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# AP in B

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meeting the mental health needs of the  
Asian service-user—a review

the use of advance directives—a service  
provider and service-user perspective

coming to terms with suicide—a personal  
reflection

staff burnout—outcome evaluation

*and more.....*



## Advancing Practice in Bedfordshire

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Guidelines for Contributors are available upon request.

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*As randomly selected by the editorial group, the following authors of two articles published in APB Edition 1 will each receive a free book:*

- ◆ Sue Stimson
- ◆ Anna Hames

## Editorial:

### John Butler

On behalf of the editorial group, I am pleased to introduce the second edition of the quarterly Trust Journal of Bedfordshire & Luton Community NHS Trust.

In this issue, we are pleased to feature a varied range of articles on topics as diverse as the mental health needs of Asian service-users, staff burnout, and the use of advance directives.

#### **I would like to highlight just a few of these articles:**

*Visu Suppiah's literature review on the mental health needs of Asian service-users is particularly topical given the high ethnic mix of our local population, and certainly highlights the need for cultural sensitivity training—a summary of his research in this area will feature in our next edition;*

*Alison Bass describes her experience of developing, implementing and reviewing an 'advance statement' with one of her clients—this is very timely, as it coincides with the current review of the Trust's Care Programme Approach Policy, which will incorporate a new facility for the development of advance statements in close collaboration with service-users;*

*Shannaz Wahid provides a personal account of her experience in coming to terms with suicide—she identifies some of her initial reactions, thoughts and feelings, which many of us may well identify with, and highlights a number of positive learning points for future practice;*

## Advancing Practice in Bedfordshire

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[www.advancingpractice.co.uk](http://www.advancingpractice.co.uk)

*Louisa Tanner outlines the findings of a recent audit of staff knowledge about the protection of vulnerable adults, highlighting key recommendations for practice and training.*

To complete our second edition, we have included an outcome evaluation, part 2 of an action research study—to complement the study presented in our first edition, and an update on an innovative practice by our colleagues in a neighbouring Primary Care Trust.

To coincide with the recent launch of the Trust Journal, we have also now established a web-site for the on-line version of the journal—you can now download individual articles or an electronic copy of full journal issues in portable document format, from: <http://www.advancingpractice.co.uk>

We are of course interested in hearing your ideas for the further development of the journal web-site, which can now also be accessed via the Trust web-site (<http://www.blct.nhs.uk>) and the NIMHE Eastern web-site (<http://www.nimheeastern.org.uk>).

# Meeting the mental health needs of the Asian service-user: a review of the literature

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## LITERATURE REVIEW

### Introduction

In reviewing some of the literature, I will: consider the definition of ethnicity and racism; the migrational background of the South Asian population in Britain in relation to mental distress; the ethnic minority service-user's experience of mental health services; the concept of need; and finally conclude by identifying some key issues for mental health workers.

### Ethnicity or Racism

The term ethnic minority or ethnic minority group is currently used to describe any group of people who share a common heritage which is distinct from that of the white British population. However, no terminology is static or acceptable to everyone, and no more so than in the categories of race or ethnic group where the use of terms is inconsistent throughout the literature. Most authors define ethnicity to suit the purpose of their particular study. Chandra (1996), for example, has noted that 'ethnicity' has replaced 'race', and Chirico et al (2000) have suggested that ethnicity or 'ethnic group' membership is a product of many interlocking influences and dimensions, which includes heredity, language, religion and history. Although the term 'ethnicity' has largely replaced race as the appropriate way to think of human difference, ethnic boundaries are not immutable and can change according to historical and political circumstances (Smaje 1995). Peach (1996) sums up the issue by suggesting that ethnicity is contextual rather than absolute, for one can be Welsh in England, British in Germany, European in Thailand, and White in Africa. Some, but not all, of these elements have relevance to the delivery of health care (Johnson et al 1999).

Given this complex nature and fluidity of the ethnicity concept, and not wanting to indulge in detailed discussion on the impact of racism on health care, it is important to realise the effects this has on mental health. Inequalities in health and health care in relation to race and ethnicity pose ethical problems, of which racism is the most disquieting.

Fernando's study (1986) demonstrated how the effects of racism resulted in depression through experience of loss, rejection and helplessness. It may also create a predisposition to depression through a feeling of hopelessness and an inability to exercise any control over external forces (Curren 1984, Cochrane et al 1977).

Bhopal's (1998) extensive research of the literature concludes that empirical evidence is scarce and hard to interpret, but much public opinion and some scholarly analysis in the United States and the United Kingdom place racism at the hub of ethnic and racial inequalities in health (including mental health), and health care. Given this to be the case, there seems little doubt that people from minority ethnic groups experience double discrimination when they come into contact with mental health services (Mind 1994).

### **Migration and Mental Distress: a brief historical background**

People of South Asian origin migrated to Britain for many reasons, and came from a variety of backgrounds. Many South Asian migrants came to Britain during the acute labour shortage in the late 1950s to fill employment vacancies in jobs which were seen as less desirable by the indigenous population. The early migrants acted as bridgeheads, helping newly arriving migrants, whether or not they were blood relatives. This created, and is currently reflected in, an uneven distribution of settlement in Britain from the fact that migrants tended to follow one another through a network to industrialised areas where factory work was available (Robinson 1996).

People of South Indian origin migrated in the 1960s mainly from the two states of Gujarat and Punjab after the Second World War, and found employment in

textile and wool manufacturing industries. Punjabis from India are mainly from the Sikh community, but the largest single South Indian group in Britain are Gujeratis, the majority of whom are Hindus. Similarly, people of Pakistani and Bangladeshi origin arrived in Britain in the late 1950s and early 1960s and they too worked mainly in the textile and engineering industries, although Bangladeshi men are now predominantly employed in the catering industry. It is evident from the history for all three groups that the men came to Britain initially and were later joined by their families. One may conclude that these workers often worked long hours without much support from statutory agencies.

The 1991 Census indicated that about half of the minority ethnic population in the UK is of South Asian origin (OPCS 1992). Rather than being a homogenous group, they are characterised by a range of diversities – of religion, language, place of origin and cultural traditions. Although the experience of disadvantage and racism is common to all members of these communities, significant differences also exist in terms of their socio-economic and health status. For example, their ability to read and write English, rates of unemployment, educational achievement, place of residence and levels of overcrowding all vary significantly between different communities, with the Bangladeshi community experiencing the greatest disadvantage and deprivation. The South Asian communities are now fairly settled in Britain and a third generation of British Asians has emerged. The first generation is reaching old age, with the Indian community having the highest percentage of older people (over 60 years) compared to all other minority groups.

As with all minority groups, many South Asians experienced cultural differences, a sense of loss, alienation and racism upon their arrival in Britain. This combination of social and cultural need is associated with an increased likelihood of mental distress. The effects of the migration process, resettlement and transition on mental health cannot be underestimated. Often this group have left the comfort of a close community and wide family networks to live in a "hostile" neighbourhood, where links between members of their community are tenuous. Studies have revealed the importance of community networks and their effects on mental well-being. Stresses from family life and culture are intensified by outside factors – for example, in Asian communities there is high unemployment, poor housing conditions, low incomes, failing businesses, the experience of racism and discrimination at work (Rawaf & Bahl 1998).

### **The ethnic minority service-user's experience of mental health services**

There has been a plethora of literature on minority ethnic groups and the allocation of services. Additionally, it is well documented that discriminatory political, economic and social processes serve to undermine the equitable distribution of resources. Mainstream psychiatry is not exempt from these factors (Cochrane & Sashidharan 1996).

Prevalence rates of mental illness for Asian groups in Britain is roughly equivalent to or slightly below the indigenous population for major psychiatric disorders, yet these groups are under-represented in outpatient services for minor mental health problems (Harrison et al 1984, Goodwin & Power 1986). Although the available published information relates mainly to

minority ethnic people who are admitted to psychiatric hospitals (Bhui et al 1995), it is now well accepted that statutory services do not seem to be effective in detecting mental health problems across all ethnic groups, nor are they able to gain the confidence of such groups. Research on the mental health of these communities has not addressed the perception that they do not receive services which they see as acceptable and relevant to their needs (Fernando 1995, Bhui 1997). The higher incidence of compulsory admission into psychiatric hospitals amongst the ethnic minorities is now well documented (Khan 1983, Ineichen 1984), with Asians being more frequently admitted by a General Practitioner (GP) under Section 4 (MHA 1983), and with 8% of those subjected to Section 136 (MHA 1983) later being deemed not to be suffering from any mental illness and thus being subsequently discharged (Webb-Johnson 1991).

Having entered the mental health service, the diagnosis of psychosis is higher amongst the ethnic minorities (Cochrane 1977, Carpenter & Brockington 1980). One cross cultural study, for example, revealed no substantial difference between groups in the number of compulsory admissions, nor in the length of stay in hospital, although a higher proportion of those from Asian groups were diagnosed with 'psychosis'. Moreover, ECT was given more frequently to Asian patients diagnosed with schizophrenia (Shaikh 1985). The effects of racism within services and the resulting misdiagnosis are well recognised as important contributory factors to the higher rates of diagnosed mental illness within the ethnic communities.

It is also evident that users of the service are more likely to receive

medication than 'talking therapies' such as psychotherapy or counselling (Campling 1989, Ilahi 1988). The issues here are complex but include: a lack of awareness and confidence amongst GPs regarding the effectiveness and availability of services; the perception that Asians lack the required psychological insight; the perception of Asians as thinking only in bodily (somatic) or spiritual terms; a lack of Asian psychotherapists; and the perception that psychotherapy is a treatment for the privileged white middle-classes.

Asian communities are also disadvantaged by language difficulties and an over-reliance on relatives and untrained staff as interpreters. The low use of mental health services among Tower Hamlet's Bangladeshi community was thought to be a consequence of language and cultural difficulties which inhibit access to services (Webb-Johnson 1991).

