous violence and criminal record, any needs arising from co-morbidity, and personal circumstances including family or other carers, housing, financial and occupational status.

Assessing symptoms

A broad-based approach to assessment comes from the bio-psycho-social perspective that incorporates biological, psychological and social aspects of a person's experience. For example: biological (e.g., physical functioning, diet, physical investigations and sleep); psychological (e.g., mood, thoughts, feeling states, behaviour, affect, early warning signs for symptoms and relapse indicators/signatures); and social (e.g., social support, family situation, housing, occupation and spirituality).

Assessing risk

Again, the *National Service Framework for Mental Health* (DoH, 1999: 22) notes:

> Evidence suggests that the quality of the initial assessments is enhanced when it is multi-disciplinary and undertaken in partnership between health and social care staff. All staff involved in performing assessments should receive training in risk assessment and risk management, updated regularly. A locally agreed pro-forma should be used, with all decisions recorded and communicated to colleagues on a need to know basis.

Assessing risk should therefore involve all professions and involve a range of assessment criteria. It can be divided as risk to self and risk to others.

Risk to self through injurious behaviour invariably involves: past self-harm attempts (nature, motivations, dangerousness); presence and severity of current depression; presence of current suicidal ideation (method, ability to complete method, motivation); past and current drug or alcohol use; and past and current psychotic symptoms and their nature. In addition, an awareness of the strengths and limitations of the in-patient environment is crucial.

Risk to others includes assessment of the following: a known history of violence; the severity of previous violence; who the victims of violence were; thoughts of violence; previous and current psychotic symptoms and their nature (e.g., paranoia, command hallucinations); and past and current drug or alcohol use. Risk, however, should not be limited to physical violence as other risks may occur (e.g., threats, stalking, dangerous driving, etc.).

Assessing previous interventions

The responses to previous interventions are important but often overlooked. Knowledge of previous responses can determine whether the services have been appropriate for the patient and where weaknesses may lie. Consequently, the assessor should try to learn why the patient has returned to hospital from a global perspective and not merely from a diagnostic or symptom perspective. As such, the following is helpful:

- chronological history of previous interventions;
- the nature of these interventions;
- the means by which these interventions were delivered (length of admission, dose of medication, practitioner delivering);
- the known effectiveness of interventions (short-term and long-term effects and how these were measured);
- the patient's views of these interventions (acceptability, intrusiveness, satisfaction);
- previous and current medication (side-effects, adherence, cost).