South Asian women are further disadvantaged, having higher levels of stress (Glover 1991) and being more reluctant to utilise services provided by male practitioners (Raleigh 1995). Studies have also indicated that suicide rates among young Asian women are higher than other groups, with rates among 15-34 year olds being 60% higher (Raleigh and Balarajan 1992).

Several hypotheses have been suggested for the apparent lower prevalence rates of mental health problems in Asian groups, despite evidence to the contrary (Dean 1981, Glover 1991, MacCarthy and Craissati 1989), and the lack of uptake of mental health services by these groups. One hypothesis is that Asians in Britain suffer fewer mental health problems than the indigenous population because Asian immigrants to Britain have been self-

selected for their psychological well-being (Cochrane et al 1977). This has never been tested and a number of studies have provided evidence to the contrary (Murray & Williams 1986, Bal 1987, McCarthy & Craissati 1989). Cochrane & Stopes-Roe (1997) showed that an Asian immigrant sample is more prosperous and better adjusted socially than their native neighbours. These discrepancies may be accounted for by the heterogeneity of Britain's Asian communities – therefore the view that they uniformly suffer fewer mental health problems than indigenous subjects is unlikely to be sustained.

The poor uptake of services by these groups may be a consequence of their help-seeking attitudes and behaviours, being more likely to consult traditional healers, or the result of cultural variations in expressing distress (Wilson & MacCarthy 1994). However, this is challenged by studies that show that Asians consult their GPs at least as frequently as their white neighbours (Brewin 1980, Murray & Williams 1986). Moreover, studies of the role of traditional medicine in Asian communities in Britain suggest that traditional healers are frequently consulted in addition to, rather than instead of, a western GP (Bhopal 1986).

There are various reasons for this reluctance to approach mental health services, as summarised by Raleigh (1995):

- ◆ psychological distress not being recognised or being perceived as a physical illness
- ◆ the family manages the symptoms
- ◆ the stigma associated with using mental health services
- ◆ a lack of awareness of local statutory services

- ◆ services are seen to be inappropriate
- ◆ language and communication problems
- ◆ common misperceptions about the lack of confidentiality
- ◆ contact with health services and the involvement of male workers being inhibiting for women

Although Raleigh (1995) does not describe the processes involved in reaching these conclusions, these appear to be important factors. The difficulties for mental health service providers are that they are dependent on information on patient satisfaction to enable them to assess and subsequently to improve the quality of their services. However, research in this area is fraught with difficulties. The concept of patient satisfaction is difficult to define and there is no universal agreement over the dimensions that should be included in any research or indeed the methodology to be employed.

### **The concept of mental health need**

Service providers need to be consistent in defining need and how this relates to prioritising access to mental health care, especially for ethnic minority groups. However, there has traditionally been little consensus about the precise meaning of 'need', with the scope and quality of assessment being dependent on the professional conducting the assessment.

The NHS and Community Care Act (DoH 1990) defined need as 'the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life'. This definition equates need with the level of social functioning. Thus, need arises as a result of social

disablement, which occurs when a person experiences lowered psychological, social and physical functioning in comparison with the norms of society (Wing 1986). Subsequent policy guidance documents from the Department of Health (DoH 1993, 1995, 1999) have provided more detailed guidance towards the implementation of a needs-led service, specifying, for example, that services should be more responsive to individual need.

Similar social and political pressures exist in other countries. In Australia, for instance, services have an increasingly user-centred orientation in their philosophy (Kral 1992), whilst in India, where 90% of the mentally ill are without medical assistance (Chandreshkhar et al 1991), there is less empowerment of individuals due to a greater involvement of families who are more concerned with helping clients to fulfil their social and familial roles.

Standardised approaches have been developed for the assessment of need, such as the MRC Needs for Care Assessment (Brewin and Wing 1987) and the Camberwell Assessment of Need (CAN) (Phelan et al 1995), that incorporate staff, patient and carer perception of needs. Although these tools have clinical utility, their reliability has been questioned (Slade et al 1996). It was found that staff and patients rated approximately the same number of needs on the CAN, but in different areas, suggesting a difference in perceptions – a factor that is well supported by Sashidharan and Commander (Rawaf & Bahl 1998). Professional discipline, work location (community, hospital etc...), cultural factors, and personal / professional agendas may all influence the way in which professionals assess the needs of

the mentally ill person, including the ethnic minority group (Slade 1994). Differences across cultures, professions and work locations in assessing need will have implications for individual packages of care as well as for service development.

Senivassen's (1997) extensive review of the literature on the concept of need highlighted its complexity both from a client and a professional perspective. He argues that stakeholders in mental health services have a stake in the way 'need' is conceptualised and operationalised, and as a concept, 'need' is complex, multidimensional, elusive, and therefore often difficult to operationalise (Lightfoot 1995, Carter et al 1995, Senivassen 1997)

**Issues for mental health workers**

It is accepted that culture plays an influential role in understanding the health behaviour of individuals (Helman 1990). Helman (1990) and Leininger (1985) suggest that in order to provide therapeutic care, nurses in particular need to have a knowledge of caring values, beliefs and practices of other cultures.

However, professionals in the statutory services have only a limited understanding of how to adapt their ways of working so that they can achieve a clearer understanding of the needs and problems of people who do not share their cultural background (Bhui 1997). Clients from ethnic minority backgrounds often differ in their styles of communicating distress, as demonstrated most poignantly by Fenton & Sadiq (1993) in their ethnographic account of Asian women's experiences of depression.

The trend in the health services of the 1990's was towards consumerism, as exemplified by the Patient's Charter (DoH 1991, 1997) which reflects the

rights of service users. This has been followed by a series of reports and recommendations (DOH 1998, 1999a, 1999b, 2000) demonstrating the present government's strong commitment to addressing a range of health issues, with a greater emphasis on the rights of the service user. Furthermore, the past decade has witnessed a growing number of studies assessing consumer satisfaction in different health care settings that include inpatient services (McIntyre et al 1998), day hospital (Rothwell et al 1989), community based services (McAuliffe and MacLachlan 1992) and multi-disciplinary services (Ferguson et al 1992).

Despite this increasing focus on consumerism and the rights of the service user, the value of this approach has been questioned. Fitzpatrick (1991) cited the most common reasons for not using the approach as: professional fear and suspicion that dissatisfaction will be discovered; and, ingrained beliefs that service user responses reflect ill-considered or unstable thoughts. It has also been argued that expecting service users to be both patient and consumer can give misleading messages, and contribute to subsequent relationship difficulties (Mangen and Griffith 1982). Supporters of consumerism in health services (Lebow 1982) recognise the merits of such arguments, but propose that they may not be enough in themselves to dismiss or invalidate the need to take steps towards accessing and obtaining the views of service users. Mind (1998) and Bhui (1997) recommend that appropriate service development for people from Asian communities, as with other Black and minority ethnic communities, requires their involvement in service and care planning and implementation from the outset, rather than attempting to slot them into services which are not tailored

to meet their needs (Reid-Galloway 2000).

### Conclusion

It is evident from the literature reviewed that the issues of ethnicity, race, the causes of mental distress, and the concept of mental health need are complex and are dependent upon who is asked and who is asking.

Although the literature highlights the difficulties in providing for an increasing demand for health care among ethnic minority groups, it indicates that the South Asian group is under-represented in mental health services. Professionals / providers in the statutory services have a limited understanding of the needs and problems of people who do not share their cultural background (Bhui 1997). Furthermore, the need to enhance awareness, knowledge and skills is not presently adequately reflected in any training curriculum for medical undergraduates (Huby et al 1989), although a recent report on ethnicity and training for nurses was very encouraging (ENB 1998).

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## Staff Burnout: outcome evaluation in an Assertive Outreach Service

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### OUTCOME EVALUATION

#### Introduction

The Key Outcomes Evaluation Project is a programme of clinical and service audit for the Bedford, Heartlands and Luton Assertive Outreach Teams. It involves collecting information based on the key outcomes identified in the National Service Framework for Mental Health (DoH 1999), from service users, carers and staff. One key measure is staff burnout.

Committed and competent staff are essential to the success of Assertive Outreach Teams. However, nationally there have been difficulties in retaining and recruiting staff to mental health services (SCMH 2001). One possible reason for this may be that staff providing these services are under significant amounts of stress. A major contributor to burnout has been found to be emotional demands, in particular when clients are experiencing distress, pain or anger (Cherniss 1993). Additionally, it has been suggested that working in intensive community care of severely ill clients may lead to a high risk of burnout (Connolly et al 1996). This is particularly likely to be a risk for Assertive Outreach given the high severity of illness, complexity of need and levels of risk presented by the client group.

Data regarding Assertive Outreach staff experience is scarce. However the Pan-London Assertive Outreach study has investigated staff experience in Assertive Outreach Teams across London (Billings et al 2003).

The Assertive Outreach teams in the Pan-London study were divided into clusters (A, B and C) based on working conditions and resources. All four cluster B teams had a mean result indicating that staff experienced high Emotional Exhaustion. These teams took full responsibility for the clinical and social care of their clients but had greater caseloads per staff member and were generally less well resourced than comparable teams with the same responsibilities. This implies that when having to work without adequate resources, the

management of clinical and social problems of clients may be more stressful and difficult (Billings et al 2003).

Data from the Pan-London Assertive Outreach study regarding staff burnout were compared to the data collected on staff burnout in the Bedfordshire and Luton Assertive Outreach Teams.

## **Burnout**

Burnout has been described as a 'syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment' (Maslach et al 1996). Emotional exhaustion occurs when emotional resources are depleted – workers feel they are unable to give of themselves at a psychological level. High emotional exhaustion is related to self-reports of somatic symptoms such as headaches and sleep disturbances (Leiter et al 1994). It has also been reported that amongst nurses greater demands were associated with increased exhaustion (Landsbergis 1988).

Depersonalisation describes a state where a staff member develops negative, cynical attitudes and feelings about clients. Depersonalisation has been reported to lead to staff members viewing clients as somehow deserving of their troubles (Ryan 1971).

The third aspect of burnout, personal accomplishment, is related to the self-evaluation of workers – workers with a reduced sense of personal accomplishment tend to feel unhappy about themselves and have low job satisfaction.

Research suggests that burnout can lead to deterioration in the quality of care or service provided by staff. Burnout also plays a part in absenteeism, staff turnover and low morale. On a more personal level,

burnout has been found to correlate with self-reported indices of personal dysfunction including physical exhaustion, insomnia and marital problems.

## **The Maslach Burnout Inventory** (Maslach et al 1996)

The Maslach Burnout Inventory (MBI) is a commonly used, 22-item, self-administered measure of burnout in research. Using the rating scale provided, the respondent is asked to read each of 22 statements and rate how often s/he feels that way about his or her job – this measures three sub-scales of personal accomplishment, depersonalisation and emotional exhaustion

Maslach et al (1996) describe the typical burnout profile as high emotional exhaustion, high depersonalisation and low personal accomplishment. Numerical cut off points have been reported for various groups of professionals (Maslach et al 1996), as shown in Table 1.

## **Method: procedure**

The MBI was sent to 20 practitioners in December 2003: all care coordinators and support workers working in the Assertive Outreach Teams in Bedford, Luton and Heartlands; and, the Associate Specialist Psychiatrist in the Bedford Team.

To ensure confidentiality, staff were asked to return questionnaires anonymously. Some items on the questionnaire are sensitive and therefore it is important that respondents feel able to respond honestly. In addition, respondents were not required to disclose the team in which they worked, as some teams were small enough that it may have inhibited people responding if they were identified by

Degree of burnout	Score on Personal Accomplishment subscale	Score on Emotional Exhaustion subscale	Score on Depersonalisation subscale
HIGH	Low ( $\leq 28$ )	High (21+)	High (8+)
AVERAGE	Average (33-29)	Average (14-20)	Average (5-7)
LOW	High ( $\geq 34$ )	Low ( $\leq 13$ )	Low ( $\leq 4$ )

team. The data from the questionnaires were then entered into a database and the results were analysed.

### Findings

Fifteen out of 20 questionnaires were returned giving a response rate of 75%. This is considered a high response rate for a postal survey. The mean score and standard deviation for each subscale is shown in Table 2. Table 3 gives the number of staff that scored high, average or low for each subscale on the MBI.

The majority of staff (66.7%) obtained a score that suggests they experience high Personal Accomplishment. This was reflected in the overall mean, which was in the high category. However 20% (3/15) scored in the low range.

The mean score on the subscale measuring Emotional Exhaustion was also high. The majority of staff (60%) obtained a score that suggests they experience high levels of Emotional Exhaustion—four of the fifteen staff had scores in the low range.

The mean score on the subscale measuring Depersonalisation was low and this also reflected how the majority of staff (60%) scored. Two staff had high scores.

### Comparison of Results

The MBI manual contains normative data for comparison purposes. Chart 1 shows the normative scores for mental health workers, mean scores from staff in the Bedfordshire and Luton Assertive Outreach Teams, and mean scores

	Personal Accomplishment	Emotional Exhaustion	Depersonalisation
Mean	33.6 (high)	20.8 (high)	3.7333 (low)
Standard Deviation	5.04	10.60	3.56

	Personal Accomplishment	Emotional Exhaustion	Depersonalisation
Low	3	4	9
Average	2	2	4
High	10	9	2

reported in the Pan-London Assertive Outreach Study (Billings et al 2003), for each subscale.

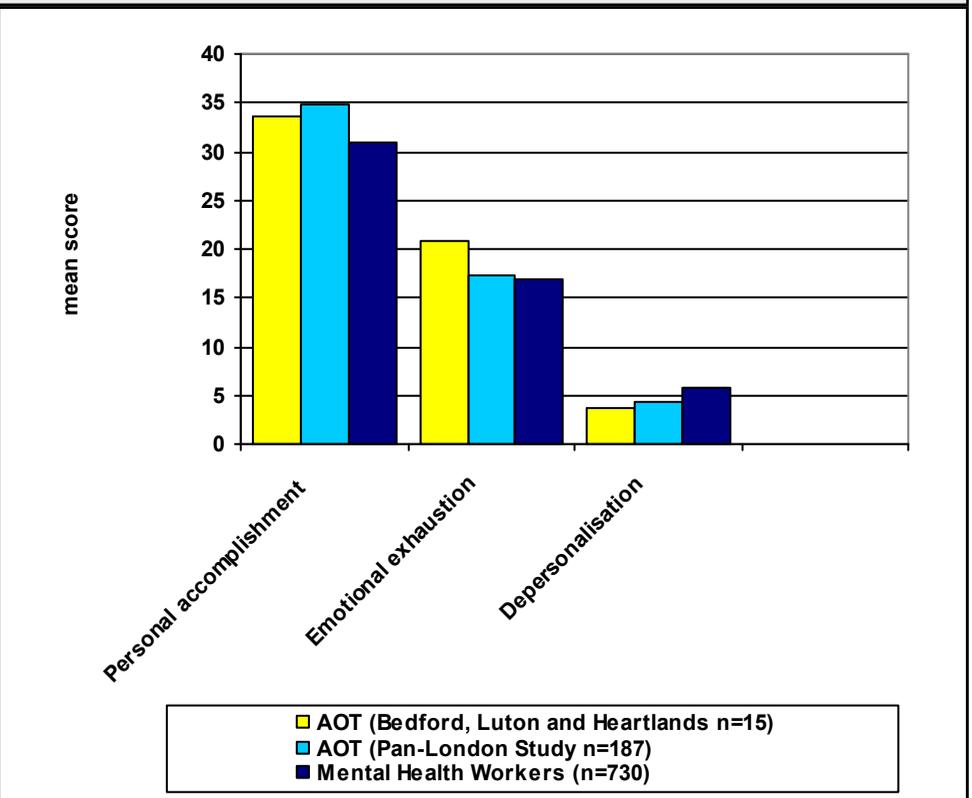
Compared to general mental health workers, the mean score reported for Bedfordshire and Luton Assertive Outreach staff suggests that Assertive Outreach staff may achieve a greater sense of Personal Accomplishment as did teams in the Pan-London study of Assertive Outreach staff.

The mean score reported for staff in the Pan-London Assertive Outreach study and the standardised norm for mental

health workers falls in the category that suggests staff are experiencing average levels of Emotional Exhaustion. The mean score for Bedfordshire and Luton Assertive Outreach staff suggests that they experience higher than average levels of Emotional Exhaustion.

The mean score for Bedfordshire and Luton Assertive Outreach staff and mean score from the Pan-London Assertive Outreach study indicate that Assertive Outreach staff may experience less Depersonalisation than mental health workers in general.

**Chart 1: Mean sub-scale scores from Bedfordshire and Luton Assertive Outreach Teams compared to mean scores from other mental health workers**



## **Discussion**

The results suggested that a majority of staff in Bedfordshire and Luton Assertive Outreach Teams may be experiencing high levels of Emotional Exhaustion. Although an average level of Emotional Exhaustion was reported overall for teams in the Pan-London Assertive Outreach study, the mean scores reported for a third of the teams in that study (nine teams) suggested that the members of those teams also experienced high Emotional Exhaustion.

Results from 66% of staff in Bedfordshire and Luton Assertive Outreach Teams suggest that they experience a high level of Personal Accomplishment. This is encouraging as it indicates low levels of burnout and also suggests that staff feel satisfied and happy with their work with clients. Compared to the standardised norms for mental health workers, Assertive Outreach staff appear to experience higher Personal Accomplishment. However this was not the case for all staff locally, as 20% reported low Personal Accomplishment scores.

Additionally, the Pan-London Assertive Outreach study found that Personal Accomplishment, reported to be experienced in Assertive Outreach Teams, was significantly higher than that experienced in Community Mental Health Teams (CMHT) included in the study (Billings et al 2003). It is possible that characteristics particular to Assertive Outreach, such as the team approach, working in an innovative service, small caseloads and working with difficult to engage clients, may be sources of satisfaction for staff. In support of this, researchers have shown that pleasant co-worker contact is related to high Personal Accomplishment (Leiter 1991).

The results from the Bedfordshire and Luton Assertive Outreach Teams and from the Pan-London Assertive Outreach study suggest that staff experience low depersonalisation compared to CMHT staff. It may be that because of the client group that Assertive Outreach aims to engage, staff working in this service have particular skills and personality traits that enable them to work effectively and therefore these staff members show low levels of depersonalisation. It is also possible that there are support systems in place, such as the team approach characteristic of Assertive Outreach, which helps prevent the development of depersonalisation.

## **Limitations**

This study has suggested that Bedfordshire and Luton Assertive Outreach staff experience high Emotional Exhaustion, high Personal Accomplishment and Low Depersonalisation. However, it was not possible to run comparative statistical analyses because the raw data from other Assertive Outreach studies was not available. It may be useful to compare future data collected to the data collected in this study. This may indicate trends in staff experience as the Assertive Outreach Teams become more established. It may also become possible to compare individual teams to each other without compromising confidentiality of responses.

Although the return rate was good and represents 75% of Assertive Outreach staff in Bedfordshire and Luton, the sample was still a small one. Generalising results to other Assertive Outreach Teams is therefore difficult. In addition, teams have distinctive characteristics, client populations and working conditions that may affect the

level of staff burnout experienced—the Bedford team works seven days a week, unlike the Heartlands and Luton teams.

Even though confidentiality was assured, staff may have found it difficult to disclose more negative feelings and it cannot be ruled out that this may be a contributing factor to the results.

Additionally, only one measure was used. To explore staff experience further, job satisfaction and other areas of staff experience could be investigated.

### Conclusion

Overall, high levels of the burnout syndrome have not been detected in this survey. Whilst significant levels of Emotional Exhaustion have been identified, the results show that the majority of staff may also be experiencing high levels of Personal Accomplishment and low Depersonalisation.

It has been argued that working with severely ill clients in the community may lead to a high risk of burnout and this in turn may be a threat to the model of intensive community care (Connolly et al 1996). In line with this prediction, results suggest that Assertive Outreach staff locally and elsewhere may experience high Emotional Exhaustion. This is a concern that needs addressing. It may be that emotional exhaustion is the first burnout feature to develop and there may be a trajectory for some individuals where this is followed by falling personal accomplishment and developing depersonalisation. For some individuals locally, lower than average personal accomplishment and/or problems with depersonalisation may be features of their experience. It will be important locally for team leaders and service

managers to review working conditions and staff experience of their role, to look at team support and supervision and to participate in the implementation of future surveys of this type.

Staff burnout should continue to be monitored as the Bedfordshire and Luton Assertive Outreach Teams are still in their early stages and will continue to develop and increase their caseloads.

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## Coming to terms with suicide: a reflective account

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### REFLECTIVE PRACTICE

for this reflective account, the name and personal details of the client have been changed to preserve anonymity and to assure confidentiality

#### Introduction:

As a community mental health nurse (CMHN), I will reflect upon a critical incident that occurred with one of my clients, using the Gibbs reflective cycle (1988). I will reflect on my learning and development through this experience, highlighting how this has enabled me to become more effective in achieving desired practice.

#### Description of the Incident:

Pete was a caucasian man in his early 60s, known to mental health services for the last 20-years or so and he was accepting treatment. He was regularly seen by the doctors in the out-patient clinic, by a support worker and by myself, as his CMHN. Pete used to abuse alcohol and on many occasions had been referred to local drug and alcohol services, although he inevitably failed to attend his appointments. Earlier last year, he was transferred from a third floor to a ground floor flat, which he had been wanting for some time as he suffered from chronic obstructive airways disease. However, within nine months of his move, he was admitted to a local mental health unit on three separate occasions, reporting suicidal ideas on each occasion—he had not previously acted on such thoughts. Pete was prescribed depot medication (*an anti-psychotic injection*), which was administered weekly, in addition to an oral antidepressant.

I attended a multi-disciplinary meeting prior to Pete's discharge from the unit, at which it was suggested that an enhanced CPA (*care programme approach*) care plan be agreed, due to his level of vulnerability. This implied that Pete required a higher level of care and supervision and further exploration of his unmet needs (Marshall 1996).

Following his discharge, Pete received weekly visits from myself, his social worker and support worker, in addition to six-weekly out-patient appointments. I had seen him on the Thursday, during the week of the critical incident, to administer his depot medication. On assessing his mental state at that time, his mood was not low, nor did he express any suicidal intent. Physically, he was well and he had been managing well within his new flat. He had been compliant with prescribed medication and said: 'I'll see you next week.'

On the Friday, one of my colleagues received a call on the CMHN telephone helpline from one of Pete's friends, stating that Pete had consumed alcohol and that he was suicidal. His friend wanted advice about what to do, and was advised to take Pete to the local casualty department. They were seen by a psychiatric doctor and a psychiatric liaison nurse, who both assessed Pete as not suicidal. He was discharged home.

It was on Monday morning that I, as Pete's care coordinator, was informed that he had jumped from a motorway bridge into the fast lane, and was killed. A critical inquiry was established and a formal investigation commenced.

Looking through the reflective window, I initially focused on myself, within the context of my own lived experience, in an effort to confront and understand the situation I was in. I quickly realised the differences between my expectations of the service and real-life practice—my expectation that I would receive debriefing and support were initially not met (Johns 2000).

A number of issues felt very significant:

- ◆ power
- ◆ support
- ◆ my response to clients receiving enhanced CPA care now
- ◆ oppression

According to Johns (1999), reflecting upon experience relates to the interconnectedness of looking in and out of many windows as part of the process of enlightenment, empowerment and emancipation (Fay 1987, cit. Johns 1999), in realising our visions of self and practice as a lived reality.

Reflection can be viewed as a critical social process moving through stages of enlightenment—with the purpose of understanding why things have come to be as they are. However, for various contextual reasons, this is often difficult in my area of practice. I had to focus on a sense of purpose, whilst feeling conflict and being fearful of negative consequences. Although I did become reflective, I also became increasingly sensitive to the more trivial and taken for granted aspects of my practice—things that would not usually be anxiety provoking or problematic. I had to deal with what was in my best interests as a consequence of taking appropriate action (Fay 1987, cit. Johns 1999). Yet natural reflection may only penetrate superficial levels of consciousness or may be geared only to relieving anxiety rather than learning from it.

As a reflective practitioner, I accept responsibility for ensuring that patients and families receive the most appropriate care. As such, I need to be in the best possible shape to be available to them. I thought that I had been until hearing of this tragedy. After finding out about Pete's suicide, I did not feel supported by my superiors—my line manager seemed only interested in whether my documentation was up to date. In response, I felt angry and fearful.

On reflecting upon my experience now, I should have challenged my manager over their lack of support as I feel that they missed the point that I had connected with my client.

According to Johns (2000), the practitioner works towards collaborative ways of managing conflict even if one party may be *reluctant to dance!*

This is both useful and desirable, and even though the team's philosophy is to work collaboratively, this cannot be assumed and has to be actively constructed (Johns 2000), although this may often feel like a struggle against the power gradients or more powerful others.

**Feelings:**

I felt extremely guilty and blamed myself for Pete's death. I thought that there must have been a weakness in the service that I provided. I obviously had not identified anything suspicious on that day—perhaps I should have? I could not talk about it as I felt that everyone must be blaming me. I did, for the first time in my life, feel oppressed.

I felt very guilty—a feature of the caring trap or, as Ann Dickson describes it, the compassionate trap, because I felt responsible for every aspect of his care—so it must have been my fault (Johns 2000).

Nurses tend to exhibit the same personal characteristics as other oppressed groups: a lack of self-esteem (Roberts 2000); warmth, nurturance and sensitivity in contrast to the characteristics of the dominant culture's intelligence, decisiveness and lack of emotion. Nursing, because of its lack of power (Hendel 1998) and control, except within its own group, has been viewed as oppressed again and again. I shared these characteristic feelings as a nurse amongst other team-members—consultants, doctors and social workers. They did not comment on any of the nursing aspects of Pete's care, even though I was the care coordinator. Roberts (2000) explained that the values of nursing are barely recognisable in patient care because of the dominance and internalising of medicine and the medical model.

I believe that nurses clearly need to stress their strengths and move forward based on an analysis and appreciation of those strengths (Gordon 1998). However, throughout the period of this incident, I did not feel able to talk about my standards of care and the quality of patient care.

**Evaluation:**

As I had not previously experienced attending a formal interview in front of a panel of five senior professionals, three of whom were doctors, I was in a state of turmoil. I felt unable to freely assert myself and identify positive ways of dealing with the situation.

Roberts (2000) proposes a five stage model to describe the behaviours of freeing oneself from oppression:

1. Examined acceptance — this represents the passive acceptance of the dominant view without exploring other alternatives. I was over-accepting and did not question anything—I felt that someone was to be blamed and it was probably me!
2. Awareness — this involves beginning to understand the power structure. As time went on, from the death to the panel interview, I began to realise that I, as the care coordinator, was in a powerful position to raise my voice.
3. Connection — I began to make linkages in forming a new positive self-image and professional identity.
4. Synthesis — this involves the new positive image becoming internalised and more authentic. My anxiety was replaced with a stability of belief in the ability of myself and my colleagues. Once the investigation was over and I

received a final report in which my work as the care coordinator was appreciated, confirming that I had indeed provided a high standard of care, my initial anger turned into energy for making strategic efforts towards change.

5. Political action — a genuine and ongoing commitment to social change.

For nursing, the need to analyse and change systems in which nurses lack power and are devalued are most important tasks. This is the true nature of multi-disciplinary teams (Holloway 2001). Nurses need to celebrate their impact on patient care and their successes as a profession, despite the forces against them.

Although I had a bad experience with the lead up to the panel meeting and completion of critical incident forms and formal reports, the outcome was a positive experience, as I was then praised by my managers and colleagues—even receiving a letter from the Chief Executive that, importantly, gave credibility to my work.

### **Analysis:**

Reviewing the value of life, and the meaning of after-life is a pre-requisite to explaining a person's preference for death. The subsequent choice of suicide is one of several options. The wish to die is experienced and becomes clinically visible when the person perceives his existence as meeting self-defined criteria for death as being the preferable action.

In this case, Pete did not at any time show or express a wish to die, neither did he look or state that he was clinically depressed. I saw him on the Thursday, and by the Sunday he was pronounced

dead—so then, how well do I really know my clients and how well did I connect with Pete?

### **Conclusion:**

Since this incident, I have started to use the suicide perception triangle model, which emphasises three key aspects relating to suicide (Cutter 2002):

- ◆ a wish to die
- ◆ a suicide plan
- ◆ sufficient distress to require relief

Together, these provide a necessary and sufficient situation for self-injurious behaviour—each is necessary but insufficient by itself.

I thought about why Pete didn't ask for help, as he usually would. Perhaps people who take their own lives regard their lives as unacceptable, because their understanding converges with self-defined criteria for death as being preferable. On reflection, I personally do not think that I could have done anything to have prevented Pete's chosen course of action—there was nothing I was particularly alarmed about. I have learned to request for time for debriefing in situations such as this, and now feel that I have a voice, no longer feeling oppressed.

### **Action Plan:**

If the same situation arose again, I think I would request clinical supervision in gaining opportunities for ventilating my feelings. If, at the time, I have questions about nursing documentation and how best to manage the client's care, I will express my thoughts and opinions rather than feeling oppressed and disempowered.

I feel more confident in empowering my colleagues, who may find themselves in a similar situation, in offering support.

Reflecting on the lived experience, I feel that I can advance my practice by maintaining an up-to-date knowledge of current studies on suicide. However, I have also started to use the suicide prevention triangle (Cutter 2002) with clients on my caseload who express suicidal ideas.

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## A Reflection on the Use of Advance Statements in Clinical Practice: a service user and service provider perspective

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### **SERVICE-USER INVOLVEMENT** Advance Statements: what are they?

'An advance directive (also known as an 'advance statement', 'advance refusal' or 'living will') is a way of making a persons' view known if he or she should become mentally incapable of giving consent to treatment, or making informed choices about treatment, at some future time. Doctors and healthcare workers must usually take these wishes (advance statements) into account. There are however certain conditions which need to be satisfied before an advance directive can be valid and there are some limits to what a person can direct.' (Mind 2004)

The British Medical Association has developed a code of practice (BMA 1995) about advance directives and advance statements, the use of which has increased over recent years and has raised ethical and legal issues throughout the profession. The code takes a practical approach and acknowledges a 'limited value' in the use of advance directives (refusals) and advance statements (preferences) in relation to the treatment of recurrent episodes of mental illness, and

especially in light of the overriding powers of the Mental Health Act 1983. (BMA 2004)

## **How do advance statements apply to mental health service users and professionals?**

### **A service provider perspective**

The use of advance statements in mental health practice is clearly advocated by the NICE Guidelines for Schizophrenia (NICE 2002: 7). The guidelines give a brief description of what an 'Advance Directive' is and what it could be helpful in achieving. They, however, do not provide advice on producing these directives, although they point out that there are limitations regarding choice of treatment and that doctors may not follow the directive for 'medical reasons'.

As a health professional working in the community, I could see the potential of the advance directive in enabling the service user to feel listened to and having some 'choice'.

Early in 2003 I was engaged in discharge planning with a client who had received treatment for a relapse of schizophrenia. The gentleman concerned, whom I shall refer to as 'H', had become familiar with admissions to psychiatric hospitals, and he has a 10 year history of mental health problems. Despite recurrent episodes of psychosis, 'H' remains extremely articulate, and intelligent.

The experiences that 'H' had regarding care and treatment of his mental health problems were negative from the very start. His treatment with medication had resulted in distressing negative side

effects and he has now lost count of the different types of medication he has been prescribed, usually when under the Mental Health Act and in hospital. 'H' felt like he was being experimented on, not in a delusional context, but as a result of having been given so many different medications as treatment, that had made him feel, in his words, 'depressed, agitated, restless, and sometimes suicidal'. He expressed distrust and open disgust at psychiatric services. This anger and hurt magnified significantly when he became unwell.

Following each admission, 'H' would discontinue his medication and there began the slow inexorable slide towards the next relapse. As I gained a better understanding of the illness experience from his perspective, I began to appreciate that, for him, being 'ill' was preferable to being 'treated for illness'.

Having read about them in the NICE guidelines, I introduced the possible use of an advance directive to 'H' in discussions about relapse prevention. The intention was that by addressing the issue of his fear of being prescribed medication that had given unwanted side effects, that 'H' would feel listened to, and by ensuring effective distribution of his treatment wishes, these would be respected where possible. These discussions engendered a more positive approach to treatment options, despite the fact that the resultant directive was quite simple.

At this time, there was little guidance available to me about the formulation of an advance statement. Therefore I followed the basic guidelines from Rethink (Rethink 2003). 'H', at the time of compiling the advance statement/directive, was competent to make those decisions, but I failed to provide formal

evidence for this. Whilst it is not imperative to have a witness signature for an advance statement, in retrospect, it would have been advisable for me to have done this as a health professional, especially given that 'H' has a long history of relapse in his mental state and past episodes where he has not had the competence to make appropriate decisions in his own best interest. It was also suggested, by Rethink, that such statements should be carefully drafted so that its terms are clear and it is obvious as to what treatment is being refused or consented to.

Unfortunately the preferred treatment also produced some 'intolerable side effects', namely akathisia and a period of depression, which were the reasons 'H' had declined to continue on this treatment from May. A further relapse did occur, towards the end of 2003, and despite being treated under the Mental Health Act, which overrides an advance directive, the treatment prescribed was the preference expressed in the advance statement.

I have subsequently appreciated the need to revisit advance statements as part of care plan reviews or if treatment preferences change: it is appropriate to do so as long as the individual is competent to make those decisions.

When his insight fully returned in April 2004 it enabled him to consider possible alternative treatments for future relapse episodes, as again he was clear that the drawbacks to his current treatment outweighed the benefits. He discontinued this treatment prior to discharge.

Providing valid and effective information to 'H' about medication based on his experiences, he explored the possible

use of an alternative atypical antipsychotic and even discussed this with fellow patients on the ward at the time. He carefully read through the information leaflets and researched side effect profiles. Discharge planning again involved the use of a further advance directive, superceding the previous one. (Practitioners should note that it needs to be made clear on the most current advance statement that it supercedes any or all previous statements.) This time, use was made of a format produced by Rethink, which includes issues wider than just medication preferences. Again it does not provide for a witness signature.

Despite being discharged without the prescribing of any medication, 'H' subsequently commenced olanzapine of his own volition, to avoid future relapses – something he has never done before. The use of an advance statement was by no means the only reason for this, but I feel that it played a valuable part in changing his experience of mental health services. By viewing the client as an authority on their illness, a sentiment strongly advocated in the use of 'The Tidal Model' (Buchanan-Barker 2004), and relapse episodes as a learning opportunity, it is possible, in collaboration, to enable the client to reach their own conclusions about their need for treatment and for them to exercise some control over what that may constitute.

**A service user perspective**

'Nobody should underestimate the lengths a person will go to in order to avoid the side effect terrors of drugs prescribed for schizophrenia. For me, living anonymously on the street in another part of the country is easily the

preferable alternative to drugs like Depixol. Any legal document lessening the possibility of the patient being terrorised with them is likely to reduce the possibility of the patient running away, or worse, committing suicide. I think it a vital part of treatment.' *'H'* (July 2004)

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## Are You Looking for Web-based Resources? Try these.....

### John Butler—Lecturer Practitioner in Mental Health

The following web-based resources will be of most interest to practitioners who work with people experiencing severe mental illness and particularly if using the concordance skills approach (medication management).

Web-site Address	Details
<a href="http://www.dh.gov.uk">www.dh.gov.uk</a>	the DOH site for government health policy and publications, and in particular for guidance papers on nurse prescribing
<a href="http://www.show.scot.nhs.uk">www.show.scot.nhs.uk</a>	Scottish Health on the web—on-line health information provided by NHS Scotland
<a href="http://www.rcpsych.org/">www.rcpsych.org/</a>	the Royal College of Psychiatrists site—fact sheets and leaflets are available free
<a href="http://www.web1.iop.kcl.ac.uk/main/mental_health.html">www.web1.iop.kcl.ac.uk/main/mental_health.html</a>	the Institute of Psychiatry mental health site—for information about current research into mental health
<a href="http://www.schizophrenia.com">www.schizophrenia.com</a>	a site with good links to patient related information
<a href="http://www.rethink.org/">www.rethink.org/</a>	the Rethink (National Schizophrenia Fellowship) site
<a href="http://www.rethink.org/at-ease/">www.rethink.org/at-ease/</a>	the Rethink (National Schizophrenia Fellowship) site for young people
<a href="http://www.sagb.co.uk">www.sagb.co.uk</a>	the Schizophrenia Association of Great Britain
<a href="http://www.mhrc.cc">www.mhrc.cc</a>	the Mental Health Resource Centre for England, run by a service-user, providing data, directories, resources and links
<a href="http://www.ukppg.org.uk">www.ukppg.org.uk</a>	the UK Psychiatric Pharmacy Group, established with the aim of ensuring best treatment with medicines for people with mental health problems and their carers—includes on-line support materials
<a href="http://www.nmhct.nhs.uk/pharmacy">www.nmhct.nhs.uk/pharmacy</a>	the Norfolk Mental Health Care NHS Trust Pharmacy Medicine Information site—a useful on-line resource for anyone interested in drug treatments for mental health

Web-site Address	Details
<a href="http://www.medicines.org.uk">www.medicines.org.uk</a>	the electronic medicines compendium, for electronic data-sheets, summaries of product characteristics and patient information leaflets
<a href="http://www.bnf.org">www.bnf.org</a>	the on-line version of the British National Formulary
<a href="http://www.npc.co.uk">www.npc.co.uk</a>	the site of the National Prescribing Centre & home of the MeReC Bulletin
<a href="http://www.mca.gov.uk">www.mca.gov.uk</a>	the site of the Medicines Control Agency
<a href="http://www.scmh.org.uk">www.scmh.org.uk</a>	the Sainsbury Centre for Mental Health (SCMH) site—includes information about the SCMH's latest research, development and training
<a href="http://www.cochrane.org/reviews/clibintro.htm">www.cochrane.org/reviews/clibintro.htm</a>	the comprehensive Cochrane library site with clinical trial data and information on many drugs currently being used in schizophrenia, including comparative data
<a href="http://www.nmha.org/pbedu/dialogueforrecovery/index.cfm">www.nmha.org/pbedu/dialogueforrecovery/index.cfm</a>	the National (US) Mental Health Association dialogue for recovery program for enhancing communication between doctors and patients about treatment goals, medication side-effects and other quality of life issues
<a href="http://www.nmha.org/pbedu/dialogueforrecovery/support.pdf">www.nmha.org/pbedu/dialogueforrecovery/support.pdf</a>	the NMHA leaflet guide for family and friends
<a href="http://www.nmha.org/pbedu/dialogueforrecovery/ClinicASCchecklist.pdf">www.nmha.org/pbedu/dialogueforrecovery/ClinicASCchecklist.pdf</a>	the NMHA Anti-psychotics Checklist
<a href="http://www.medicationmanagement.org">www.medicationmanagement.org</a>	a site offering guidance materials on the use of the medication management / concordance skills approach—take a look at the Concordance Skills Manual (Dr Richard Gray)
<a href="http://www.mhtu.co.uk">www.mhtu.co.uk</a>	JB's local Mental Health Training Unit web-site offering numerous materials to support mental health training and practice initiatives—this includes educational resources and practice worksheets to support the implementation of the concordance skills approach

## The Protection of Vulnerable Adults: a staff awareness survey

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### **QUALITY IMPROVEMENT & AUDIT CYCLE**

#### **Introduction**

Research into abuse and living conditions in institutional environments has long been an area of interest with notable work conducted by Goffman (1961) on asylums and Townsend (1962) on refuge. In 1975, Baker coined the phrase 'granny battering' to encompass the identified problem of physical abuse of older people.

Following on from this earlier research, Eastman (1982) & Clough (1988) extended their area of interest to include the abuse of vulnerable adults in family or domiciliary settings. It has become more apparent over the last 12 years just how prevalent incidents of abuse are, and research by McCreadie (1991), Biggs et al (1995) and Stanley et al (1999) in elder abuse in institutional settings identified a number of different categories of abuse along with the different environments where it can happen.

Research has primarily focused upon the characteristics of the person who is being abused, and it has been suggested that people with dementia may be particularly vulnerable. More recently, research has placed greater emphasis on the circumstances and the characteristics of the abuser.

A large telephone survey of Nursing Home staff was conducted by Pillemer & Moore (1989) in America—they found that 36% of staff had witnessed physical abuse, with 10% admitting to committing such once or more themselves; and, 81% had witnessed psychological abuse, with 40% personally admitting to it. In the UK, an average of 1,000 phone calls are made to the UKCC each year voicing concerns of abuse. Half of these calls report verbal, physical or sexual assaults.

Awareness of the risks that vulnerable adults are exposed to has been heightened partly as a result of research findings. Although there has undoubtedly been a great deal of progress, the risk of abuse to vulnerable adults is still a very real one.

In 1991, the Minister of Health at that time stated that the abuse of older people was not a major issue although there has now been a general acceptance that there is a problem.

The Government has more recently recognised the need to provide greater protection for vulnerable adults from abuse, and has proved its commitment with the production of the 'No Secrets' paper in March 2000, issued under Section 7 of the Local Authority Social Services Act 1970, which includes guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

During the period 2000-2003, CHI (Commission for Health Improvement) conducted and published 12 independent investigations of serious service failures within the NHS, which included the 'Services for People with Learning Difficulties' Directorate of Bedfordshire & Luton Community NHS Trust (BLCT). Common features were identified from all of the organisations investigated which led to the formation of three categories of serious service failure—one of these is the 'failure to protect vulnerable adults or service users – abuse of vulnerable people'.

### **Evidence for Concern**

In December 2001, the Commission for Health Improvement (CHI) conducted an investigation into Manchester Mental Health and Social Care NHS Trust amid concerns about the standard of care for older patients with mental illness on Rowan Ward. Concerns included allegations of older people being subjected to mental and physical abuse whilst on the ward. CHI also investigated claims of bullying and intimidation of staff and whether the Trust's whistle blowing policy was working effectively. The findings from the investigation into Rowan Ward, and additional investigations involving 34 Clinical Governance reviews, 3 investigations,

165 concerns from the public and 11 concerns from the public in Older People Services led to the identification of the following common themes:

- ◆ a lack of support for whistle blowing
- ◆ allegations of abuse not being listened to
- ◆ poor external monitoring
- ◆ low staffing levels
- ◆ inward looking cultures
- ◆ outdated practices
- ◆ weak leadership and management
- ◆ poor clinical leadership
- ◆ previous enquiries not being acted upon
- ◆ poor monitoring of prescribing
- ◆ lack of clinical supervision
- ◆ isolation from other services
- ◆ an absence of root cause analysis to learn from incidents
- ◆ an absence of standards for basic or essential care in areas such as hygiene, food and nutrition
- ◆ patients with organic and functional illnesses on the same ward became an issue in terms of staff inability to deal with these challenges—staff need to know how to respond
- ◆ role of non-executives was not always explicit
- ◆ a lack of accountability to partnerships

CHI also found that most staff who were interviewed in Older People Services had limited or no understanding of the Protection of Vulnerable Adults Policy. There was also no evidence of multi-agency guidelines being implemented on the wards and a lead person for the Trust's Policy had not been identified.

Previous research has shown that suitably targeted educational seminars can improve knowledge and management but simply producing printed educational material alone is ineffective. The content of a training course needs to be tailored to individual needs according to pre-existing knowledge if it is to be of value (Richardson et al 2002).

**Aims**

The protection of Vulnerable Adults has always been a high priority for the Trust, and the ratification of BLCT's 'Protection of Vulnerable Adults Policy & Procedures', in April 2003, has prompted further investigation into staff knowledge surrounding this area, to ensure that the Policy becomes truly embedded in the organisation.

Our aim for this study was to measure staff knowledge and understanding of the Protection of Vulnerable Adults Policy & Procedures (BLCT 2003) with a view to developing future training in this subject area.

**Objectives**

A series of specific objectives were developed for this study:

1. to discover how many staff have actually received training on the Policy;
2. to find out if staff are actually aware that the Policy exists and if they know how they can access it;
3. to assess how knowledgeable staff are on the contents of the Policy;
4. to judge staff awareness of the definition of a 'Vulnerable Adult';
5. to assess staff awareness of the different categories of abuse;

6. to gauge staff awareness of who an abuser could be;
7. to discover what course of action staff would take upon their suspicion of abuse;
8. to use the findings to determine whether formal training on the Policy is needed.

**Methodology**

It was decided that a staff questionnaire would be the method used to collect data via a series of multiple choice questions, in addition to questions that required written descriptive responses. The questions were developed jointly by the Clinical Governance Assistant and Clinical Audit Manager and were focused around the information found in the Protection of Vulnerable Adults Policy. A computer software package was then used to create the questionnaire.

A pilot of the questionnaire took place prior to the actual audit to determine if the questionnaire was user friendly and measured exactly what was intended—this involved five representative staff in the Weller Wing acute in-patient setting. These questionnaires were analysed by the Clinical Audit Department—no further changes were considered necessary or made to the questionnaire.

For the main audit, the sample consisted of staff from 11 community mental health bases for older people in Bedfordshire: 2 acute in-patient wards, 1 long stay unit, 4 assessment centres, 3 day hospitals and 1 community and social services base.

It was decided that the audit would take place over a 24-hour period to cover a morning and evening shift. A letter was sent in advance to all ward managers to

notify them of the project and their involvement in the process. The questionnaires were hand delivered to the ward managers of each unit / ward by the Clinical Governance Assistant to ensure distribution to all staff working between 06:45am on 6-4-04 and 06:45am on 7-4-05. The questionnaires were collected by the Clinical Governance Assistant on the day of completion and delivered to the audit department for data entry.

In total, 154 questionnaires were distributed to staff across the various units / wards in the county. This sample included all categories of staff: registered and unregistered staff, therapists, medical, administrative, social services and agency staff.

Staff respondents were not asked to

identify themselves on the questionnaire, thereby maintaining anonymity and allowing the respondents the freedom to express their opinions without fear of reprimand. Upon completion, staff respondents were asked to place the questionnaire in a large envelope that was strategically placed in the unit, as another way of maintaining anonymity.

### Findings: a summary

A total of 126 staff returned completed questionnaires, representing a response rate of 81.8%.

- ◆ 67% of staff respondents were aware that the Trust has a Vulnerable Adults Policy—of these, 64% had actually familiarised themselves with the Policy
- ◆ all of the staff (100%) at three of the units were aware of the Policy, whereas only 19% of staff at another unit had any knowledge of it—however, consideration needs to be given to the number of staff that responded from each unit (range = 22) as this could influence the results when making comparisons across bases
- ◆ only 15.5% of respondents had received a Trust induction relating to the Policy—however, it should be noted that the corporate induction programme has only included a section on the Protection of Vulnerable Adults since 2004, so only individuals who are new to the Trust will have been familiarised with the policy in such a way
- ◆ of those who had not received any Trust induction to the Policy (81% - as 5% did not respond),

**Table 1: Staff Response to: 'where is the policy stored?'**

Places where staff stated policy is stored	Response (actual number)	Response (%)
ward office	16	21.5%
admin / main office	21	28%
managers office	4	5.4%
intranet	2	3%
on shelf with other policies	4	5.4%
meeting room	14	19%
specified room	4	5.4%
unknown	7	9.5%
can't remember	1	1.4%
have own copy	1	1.4%

only 49.5% felt that they actually needed one

- ◆ 94% of respondents stated that they would speak to their line manager if suspecting abuse
- ◆ 60% of respondents felt that it was the responsibility of the person who witnessed the suspected abuse to complete the suspected abuse reporting form
- ◆ 36% of respondents reported that they had been in a situation in the last year where they felt that someone was at risk—60% of respondents reported that they had *not* been in a situation in the last year where they felt that someone was at risk

**Findings: further detail**

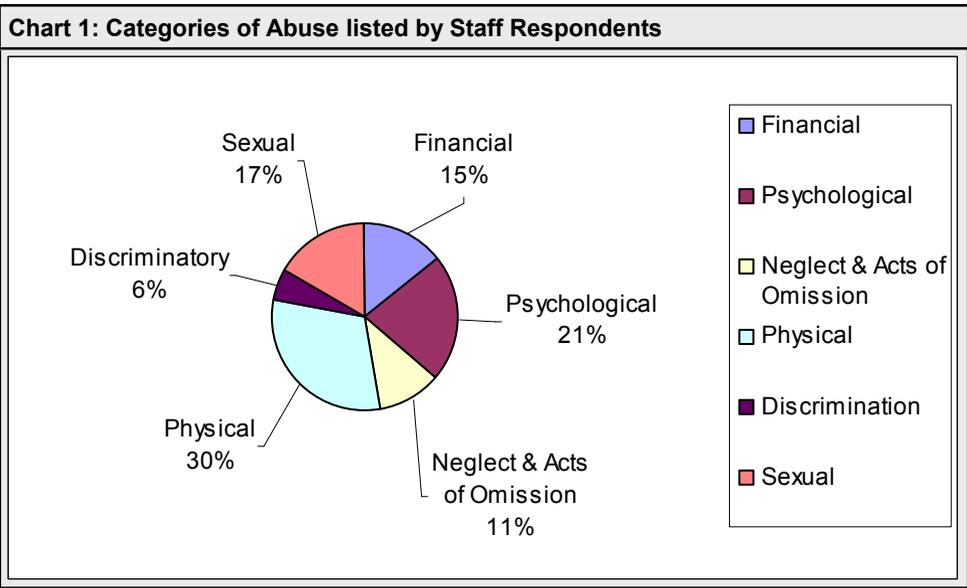
Staff were able to quite clearly define a vulnerable adult with the most common descriptions mentioned being: *a person at risk, mental health problems, someone needing support, unable to*

*look after themselves, difficulty communicating, cannot defend themselves, dependent on others.*

When asked to list the several different categories of abuse (Chart 1), physical (30%) and psychological (21%) abuse accounted for just over half of all responses, whereas only 6% of responses noted discriminatory abuse.

Staff recognised that all of the examples listed as to who could be a suspected abuser were applicable, with all examples receiving a high staff response rate, ranging from 97 – 121 (no. of respondents).

The majority of staff (119) said that they would ‘inform their line manager’ if they suspected abuse—only one person admitted to being ‘unsure’ of who to contact. Encouragingly, no one stated that they ‘would do nothing’. However, this question offered a number of possible responses and there was no restriction as to how many could be



selected, so although 'speaking to the manager' was the most popular answer, a number of other options were indicated by each individual: 'telling a colleague' (47); 'considering the type of abuse' (41); 'confronting the abuser' (29).

A high number of staff knew that it was the responsibility of either the person who witnesses the suspected abuse (75 responses) or the ward manager (61 responses) to complete the appropriate reporting form. A further 16 respondents were unsure and 16 others thought that the person who was being abused should fill in the suspected abuse reporting form.

A variety of responses were given in relation to describing situations where respondents might have concerns about reporting abuse, which included:

- ◆ concerns about the incident causing friction amongst staff
- ◆ the abuser being the line manager
- ◆ causing an awkward situation if the abuser is a fellow care worker
- ◆ the risk of being personally abused as the informer
- ◆ the client being adamant that they don't want the abuse reported
- ◆ a lack of concrete evidence
- ◆ if they knew about the carers (abusers) burden

Encouragingly, there were a number of responses that indicated that staff would not have any concerns about reporting abuse and they felt that all types of abuse should be reported.

## Conclusions

Although awareness of the Policy is relatively high, there is much room for improvement as all staff need to be aware of the Policy and become familiarised with it, without exception.

With only 15.5% of staff receiving a Trust induction to the Policy, it is necessary to increase this number and ideally ensure that: all new staff have a corporate induction; and, all other staff complete a local induction on this Policy. Further enquiries need to be made into how staff can access this.

Although the majority of staff can name different categories of abuse, more education is needed in recognising the individual types of abuse, particularly discriminatory abuse, and how they manifest.

Staff are not clear on what course of action they should take if they suspected abuse, as they mentioned a variety of options. Staff need to be aware of a clear procedure that they must follow in the event of suspected abuse. More staff need to be made aware of whose responsibility it is to complete the suspected abuse form.

The reasons that were given for situations 'where staff would have concerns about reporting abuse' raise important issues about whistle blowing, identifying and collecting evidence, and a perceived lack of support, which need addressing.

## Recommendations

- \* Upon local Induction, staff should be made aware of the Policy and have time to become familiarised with it.

- \* Formal training on the Policy needs to be introduced and made available to all staff.
- \* Staff need to be made aware of where the Policy is stored and to have unrestricted access.
- \* The Protection of Vulnerable Adults Policy needs to be stored in the Trusts Policy folder, in an easily accessible place on all wards and units.
- \* The training programme should aim to educate staff on:
  - ⇒ the definition of abuse
  - ⇒ the different categories of abuse
  - ⇒ the different type of people who could be the abuser
  - ⇒ how to recognise the signs of abuse
  - ⇒ who to report suspected abuse to
  - ⇒ how to preserve evidence of abuse
  - ⇒ how to complete a 'suspected abuse' reporting form
- \* A Protection of Vulnerable Adults Working Group needs to be formed to act as a resource for all operational staff.
- \* There needs to be more support for whistle-blowing which needs to stem from ward / unit managers.
- \* A re-audit will be undertaken within a year, to evaluate improvement.

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## Providing Education on Medication Management: using the action research approach to understand and enhance the effectiveness of teaching methods

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### ACTION RESEARCH

As a follow-up to the action research study presented in edition 1, this paper describes how the action research approach was used to enhance interactive teaching methods.

#### Introduction:

A short skills-based course in medication management for mental health practitioners has been facilitated using more novel and innovative teaching and learning methods (Bradshaw 2002), in helping participants to develop knowledge, skills and attitudes to support their practical application of this evidence-based intervention within the clinical setting (Gray et al 2002). With a co-facilitator colleague, we have increasingly provided demonstrations of new skills, followed by guided role-play and feedback, primarily to directly illustrate and aid the participant's understanding of the principles and key skills involved in a series of collaborative medication management interventions: reviewing the illness history with the client; exploring his/her ambivalence about taking medication; testing beliefs about medication; problem solving; and, planning for the future (Gray et al 2002, Kemp et al 1998).

As a component of an action research study that focused on the application of newly-acquired practical skills following a short course programme in medication management (Butler 2004), my aim for this part of the study was: to identify and understand the style and methods of teaching which help and encourage participants to acquire new skills in medication management—which teaching style and teaching methods help participants to gain knowledge and apply newly acquired skills in medication management?

#### Methodology: *a rationale for the action research approach*

Originating with Kurt Lewin, Kemmis & McTaggart (1988: 5) define action research as: 'a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out...'.

McNiff et al (1996: 12-14), in expanding Bassey's (1995: 6) description, outline a number of characteristic and attractive features of action research: describing, interpreting and explaining events (systematic critical *enquiry*) while seeking to change them (committed, intentional *action*) for the better

(demonstrably worthwhile *purpose*). It is thus a method 'to bring about practical improvement, innovation, change or development' in practice, 'and the practitioners' better understanding of their practices' (Zuber-Skerritt 1996: 83), based on research activity organised by professionals', which involves taking a critical view of existing practice (Webb 1991: 156).

Rather than the uni-directional approach of other forms of research, the action research process develops through a self-reflective cycle or spiral of steps (Bruner 1960, Denscombe 1998, Kemmis & McTaggart 1992), each composed of a cycle of planning, acting (implementing), observing and reflecting about the outcomes of action, towards the achievement of an identifiable end point, achieved through a collaborative process between practitioners and researchers (Griffiths 1990, Webb 1991). Constant monitoring and evaluation of the activity, with the participants, is one of the key principles of the approach (Lauri 1982).

Used in a number of settings which have included nursing and education, action research seems 'highly suited to the kind of problem-solving and evaluation research which the profession needs', being very similar 'to the stages of the nursing process', and encouraging 'practitioners to take control of and change their own work' (Webb 1991: 155). As a discovery approach, Cohen et al (2000) highlight its value in studying teaching methods, learning strategies and evaluation procedures, assisting the continuing professional development of teachers.

Given the above, I considered the action research approach to be appropriate and potentially valuable in investigating, understanding and enhancing aspects of my own teaching practice.

### **Medication Management: an action research side spiral**

My study is represented as a series of self-reflective spirals, one of which is shown in *Fig. 1*: a dynamic side spiral (McNiff et al 1996: 22-23)—a component of the main study (Butler 2004).

### **Methods of Data Collection**

As a component of the main study (Butler 2004), I planned to use two qualitative methods in gaining an insight into my research question.

#### *Semi-structured Group Interview:*

A short semi-structured interview was developed to gain feedback from participants on their perceptions of the helpful and unhelpful methods of teaching and learning. A set of open questions was developed and used flexibly as the basis for a short group interview (Robson 1996: 231), as an efficient, non-threatening way of gathering data with the potential for discussions to develop.

#### *Group & Peer Feedback / Review:*

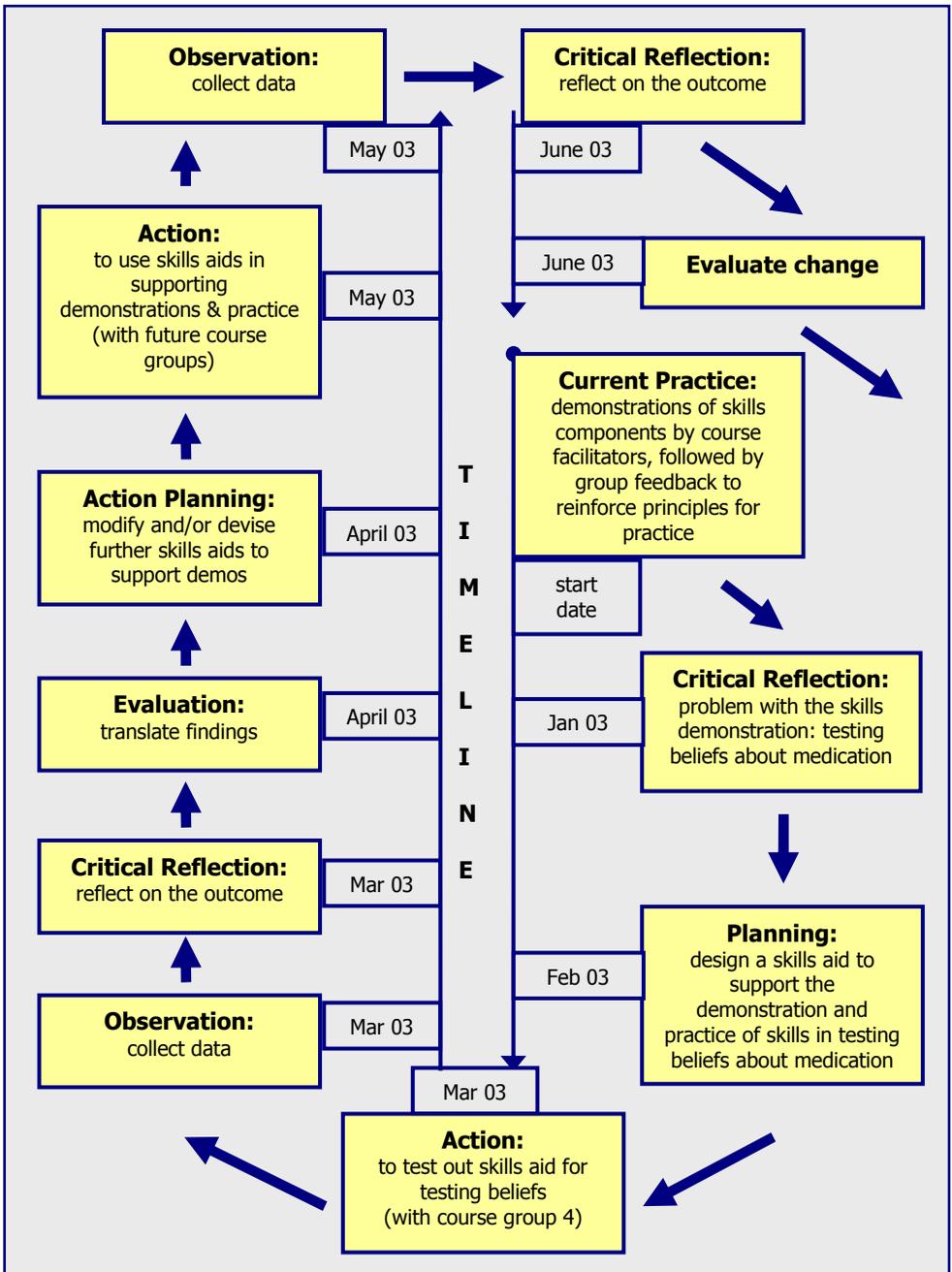
Particularly in investigating my use of skills demonstrations, as a side enquiry, group and peer (co-facilitator) feedback was sought directly after my use of demonstrations.

### **Implementation: data collection and analysis**

#### *Semi-structured Group Interview, representative of participants*

Prior to conducting any group interviews, a briefing sheet and consent for participation was developed (McNiff et al 1996) and a short interview guide was written, tested and modified. An audio-recorded group interview was subsequently held with six participants, as an optimal group size, for about 40-

Fig. 1: action-research side-spiral—enhancing skills demonstrations



minutes, as an acceptable length (Robson 1996: 229). A full transcription of this audio-recording was made.

The value of demonstrations, guided role-play, facilitator and peer feedback were highlighted by several participants as particularly helpful:

**facilitator demonstrations:** *'these particularly helped in showing how to conduct sessions with clients'; 'these were much more useful than the video demonstration (reference to use of an Institute of Psychiatry video) of the 'Illness Timeline' exercise'*

**guided role-play:** *'although difficult for some people, this was valuable in encouraging learning'*

**feedback:** *'it's very useful to get feedback on how you're doing the job'; 'receiving positive feedback on practice was very useful'; 'it was important when taking the role of 'assessor' to get my own opinion in first during feedback, and for it not to be diluted by feedback from others'; '.....you gave positive feedback – whereas I'm thinking I'm rubbish, (that) I won't be able to do it, but you seemed to pick out the things that I brought out... I thought to myself: 'did I really say that?', did I really do that?'... it was quite positive, it made me feel like 'you' can do something'*

Another participant highlighted the value of the **interactive style of presentation:**

*'you can be half way through a presentation and someone will bring something up and you don't sort of 'wait a minute, questions at the end', you let it flow very naturally and you let us contribute, let us join in, just add to the presentation, and you then go right back to where you stopped again... you're not the least bit phased by it, you don't get lost'*

**Group & Peer Feedback & Review:**

During course 3, using a pre-set clinical scenario, I provided a 15-minute demonstration of the use of a cognitive-behavioural practice strategy aimed at exploring and testing the client's beliefs about medication and treatment, adopting the role of therapist, with my co-facilitator as the client. Importantly, my co-facilitator was substituting for my usual co-facilitator and our briefing for this exercise had been very limited. As the third demonstration with this group, I was aware that this had not proved as successful as previously. The participant group (N=15) and co-facilitator provided mixed feedback on my demonstration of the principles of the approach—general feedback is shown in *box 1*.

Following discussion with both course facilitators, a skills worksheet was designed, specifically to support the demonstration and practice of this skills strategy. In addition, the practice and thorough briefing of the various skills demonstrations with my co-facilitators was planned.

During course 4, I demonstrated the same practice strategy using the same clinical scenario, but this time introducing the client to the use of a skills worksheet. Following this demonstration, the participant group (N=10) and co-facilitator provided much more positive feedback—general feedback is shown in *box 2*. Consequently, skills worksheets have been designed for all five skills components of this short course in supporting tutor demonstrations and the application of skills within the participant's clinical practice. These skills worksheets have been validated by my co-facilitator and two other colleagues and are now being tested by participants in clinical practice.

**Box 1: Feedback on Facilitator Demonstration No. 3—by course group 3****What went well?**

1. Good agenda setting
2. Making and reinforcing links to previous sessions with the client
3. Attempts were made to collaborate with the client
4. Reflecting
5. Focused on the nature of the strategy with the client
6. Accepting of the client and acknowledging his concerns
7. Empathic
8. Clarifying, probing and encouraging the client to elaborate
9. Providing useful summarising
10. Clearly establishing homework with the client

**What could I have improved?**

1. To more thoroughly brief my co-facilitator in undertaking the client role
2. To be more prepared for using the strategy with a client
3. Give more of a rationale for the strategy
4. To select and focus on a belief earlier in the session
5. To use a visual sketch when asking the client to rate his level of conviction in the belief statements
6. To plan and take more time, slowing the pace, as this demonstration appeared rushed
7. To ask fewer questions, as this demonstration appeared confusing for the client at times
8. Re-state the client's original belief in his own words, and when considering the client's level of conviction in the opposite of the unhelpful belief, to rephrase this into a positive statement
9. Be more explicit about the homework task
10. To design a worksheet to support the practice of this strategy, as an aid for both the therapist and client

**Box 2: Feedback on Facilitator Demonstration No. 3—by course group 4****What went well?**

1. Good agenda setting
2. Making and reinforcing links to previous sessions with the client
3. Clear evidence of collaboration with the client
4. Reflecting
5. Focused approach
6. Accepting of the client and acknowledging her concerns
7. Empathic
8. Using guided discovery
9. Clarifying, probing and encouraging the client to elaborate
10. Adopted the 'curious style'
11. Providing useful summarising
12. Clearly establishing homework with the client

**What could I have improved?**

1. To give more of a rationale for the strategy
2. To attend to environmental factors
3. To be more explicit about the homework task

**Conclusion & Discussion:**

As a practitioner – researcher, I have gained an understanding of some of the

methods and styles of teaching and support which encourage participants in their acquisition and application of skills,

including the particular value of demonstrations and guided role-play, which to be effective requires: clear guidelines and preparatory practice with co-facilitators; explaining and setting out the sequence of skills involved on a flipchart / whiteboard; performing the skills, which is helped by using a skills worksheet; engaging the group in ensuing discussion to reinforce key principles; providing an immediate opportunity for practice and planning time for constructive feedback, which ideally should begin with the principal role-player – this requires skilful facilitation. This reinforces several of the principles described by Quinn (2000: 348-50).

The action research approach has been especially useful for evaluating and improving my practice, providing me with 'a powerful tool for change and improvement at local level' (Cohen et al 2000: 226), which has encouraged my analysis and reflection of practice, leading to my professional development (Lathlean 1994) and to a more positive attitude towards the value of research activity.

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## Providing a Feeding Improvement Clinic: *a brief update*

**Jan Jones**

**Health Visitor, Heartlands Primary Care Trust**

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### **Background:**

*In July 1999, I was asked, as a member of the clinical audit team, to join a group to look at setting up a pilot scheme for children with feeding problems. At the time, health visitors were still employees of the Community Trust and the multi-disciplinary project group included health visitors, a nursery nurse, dietician and community paediatrician. Having experienced first-hand the distress caused by a toddler who refuses to eat for no apparent reason, I was very keen to be part of this initiative.*

*Following extensive research into this subject by the group, including an investigation of similar clinics in other areas of the country and a training day on feeding problems at Great Ormond Street Hospital, a pilot feeding improvement clinic commenced in January 2001. Their project lead has given the following update. —MQ*

### **Present:**

In Heartlands, children encountering feeding problems continue to be seen at a multidisciplinary Feeding Improvement Clinic. Initially established in 2001 as a pilot service in the Ivel Valley (now Heartlands) area, we work with pre-school children who have faltering growth, in the absence of any organic medical condition.

The age group accepted has changed to include older children: 6 months to 7+ years. Until June 2004, the team had regular input from a community paediatrician, but unfortunately, due to work commitments, future access to the Paediatrician will be via a community clinic.

The aims of the clinic are: to improve feeding behaviour in the age group 0 – 7+ years; to reduce parental anxiety; and, to provide a seamless service.

Our original intention was to extend the service to cover the whole Trust, if successful. However, due to a lack of human resources this has not yet been possible.

Referrals of children, aged 6 months to 7+ years, whose height has crossed through two centiles but whose growth has dropped for at least a 3-month period and for whom core programme interventions have not been successful, are accepted from general practitioners, health visitors and paediatricians.

Audit demonstrates that interventions offered by the multidisciplinary team show a considerable improvement in parental perceptions of their child's feeding problem.

### **Future Plans:**

In September 2004, we will be starting a Food Modelling Group at the Early Excellence Centre, Biggleswade. This will provide social contact through play for parents and children. The group will run once a month.

We have approached CAMH to join our team and they have shown an interest.

We intend to include Obese Children in our remit.

Other areas have expressed an intent in setting up a similar clinic in their localities and we encourage this interest by inviting them to observe clinic sessions and shadowing the key worker.

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